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AN EXAMINATION OF FAITH COMMUNITY NURSING INTERVENTIONS IN THE PROMOTION OF SUCCESSFUL AGING

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ABSTRACT

Background: Faith Community Nursing is a specialty nursing practice providing ongoing supportive health care to community dwellers of all ages. Practicing within the context of a community of faith, these nurses focus on health promotion and disease prevention using their expertise to combine spiritual and physical dimensions of care. As the population of Americans continues to age at a rapid rate, the number of older adults is expected to more than double by the year 2060. Many older individuals live with one or more chronic diseases, however living with a chronic disease does not always require inpatient or home care services. Therefore, other strategies to maintain health, despite chronic disease, are needed. Recent research has been conducted on the range of interventions provided by Faith Community Nurses (FCNs). What is less known is how FCNs are contributing to the health and well-being of community-dwelling older adults in the support of successful aging?

Purpose: The purpose of this study was to describe ways in which FCNs contribute to the health and well-being of older adults to successful aging as well as identify gaps in supportive health care to serve this growing population.

Methods: To examine interventions provided by FCNs, with a specific focus on older adults, a secondary analysis of data from the Henry Ford Health System Faith Community Nursing/Health Ministries Documentation and Reporting System was conducted. Descriptive statistics were used to analyze the distribution of interventions across age groups, and then data was filtered into two distinct age groupings, 0-65 years and 66 years and older, to focus on interventions specifically involving older adults. Data from the 66 years and older age group was then mapped to the multidimensional model of successful aging to reveal how FCNs contribute to the health and well-being of older adults.

Results: Across all age groups, FCNs are promoting health. Large numbers of people are participating in education and support group activities. Nutrition education and healthy lifestyle support groups are two of the most frequently attended group activities. However, when examining group activities for older adults, there appears to be no specific education or support group focused on the 66 years and older age group. The spiritual aspect of care begins to emerge as a support group activity for all ages, and the unique specialty of Faith Community Nursing starts to become more evident in individual interventions. Here, individual intervention contacts with older adults more than double compared to the 0-65 age group, and the intervention of active listening becomes the primary focus. One of the unique features of Faith Community Nursing practice is lack of time constraints for interactions with clients as well as the spiritual aspect of care. When mapped to the model domains, a cluster of group and individual interventions do align with the multidimensional model of successful aging suggesting FCNs are contributing to the health and well-being of older adults.

Conclusion: Considering more than half of the clients seen by FCNs in this study were age 66 and older, there does not exist a clear delineation of education and support group activities specifically for older adults. Greater effort could be put forth in promoting physical and mental health for this age group as well as providing opportunities for social interaction exposure. This study informs and advances research in this specialty practice. It also highlights the contributions FCNs are making to promote health and prevent disease for all age groups. Findings from this study provide recommendations to simplify electronic documentation to improve precision for future analysis and the need for greater care coordination between FCNs and nurse navigators. Further research on the linkage between Faith Community Nursing interventions and outcomes for persons with chronic disease is needed.

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Epigraph

"Trust in the LORD with all your heart and lean not on your own understanding; in all your ways acknowledge him, and he will make your paths straight." – Proverbs 3:5-6

CHAPTER I

INTRODUCTION TO THE STUDY

Overview

Faith Community Nursing is a specialty nursing practice providing ongoing supportive health care to community dwellers of all ages. Practicing within the context of a community of faith, these nurses focus on health promotion and disease prevention by offering a variety of health care services (Dyess, Chase, & Newlin, 2010). While the majority of clients served are over age 55 (McDermott & Burke, 1993), Faith Community Nurses (FCNs) provide health promotion and disease prevention through education, health counseling and screenings, referral and resource advocacy with community health organizations, and coordination of volunteers to share assets (McGinnis & Zoske, 2008). These health professionals use their expertise to combine spiritual and physical dimensions of care (Maddox, 2001). In fact, integrating faith and health is central to the roles of the FCN (Hickman, 2006). There are approximately 12,000 Registered Nurses in the United States (US) who have completed the educational preparation in the specialty of Faith Community Nursing (King & Pappas-Rogich, 2011).

Historically, faith communities have not been considered as sites for health promotion (McCabe & Somers, 2009). However, faith communities are becoming recognized as ideal sites for promoting health, especially for older adults (Rydholm et al., 2008). Currently, 90% of Americans over the age of 65 live with one or more chronic diseases (Dyess & Chase, 2012). According to the Centers for Disease Control and Prevention (CDC), the risk of chronic disease increases with age and presently two out of every three older Americans have multiple co-morbidities (2013). The CDC projects that

by the year 2060, the population age 65 and older is expected to more than double from 43.1 million to 92.0 million (Centers for Disease Control and Prevention, 2013) and will represent one in five U.S. residents (U.S. Census Bureau, 2012). This projected demographic shift will likely place greater demands for chronic disease management on the health care system.

For seniors with chronic illness not requiring inpatient or home care services, other strategies for promoting and maintaining health are needed (McGinnis & Zoske, 2008). A 2008 survey report on the age distribution within United States religious traditions i.e., Evangelical, Mainline Protestant, Catholic, Historically Black, Mormon, Orthodox, Jehovah's Witness, Jewish, and other Christian faiths reveals that between 14% to 23% of participants are age 65 or older and identify with one of the previously mentioned denominations (The Pew Forum on Religion & Public Life, 2008). FCNs are well positioned to serve the health care needs of these older adults.

Statement of the Problem

The range of interventions provided by FCNs, identified from client and nurse perspectives, are well described in the literature (Bergquist & King, 1994; Chase-Ziolek & Gruca, 2000; Dyess et al., 2010; King, 2011; King & Pappas-Rogich, 2011; McDermott & Burke, 1993; McGinnis & Zoske, 2008; Wallace, Tuck, Boland, & Witucki, 2002). Personal interactions between the client and the nurse are focused on health education, counseling, screenings, referral, and emotional support – integrating spirituality within all aspects of care (Chase-Ziolek & Gruca, 2000; McGinnis & Zoske, 2008; Wallace et al., 2002). Still not enough is known about how FCNs are contributing to the health and well-being of older adults in support of successful aging.

This study explored interventions delivered by FCNs through a secondary analysis of data in a large web-based documentation system used by the FCN community. Analysis specifically focused on the distribution of interventions with older adults in relation to the multidimensional model of successful aging. No study to date has explored the distribution of interventions and extrapolated those interventions as they relate to successful aging in older adults. Mapping the documented interventions to the operationalized domains of successful aging will provide a descriptive analysis of how FCNs are contributing to the health and well-being of older adults in support of successful aging. The findings of this study are foundational to shaping FCN practice to meet the demographic demands facing our nation.

Purpose of the Study

The purpose of this study was to describe ways in which FCNs contribute to the health and well-being of older adults. Prior to focusing on interventions targeting older adults, the distribution of services across all age groups were examined using documented records in a large Faith Community Nursing Network. Following the anaylsis of the distribution of interventions across age-groups, analysis of interventions delivered to older adults in relation to the multidimensional model of successful aging ensued.

In order to examine the ways in which FCNs contribute to the health and well-being of older adults, the older adult-specific analysis; identified types of interventions delivered to older adults; and clarified the mode of delivery of interventions (i.e., individual versus group venues). In the final phase of analysis of the interventions, the interventions targeting older adults (both individual and group) were classified to

determine alignment with the multidimensional model of successful aging. In this way, this study provided insights regarding the ways in which FCNs currently support successful aging and opportunities to better serve this growing population. These findings will form the basis of recommendations to enhance the delivery of services by FCNs to support older adults in the community.

Research Questions:

1. *What is the distribution of interventions provided by FCNs across age groups?*
2. *In what ways do faith community nurses contribute to the health and well-being of older adults?*
    a. *What is the distribution of interventions involving older adults currently reported by FCNs in a large network?*
    b. *What is the mode of delivery (i.e., individual or group) of interventions targeting older adults?*
3. *How do the interventions documented by faith community nurses align with the multidimensional model of successful aging?*

Conceptual Framework for the Study

The conceptual framework used to guide the study is the multidimensional model of successful aging by Young, Frick, and Phelan (2009). This model captures the ability of older adults to adapt to physical limitations if psychological and/or social mechanisms are used. The multidimensional model adds strength to tailoring interventions focused on health promotion by recognizing the importance psychosocial factors have in moderating debilitating physical conditions, therefore improving the well-being of older adults. The

model assists health professionals and faith-based organizations to work collaboratively in helping to promote holistic wellness among older adults. The multidimensional model is an adaptation of Rowe and Kahn's 1997 three-factor model which described successful aging as "avoiding disease and disability, high cognitive and physical function, and engagement with life" (pg. 433). Rowe and Kahn's seminal work on successful aging is the basis for the theoretical refinements proposed by Young et al. (2009).

As pioneers in gerontological research, Rowe and Kahn's model was developed to frame and promote understanding of the complex interactions between the physiologic, psychologic, and social relationships that enhance successful aging (Rowe & Kahn, 1997). Their purpose was to propose a distinction between older adults with usual aging (non-pathologic but living with high risk of disease) and older adults aging successfully (living with low risk of disease and experiencing higher functional ability). Their model has been challenged because it underemphasized the effect of lifestyle and other psychosocial factors (Young, Frick, & Phelan, 2009) as well as the contribution of positive spirituality that may improve the health and well-being of older adults (Martin & Gillen, 2014).

In order to address some of these challenges, the model by Young and colleagues (2009) suggests a multidimensional approach to re-framing an understanding of successful aging. Young et al. acknowledged the dynamic interplay among the domains of successful aging in older adults who are living with chronic conditions. For older adults living with one or more chronic illnesses, successful aging may still be accomplished through compensatory mechanisms in the psychological and/or social

domains (Young et al., 2009). As in Rowe and Kahn's work, the three domains of health from this framework include the physiological, psychological, and sociological.

Multidimensional Model of Successful Aging

The multidimensional model of successful aging proposed by Young, Frick, and Phelan (2009) suggests that "successful aging may coexist with diseases and functional limitation if compensatory psychological and/or social mechanisms are used" (pg. 87). To accomplish successful aging by compensating for physiological deficits or limitation, Young et al. propose that greater emphasis can by placed on the mechanisms involved in the psychological and/or social domains such as coping, adaptation, resilience, and spirituality (2009). The purpose of identifying other discernable domains outside of the physiological domain is that psychological and social aspects of aging do not always parallel changes that occur physiologically. By fostering compensatory mechanisms, older adults may perceive a sense of well-being and quality of life that stems from personal fulfillment which can reflect successful aging despite declining physiological or functional health. Identifying other factors that can promote successful aging, FCNs can help to bridge the gap between the increasing need for healthcare among older adults and available health resources to improve older adults sense of well-being (Young et al., 2009).

The multidimensional model integrates three domains of health: physiological, psychological, and social (Figure 1). Where the domains intersect in Figure 1 represents where successful aging is attained. The central shaded area (A) represents those older adults that experience little or no deficit in all three domains. The other three shaded areas (B,C, and D) represent two domains of success. For example, someone with

functional limitations due to multiple co-morbidities may compensate in the psychological and social domains to attain successful aging. The authors identified spirituality as an important construct in the sociological domain that may contribute to health and well-being in older adults (Young et al., 2009). The interventions that incorporate spirituality can be used as a guide for health professionals and faith-based communities.

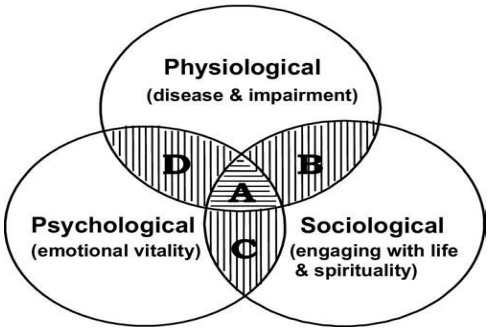


Figure 1. Multidimensional Model of Successful Aging

With multiple pathways or dimensions suggested as representations of successful aging, Young et al. propose that spirituality must be considered alongside engagement with life in the sociological domain and can intersect with either the physiological or psychological domains or both for success in aging (2009). FCNs play a critical role in advocating for those in need and promoting healthy aging. Use of this conceptual model to align FCNs interventions with successful aging will enhance the role and describe how FCNs are contributing to the health and well-being of older adults to promote successful aging.

Definitions of Key Terms

The following definitions are for key terms related to this study. The conceptual definitions related to the theoretical model will be presented in the chapter two literature review.

Faith Community Nursing: "The specialized practice of professional nursing that focuses on the intentional care of the spirit as part of the process of promoting holistic health and preventing or minimizing illness in a faith community" (American Nurses Association & Health Ministries Association, Inc, 2012, pg.1).

Faith Community / Health Ministry Network: A community-based, institutionally supported network of congregations, nurses, and other health ministers designed by the community to help meet the needs of congregations of all denominations and faiths.

Individual Interventions: Documented individual interactions with a patient or client related to spiritual/emotional or relational issues; health/wellness issues; nursing interventions; and advanced care planning conversations.

Group Interventions: Documented group interventions related to education/information activities; screenings; and support groups related to a specific topic. Documentation identifies the number of participants, the time set aside for the class/activity, and cost savings/avoidance developed by each network's reference list.

Religion: "An organized system of beliefs, practices, rituals and symbols designed to facilitate closeness to the sacred or transcendent" (Crowther et al., 2002, p.614).

Spirituality: A personal quest for understanding answers to the ultimate questions of life such as meaning, relationship to the sacred or transcendent, which may (or may

not) lead to or result from the expansion of religious rituals and the formation of community (Crowther, Parker, Achembaum, Larimore, & Koenig, 2002).

Spiritual care: "The practical expression of presence, guidance, and interventions, individual or communal, to support, nurture, or encourage an individual's or group's ability to achieve wholeness; health; personal, spiritual, and social well-being; integration of the body, mind, and spirit; and a sense of connection to self, others, and a higher power" (American Nurses Association & Health Ministries Association, Inc, 2012).

Successful Aging: "a state wherein an individual is able to invoke adaptive psychological and social mechanisms to compensate for physiological limitations to achieve a sense of well-being, high self-assessed quality of life, and a sense of personal fulfillment even in the context of illness and disability" (Young et al., 2009, pp.88-89).

Limitations and Assumptions

The limitations for this study include; 1) the variety of congregations reflected in the documentation is limited both by the target organization and the geographic region of the United States but, the Henry Ford Health System Faith Community Nursing/Health Ministries Network Documentation and Reporting System is one of the largest electronic documentation systems in the United States for FCNs; 2) the predetermined categories for charting may limit the preciseness of actual interventions, both group and individual, but they are reflective of targeted group activities and provide a record of individual interventions.

The following assumptions apply to this study; 1) the data in the Faith Community Nursing/Health Ministries Network Documentation and Reporting System is representative of the actual experience between the FCN and their clients; 2) the sample

is representative of persons receiving health care services from FCNs.

Significance of Study

The population of Americans is aging at a rapid rate, with the number of older adults age 65 and over expected to more than double from 43.1 million to 92.0 million by the year 2060 (Centers for Disease Control and Prevention, 2013). Ninety percent of individuals age 65 and older currently live with one or more chronic diseases (Dyess & Chase, 2012), and presently two out of every three older Americans live with multiple co-morbidities (Centers for Disease Control and Prevention, 2013). Chronic illness is a persistent condition; one for which there is no curative treatment. Older adults live everyday life with chronic disease; their health status does not always require inpatient or home care services. Therefore, other strategies to maintain health, despite chronic illness, are needed (McGinnis & Zoske, 2008). The interventions provided by FCNs to community-dwelling older adults may foster the compensatory mechanisms described by Young et al. to enhance older adults' holistic health status, despite their disease states.

The range of interventions provided by FCNs has been well described in the literature (Bergquist & King, 1994; Chase-Ziolek & Gruca, 2000; Dyess et al., 2010; King, 2011; King & Pappas-Rogich, 2011; McDermott & Burke, 1993; McGinnis & Zoske, 2008; Wallace et al., 2002). However, no study to date has examined documented interventions in relation to a successful aging model that addresses varied domains of health. Research has been conducted on the differences between faith community nursing and other community nursing practice (Bergquist & King, 1994) as well as the perspectives from recipients of faith community nursing care (Chase-Ziolek & Gruca, 2000; King, 2011; Wallace et al., 2002). These studies inform FCN practice; however,

do not provide direction for supporting successful aging.

The significance of this study is amplified since the current focus of the faith community nursing literature has been on providing theoretical frameworks to guide practice advances. For example, Dyess and Chase (2012) conducted a grounded theory describing the processes of faith community nursing practice that could provide a foundation for future middle-range theory development. A more recent study by Ziebarth and Campbell (2016) described a model specific to the role of FCNs to help reduce hospital readmission rates by refining the discharge procedure through the use of collaborative hospital-faith community partnerships. This study will further inform the theoretical basis of faith community nursing practice by illustrating how interventions are distributed across the domains of successful aging.

As the population ages, the demand for older adult-specific care will grow. Medically focused care is instrumental to maximizing physiological health; however, the multidimensional model of successful aging illustrates the importance of interventions that maximize psychological and social health as well. Exploring the current distribution of interventions by FCNs as they relate to successful aging will inform next steps in advancing faith community nursing research. Based on the findings of this study, opportunities to enhance the holistic care of community-dwelling older adults toward successful aging will be identified. Targeted interventions could be implemented and the effect on the older adults' sense of well-being could be tested. Eventually, an analysis of cost savings and avoidance attributable to the supportive care provided by FCNs could demonstrate the value of services provided by FCNs. As an important component of the continuum of healthcare available in the community, FCNs are well-positioned to support

older adults in the community. This study provides foundational information that will permit strategic advancement of the specialty to better meet the needs of growing numbers of older adult clients.

Chapter Summary

Faith Community Nursing is a unique and specialized area of holistic nursing practice that influences several dimensions in the lives of individuals, families, and groups within a faith community. While the practice of this nursing specialty has grown regionally, nationally, and internationally, research that focuses on Faith Community Nursing has not experienced comparable growth. This study will answer the question of how Faith Community Nurses are contributing to the health and well-being of older adults by: identifying the types of interventions delivered to older adults; and clarifying the mode of delivery of interventions (i.e., individual versus group) targeting older adults provided by FCNs in the faith community. Further analysis of how group and individual interventions align with the multidimensional model of successful aging will illustrate how FCNs are contributing to the health and well-being of community-dwelling older adults.

CHAPTER II

REVIEW OF RELATED LITERATURE

Introduction

Faith Community Nursing is a model of care providing holistic interventions within a faith or religious setting. Intentionally integrating faith with holistic care, a Faith Community Nurse (FCN) provides health promotion and disease prevention through education and personal counseling, screening, collaboration and advocacy for needed medical care and other non-clinical nursing services (Dyess et al., 2010; King & Pappas-Rogich, 2011; McDermott & Burke, 1993; McGinnis & Zoske, 2008). Approximately 12,000 nurses in the United States have received educational preparation to assume the role of an FCN (King & Pappas-Rogich, 2011). This specialty nursing practice can be found in an estimated 23 countries around the world (Church Health Center, 2015). Empowering others to take responsibility for their health, FCNs provide support to individuals and families through all stages of life.

In a descriptive study of Faith Community Nursing practice, nineteen FCNs who practice in 22 faith communities in a specific region of the US revealed that 71% of the clients receiving care from FCNs were between the ages of 60 and 80 years (Weis & Schank, 2000). With 90% of Americans over the age of 65 living with one or more chronic illness (Dyess & Chase, 2012), increased demands will be placed on the current healthcare system to meet these health care needs. For older persons with chronic illness not requiring inpatient or home care services, other ways of promoting and maintaining health are needed (McGinnis & Zoske, 2008). The church has been identified as an ideal place to educate and provide caring, instructional support to persons with chronic illness

(Bergquist & King, 1994; Dyess & Chase, 2010; Lewis, 2011). While the range of interventions provided by FCNs has been identified from the client and nurse perspectives (Bergquist & King, 1994; Chase-Ziolek & Gruca, 2000; S. Dyess et al., 2010; King, 2011; King & Pappas-Rogich, 2011; McDermott & Burke, 1993; McGinnis & Zoske, 2008; Wallace et al., 2002), not enough is known regarding the documented interventions of FCNs and how they are contributing to the health and well-being of older adults.

This chapter will focus on empirical findings related to Faith Community Nursing, the supporting theoretical framework of successful aging that will guide this study, and the health of older adults. The review of literature includes research articles published in peer-reviewed journals describing the history of Faith Community Nursing; the roles and interventions of FCNs; clients' perceptions of Faith Community Nursing; the evolution of the concept of successful aging and the supporting theoretical framework; as well as health in older adults. Databases searched for relevant literature consisted of CINAHL, PubMed, JSTOR (Journal Storage), and a frequently utilized database for religious based literature, ATLA (American Theological Library Association). The search terms used were; faith community nursing, parish nursing, health promotion, disease prevention, spirituality, older adults, and successful aging. Many of these terms were cross-referenced by using "and" to combine terms and narrow the search. The chapter will conclude with a summary of the literature review.

Faith Community Nursing

Historical Perspective

Faith Community Nursing was initiated in the United States in 1984 by the Reverend Granger Westberg, a Lutheran minister. Rev. Westberg implemented a pilot project to place registered nurses in faith communities to provide ongoing nursing care to community dwellers (Pappas-Rogich & King, 2013). Called parish nursing at the initial inception because the nurses were placed in Christian faith communities, the title was officially changed to faith community nursing in 2005 by the American Nurses Association (ANA) in collaboration with the Health Ministries Association (HMA) to reflect a broader range of faiths (Dyess et al., 2010).

Recognized by the American Nurses Association (ANA) since 1984, the first Scope and Standards of Practice was published in 1998 and revised in collaboration with the Health Ministries Association in 2005. Faith community nursing is defined by the ANA as "the specialized practice of professional nursing that focuses on the intentional care of the spirit as part of the process of promoting holistic health and preventing or minimizing illness in a faith community" (American Nurses Association & Health Ministries Association, Inc, 2012). A basic FCN foundations course has been developed by the International Parish Nurse Resource Center (IPNRC). It is offered throughout the United States at a number of faith and academic institutions for a fee over a period of days or weeks (McGinnis & Zoske, 2008). Currently offered at forty-seven institutions throughout the United States and Canada, this training course is specifically designed to provide an understanding of the focus and tasks of the ministry. Other courses are also offered for educational partners and network coordinators. As of 2011, there were more

than 120 educational partners teaching parish/faith community nursing in their communities and on-line (Church Health Center, 2016).

Acknowledged as the one of the "fastest growing specialties in nursing" (McGinnis & Zoske, 2008), there are limitations and barriers to introducing FCNs within faith communities. Lack of knowledge regarding the role can result in limited congregational and clergy support as well as a shortage of funds for financial assistance (Thompson, 2010). To enhance understanding of the specialized practice of faith community nursing, a brief description of the role will also include the specific nursing interventions primarily used by FCNs. How these interventions are reflected within the theory of successful aging will be discussed in a later section of this chapter.

Roles and Interventions of FCNs

Focused on health promotion and disease prevention, FCNs address the physical, emotional, cultural, and spiritual needs of faith communities (Bergquist & King, 1994; Dyess et al., 2010; McGinnis & Zoske, 2008; Swinney, Anson-Wonkka, Maki, & Corneau, 2001). The roles of FCNs have been sufficiently identified in descriptive studies as health educator, personal health counselor, referral source, liaison with community resources, and coordinator of volunteers and support groups (Bergquist & King, 1994; Dyess et al., 2010; King & Pappas-Rogich, 2011; McDermott & Burke, 1993; McGinnis & Zoske, 2008). Interventions have been identified from a small sample of studies through survey questionnaire or situational contact with FCNs (Dyess et al., 2010; King & Pappas-Rogich, 2011; McDermott & Burke, 1993; McGinnis & Zoske, 2008). The interventions listed here, while not exhaustive, are identified as those most frequently performed. They include health screenings; visitation to the hospital, home, or long-term

care setting; health teaching; phone calls; referrals to physicians, clergy, or home care programs; personal health counseling; program development and management; active listening; and newsletter development (Dyess et al., 2010; King & Pappas-Rogich, 2011; McDermott & Burke, 1993; McGinnis & Zoske, 2008). To determine the specific interventions appropriate for population-based wellness and program planning a needs-assessment survey is distributed to adult members of the faith community.

A faith community needs-assessment determines the health status of the faith community members as well as their perceived health needs and barriers to meeting those needs. The survey assesses health-related beliefs and needs, which encompass physical, emotional, relational, spiritual, and health system realms. The results of the needs-assessment can assist FCNs to determine their faith community's demand for a health ministry program as well as future health education programs (Matteson, Reilly, & Moseley, 2000; Miskely, 1995; Swinney et al., 2001).

McGinnis and Zoske (2008) examined the characteristics of faith community nursing with particular attention directed to the nurse's employment status and congregational needs. Surveys were mailed to 1,825 FCNs. A 35% response rate revealed 87% of faith community nurses volunteered their nursing expertise in a faith community setting and 72% anticipate they would remain in the role for two additional years. The most common health issues addressed by faith community nurses are chronic disease (67%), stress (34%) and nutrition/obesity issues (29%).

The holistic care provided by FCNs to promote health and well-being were interwoven with the five broad categories of professional nursing practice by Bergquist and King (1994). The purpose of their work was to initiate development of a conceptual

framework to help define the practice of faith community nursing as separate from other holistic nursing practices. Extrapolating specific components of the concept of Faith Community Nursing into the five broad categories of client, health, nurse, environment, and the nursing process, Bergquist and King provide a rich description of the differences between faith community nursing and other holistic nursing practice. Examples of interventions within each category are as follows:

Clients are individuals or families across all age groups within and outside of the faith community. Those within the faith community may contact the FCN regarding concerns about medication, diet, grief and loss, chronic illness problems, parenting or relationship issues or a multitude of health promotion issues. For individuals not associated with a faith community, their first contact with a FCN may be at a church-sponsored health fair or blood pressure screening.

Health incorporates spiritual care emphasizing the sanctity of the body, strength in times of grief, a source for self-esteem, and emotional well-being through prayer.

The nurse is a Registered Nurse, identified as being spiritually mature and trained to fulfill various health care roles such as health educator, health counselor, leader of groups and individuals, as well as a community liaison.

The environment of the faith community setting, such as a church, temple or synagogue, is a unique natural setting for support, which includes an extended family of caring individuals.

The practice of the FCN promotes holistic wellness within the categories of body, mind, and spirit to reflect an interrelationship between the physical, emotional, and spiritual (Bergquist & King, 1994).

The five broad categories provide a framework for organizing the concept of this specialty nursing practice, but further research is needed to validate each component. To assist in the development of a research model related to faith community nursing, Dyess and Chase (2012) investigated the processes of faith community nursing practice in a grounded theory study.

Using situational stories, Dyess and Chase (2012) recorded and transcribed, as written narrative reflections, encounters amongst three practicing FCNs and clients receiving care in the 1990's. The researchers used the techniques of generalized coding, memoing, and constant comparison to identify four core processes of faith community nursing practice. The four processes of faith community nursing practice that emerged from the analysis may provide a preliminary description for future middle-range theory development. However, the small number of FCNs recruited for the study is an important limitation. The four core processes were described as being non-linear and bi-directional, they include the following:

1). Entering the private world of another through invitation with no time constraints for interaction allows for a deeper and more personal encounter along with shared commonality of a faith relationship.

2) Connecting faith to the encounter provides an opportunity for prayer and sharing of scripture. There was also a sensitive connection to faith community resources and texts between the FCN and the client.

3) Both parties benefit from the encounter through relationship development resulting in a mutually transforming experience.

4) Access to community resources and providing individualized guidance through health counseling, education and follow-up care provided assistance with achieving sustained health (S. Dyess & Chase, 2012).

The limited quantity of research findings related to faith community nursing reveals that the holistic practices performed by FCNs consistently address health concerns often encountered in community health settings. However when compared with traditional community health nursing practice, the unique feature of faith community nursing is the intentional use of spiritual and religious practices. Differentiating this single aspect of care will be discussed further.

Client Perspective

Only three studies have examined the client perceptions of faith community nursing. Chase-Ziolek and Gruca (2000) used naturalistic inquiry to understand the unique qualities of nursing care received from a FCN compared to care received from nurses in acute or office visit care. An ethnographic study by Wallace, Tuck, Boland, and Witucki (2002) explored the usefulness of FCNs in the provision of health care from the perception of the client. A more recent study by King (2011) described the role of the faith community nurse from the client perspective and asked the participants why they chose the FCN for health care services.

Chase-Ziolek and Garcia (2000) analyzed interviews conducted in 1998 with 11 recipients of faith community nursing care. The researchers identified two main categories that help describe the nursing care provided in a faith community setting. In both categories, the clients described the quality of the nurse/client interaction and the quality of the church environment as a site of care. Faith community nursing was also

found to enhance other traditional care services in two significant areas. Clients noted the personal level of care provided and the feeling of self-empowerment established to allow them to communicate better with other health care professionals from an informed approach (Chase-Ziolek & Gruca, 2000).

Five themes emerged in the ethnographic study by Wallace et al. (2002) to describe client perceptions of the usefulness of care provided by the FCN. The five themes were: being available; integrator of spirituality and health; self-help promoting; understanding what a FCN does; and evaluating the effectiveness of the role (Wallace et al., 2002). Overall, the clients in the Wallace et al. (2002) study viewed the FCN as a valuable link between the physician, the acute care setting, and the client in providing continuity of care.

An exploratory descriptive study by King (2011) surveyed a purposive sample of 17 faith community members with a seven-item demographic questionnaire along with face-to-face interviews. The face-to-face questions focused on functions of faith community nursing identified by the IPNRC, ANA and Health Ministry Association (HMA). The analysis of the members' descriptions of the care revealed holistic care descriptors such as an interconnectedness of body, mind, spirit, and environment (King, 2011). The researcher concluded that what separates faith community nursing from other community care settings is the spiritual aspect found within holistic care.

Acknowledged by the ANA with recently revised scope and standards for practice, faith community nursing is recognized as a model of care provided by nurses within a faith community to its members and those that encounter the faith community. Working within the scope of faith community nursing practice, FCNs can assist

individuals to adapt to physical limitation through education and counseling thereby reducing hospitalization, ER visits, and associated costs by averting adverse medical events through early intervention. With the majority of clients served by FCNs over the age of 55, aligning interventions with the framework of successful aging will help to describe and quantify the effects of faith community nursing programs on community health.

The Theoretical Framework of Successful Aging

Rowe and Kahn's Model of Successful Aging

Successful aging research has a long history as evidenced by its emergence in the gerontology literature dating back to the first conceptual definition by Havighurst in 1961. At that time, successful aging was seen as an adaptable and testable experience described as life satisfaction encompassing the positive characteristics of aging (Katz & Calasanti, 2014). When Havighurst postulated that "individuals will age as they have lived" (pg. 6), he was suggesting that aging assumes a life course perspective drawing upon developmental processes such as early childhood influences and lifestyle preferences as predictors of successful aging attainability (Stowe & Cooney, 2014).

Rowe and Kahn focused on more objective criteria, identifying with societal trends and an individualistic perspective influenced by lifestyle, cognitive, and physical factors (Katz & Calasanti, 2014; Pruchno, Wilson-Genderson, Rose, & Cartwright, 2010). In 1987, Rowe and Kahn first introduced a distinction between usual aging and successful aging. They defined usual aging as the normal non-pathologic changes that occur with aging. These non-pathologic changes involve hearing, vision, renal function, glucose tolerance, systolic blood pressure, bone density, pulmonary, and immune

function. In successful aging, positive extrinsic factors such as diet, exercise, and nutrition, or negative extrinsic factors such as tobacco use, alcohol intake, and sedentary lifestyle can effect aging (Rowe & Kahn, 1987). Again, if usual aging associated declines can be modified by these identified extrinsic factors, avoidance or even reversal of functional loss associated with usual aging can be achieved. As well, adverse health outcomes may be reduced or avoided through positive extrinsic factors. The researchers also considered psychosocial factors such as autonomy or the ability to make decisions, as well as social support or the connectedness to family and friends as multiple influences on successful aging (Rowe & Kahn, 1987). In 1997, Rowe and Kahn added the three components of successful aging which helped to form an initial definition. Each of the three components of successful aging will be disseminated against usual aging and aging successfully in Table 2a.

Table 2a. Components of Successful Aging applied to Usual Aging and Aging Successfully

Three components of Successful Aging	**Usual Aging**	**Aging Successfully**
Physiologic (disease and impairment)	Reduced physical activity and higher body mass index	Moderate to strenuous levels of exercise activity, diet-induced weight loss, pulmonary peak expiratory flow
Psychologic (emotional vitality)	Age-related reduction in functional reserve capacity or cognitive losses (inductive reasoning and spatial orientation)	Perceived self-efficacy in solving cognitive problems enhances plasticity (capacity for positive change), years of schooling
Sociologic (engagement with life)	Lack of connectedness to others and isolation	Emotional support from family and friends

Once defined as the linkage between various physiologic and psychosocial variables impacted by positive intrinsic factors supported through health promotion and disease prevention in the elderly (Rowe & Kahn, 1987), in 1997 the same researchers defined successful aging occurring at the intersection of three newly identified

components (see Figure 2). Rowe and Kahn (1997) define successful aging as including three main components: low probability of disease and disease-related disability, high cognitive and physical functional capacity, and active engagement with life. These three elements associated with Rowe and Kahn's definition of successful aging will be further elaborated upon later in this section.

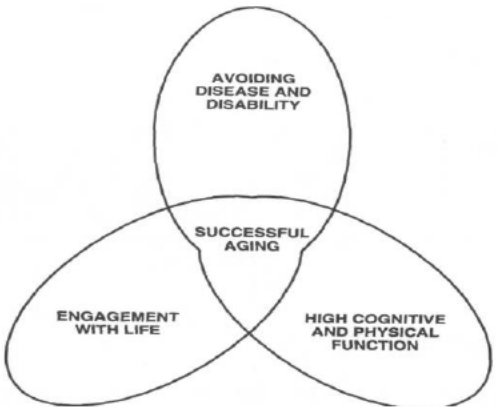


Figure 2a: Rowe and Kahn's Model of Successful Aging

Cited and utilized currently in thousands of successful aging publications (Stowe & Cooney, 2014), the concept of successful aging depicts decline and loss as modifiable factors. What this concept has failed to include is the opportunity to view successful aging from a developmental perspective as well as from individual and cultural interpretations (Stowe & Cooney, 2014). An attempt to reach consensus on a definition for successful aging reflects the ongoing struggle to understand the important influence of these factors. Each of these factors will be discussed as an attempt to clarify why there is a lack of universal agreement on how to define and measure successful aging.

Early life influences and contemporary behaviors can act as modifiers on the subjective and objective dimensions of successful aging. Early life influences such as gender, genetics, ethnicity, education level, environmental conditions and risks, and

family circumstances and relationships can result in long-term consequences, which are either positive or negative. These early childhood influences can be predictive of late-life outcomes making successful aging unattainable for some (Pruchno et al., 2010; Stowe & Cooney, 2014). Contemporary behaviors such as marital status, employment, volunteer capacity, tobacco use, alcohol consumption, body mass index, exercise, social support, and religiosity are critical determinants of successful aging (Pruchno et al., 2010). When successful aging is viewed from a lifelong perspective, objective and subjective indicators can help to identify people successfully aging.

The lack of a universally agreed upon definition for successful aging is due in large part to participants' perceptions of the concept. The perceptions of aging individuals may differ from those of theorists and researchers (Stark-Wroblewski, Edelbaum, & Bello, 2008). The subjective dimension by older adults adds to the definition of successful aging. A number of coping strategies identified by older adults to achieve successful aging were acceptance; attitude; adaptation; emotional well-being; and resilience (Montross et al., 2006; Romo et al., 2013; Stark-Wroblewski et al., 2008). When older adults were asked what successful aging means to them, there was a shift from viewing aging as unsuccessful due to functional impairment as the result of disease and disability (Katz & Calasanti, 2014), to aging successfully within the same context when spirituality and social engagement with life were involved (Romo et al., 2013). In other words, older adults who do not meet the objective criteria for successful aging outlined by Rowe and Kahn often still perceive themselves as aging successfully (Romo et al., 2013). These findings support the notion that self-report of successful aging may be more valid than research criteria.

A lack of consensus on a standard definition for successful aging continues to exist (Hilton, Gonzalez, Saleh, Maitoza, & Anngela-Cole, 2012; Stark-Wroblewski et al., 2008; Young et al., 2009). While there is no consistent definition, there is a long list of alternative terms used to describe successful aging. The alternative terms are *healthy aging, aging well, effective aging, productive aging, resourceful aging, independent aging, active aging, positive aging, and meaningful aging* (Hilton et al., 2012; Katz & Calasanti, 2014; Strawbridge, Wallhagen, & Cohen, 2002). Despite the fact there have been modified interpretations of successful aging since the model by Rowe and Kahn, a critique of the core components embedded in the construct will follow.

Since 1987, when Rowe and Kahn proposed successful aging as individuals with little or no age-related decrements compared to those aging "usually", an expanded definition to include three components resulted in the recognition of environmental and lifestyle factors that could improve well-being (Strawbridge et al., 2002). These very broad areas of functioning: physical, functional, cognitive, as well as social engagement will be discussed as determinants of the outcome of successful aging.

Avoiding disease and disability can be viewed from a lifelong aging perspective. Through effective prevention and intervention approaches, there is potential to influence outcomes across the lifespan. According to Rowe and Kahn, the probability of disease is related to risk. These include intrinsic risk factors such as heredity or genetics and extrinsic risk factors that include environment, lifestyle, and modifiable variables such as BMI, nutrition, and exercise (Rowe & Kahn, 1997).

Maximizing cognitive and physical function as the second component identifies the potential capacity for active engagement, "what the person can do" (pg. 433).

Predictors of high cognitive and physical function include educational level, engaging in strenuous activity, peak pulmonary flow rate, and self-efficacy (Rowe & Kahn, 1997).

Engagement with life, the final component, has to do with maintaining interpersonal relations and engaging in productive activities. These include being part of a social network that encourages socio-emotional expression through relationships with family and friends. As people age, they tend to engage in fewer hours of paid work but continue to provide informal work through unpaid help-giving and volunteer work (Rowe & Kahn, 1997).

People can move in and out of success in aging as there is a static nature to the model when it focuses on individual influences on outcomes and considers the life-long influences as determinants of successful aging. The components identified can provide long-term consequences, both positive and negative. However, since the model's initial development over 20 years ago, the groundwork for academic inquiry and framework to understand successful aging has been tested. The following discussion will highlight how Rowe and Kahn's framework has been used, and its validity examined.

As mentioned earlier, Rowe and Kahn's 1997 expanded definition of successful aging includes three objective criteria. The expanded definition recognizes the environmental and lifestyle factors that could improve or detract from well-being. These factors impact successful aging with the presence of chronic illness or multiple comorbidities. The framework appears to have a solid foundation built on the three objective criteria, however the multiple factors imply that there are winners and losers in achieving success with aging (Strawbridge et al., 2002). Several studies have used Rowe and Kahn's operationalized definition of successful aging but have considered other

perspectives such as subjective well-being (Liu & Richardson, 2012; Montross et al., 2006; Romo et al., 2013; Strawbridge et al., 2002), life course perspective (Pruchno et al., 2010; Stowe & Cooney, 2014), and spirituality (Stark-Wroblewski et al., 2008; Vance, Struzick, & Raper, 2008). With the inclusion of the three previously mentioned components, the number of chronic illnesses experienced by an older adult limits the ability of the individual to be associated with the definition of successful aging.

Many researchers (Liu & Richardson, 2012; Montross et al., 2006; Peterson & Martin, 2015; Pruchno et al., 2010; Romo et al., 2013; Strawbridge et al., 2002) have debated Rowe and Kahn's conceptualization. Some argue for the inclusion of subjective well-being such as health, income, and marital status, the so-called "structural factors" that enable successful aging (Liu & Richardson, 2012; Pruchno et al., 2010; Strawbridge et al., 2002). Other subjective inclusion criteria are living situation, degree of everyday functioning, and resilience (Liu & Richardson, 2012; Montross et al., 2006). The one component, engagement with life, has been shown to contribute to improved subjective well-being. Health satisfaction, engagement with work, and socialization have also been identified as significant factors that contribute to successful aging (Liu & Richardson, 2012; Montross et al., 2006).

The strength of Rowe and Kahn's model is the ability to build upon a solid framework of components using alternative concepts that either build or detract from the capacity to successfully age. These can include social factors such as employment and income patterns, ethnic minority status, and the influence of negative or positive early life effects. The model's individualistic perspective draws upon individual choice and effort

as determinants of successful aging although current researchers are positing that life changes or influences limit individual options and choices (Katz & Calasanti, 2014).

Missing from Rowe and Kahn's model are external factors that either prevent or enable successful aging (Peterson & Martin, 2015). These external factors include personality and mental health aspects. According to Peterson and Martin (2015), when viewed from this perspective, successful aging should focus more on the substance of aging, not on the success or failure (pg. 10). Also lacking within the Rowe and Kahn model of successful aging is the spiritual component, which has been identified by older adults as a vital dimension of overall successful aging (Iwamasa & Iwasaki, 2011).

In a systematic review of the gerontology literature, Martinson and Berridge (2014) argue that the shortfalls in successful aging models are the narrow criteria limiting successful aging to "near perfect health". The missing subjective measures, as well as the oversight of a variety of socio-structural contexts of aging, lead the reader to conclude that these blinding influences decrease the conceptual clarity of successful aging. A shift in the successful aging paradigm is in order.

Modification of the model to incorporate coping and other external strategies is essential. Since health, wellness, and improved quality of life are becoming national priorities, the growing older adult population has created opportunities for health care providers to emphasize health promotion and illness prevention (Liu & Richardson, 2012). Identifying factors associated with successful aging has become a critical healthcare agenda item (Stark-Wroblewski et al., 2008). Spirituality has been identified as an internalized resource to help buffer the adverse effects of aging with chronic illness and described as a resource to help in disease management. Community organizations

such as churches, who aim to develop religious practices and rituals, can also offer resources to assist older adults to adapt to the normative changes of aging (Romo et al., 2013; Vance et al., 2008).

Incorporating spirituality as a separate component of the model of successful aging was introduced by Crowther, Parker, Achenbaum, Larimore, and Koenig in 2002. Limited research has used this expanded component; however, the groundwork has been laid to examine the significance of spirituality in contributing to successful aging research. The following discussion will present the revised version of Rowe and Kahn's model by Crowther et al.

SA Revisited: Integrations of Positive Spirituality

The year 2013 marked the 110th anniversary when Metchnikoff declared the discipline of gerontology the scientific study of old age. At that time, Metchnikoff noted that spiritual needs must be considered alongside the physical needs of the older adult. When Rowe and Kahn expanded their model of successful aging in 1997 to include the three components; physical, psychological, and social, participation in religious activities was considered a source of social engagement. While their model did include this vital need, they neglected to address fully the contribution of spirituality in health and well-being later in life. Crowther and colleagues addition of positive spirituality to Rowe and Kahn's model created a much needed four-pronged approach acknowledging that spirituality extends beyond the medical purview of successful aging (Martin & Gillen, 2014).

Crowther et al. (2002) argue that positive spirituality is a missing separate component in Rowe and Kahn's model of successful aging. Positive spirituality should be

included because it addresses the interrelatedness between the older adults' beliefs and values and the efficacy of interventions focused on successful aging. These researchers maintain that the expanded model will enhance the percentage of seniors who age successfully by affirming this significant and positive aspect of their lives.

The authors of this enhanced model concur that the three biological, psychological, and social components of Rowe and Kahn's model are part of the overall system that defines successful aging. They argue that positive spirituality is the missing component in the spiritual process. They describe the original three elements as temporarily related to one another, identifying weaknesses and strengths that must be considered as individual characteristics and as contextual factors in successful aging. However, they too never succinctly define the construct of successful aging (Crowther et al., 2002).

Positive spirituality is identified as a core construct in the enhanced version of Rowe and Kahn's model of successful aging. Using aspects of both religion and spirituality within the context of health, Crowther, et al. (2002) refer to positive spirituality as developing an internalized personal relation with the sacred or transcendent thereby promoting wellness and welfare for self and others. The internalized personal relationship with the sacred or transcendent is not bound by race, ethnicity, economics, or class thereby promoting the wellness and welfare of self and others (Crowther et al., 2002; Martin & Gillen, 2014; Parker et al., 2002). It is important to note that in defining positive spirituality, Crowther et al. make a point of defining and distinguishing religion and spirituality to provide clarity and consistency in applying this construct.

Within the Crowther et al. model, the four successful aging components were elaborated upon (see figure 3). Incorporating the expanded version of Rowe and Kahn's model of spirituality as a community model of health promotion, each component will be briefly discussed as it relates to community health issues.

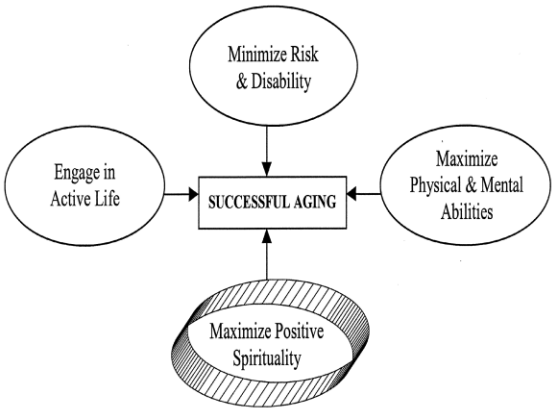


Figure 2b: Revised Rowe and Kahn Model of Successful Aging

Minimize risk and disability can be emphasized by risk screening and assessment.

Maximizing physical and mental abilities can be promoted by fitness activities, memory enhancement, medication adherence teaching, and driving safety.

Engage in active life can be addressed by informational seminars on health insurance and Medicare, caregiving and grand-parenting issues, dementia recognition, and legal issues.

Positive spirituality can be encouraged by spiritual growth and development exemplified by serving God in the community, end of life care, and pastoral support (Crowther et al., 2002).

The revisited model as it relates to the concept of positive spirituality has seen limited use in current research (Flatt, Settersten, Ponsaran, & Fishman, 2013; Parker et al., 2002; Wiles, Wild, Kerse, & Allen, 2012). However, it is important to discuss the

initial findings. One of the noteworthy findings from an exploratory study of older adults understanding of living with chronic illness is the characteristic of resilience as a result of relying on spiritual and religious practices. Resilience was characterized as having a positive attitude, counting one's blessings, and keeping busy. Some of the 121 older adults interviewed revealed that their beliefs helped them sustain a particular attitude towards life which provided a sense of purpose contributing to well-being. If an individual was weak or struggling in one area of successful aging, they became resilient in another capacity (Wiles et al., 2012).

The second noteworthy finding was the use of the revisited model to implement a spiritually based community model of health promotion. Emphasizing an ecumenical spirit of community, groups worked together with a focus on older adults in the faith setting. Collaboration among healthcare providers, academic institutions, and faith communities was maximized (Parker et al., 2002).

Use of the expanded Rowe and Kahn model has the potential to unify religious communities around the task of promoting successful aging. Older adults who may have been previously suspicious of traditional health promotion messages can therefore receive accurate health information regarding lifestyle and screenings within an atmosphere of trust and security (Parker et al., 2002).

Further research is needed on the role of spirituality in successful aging as a conceptual component within a theoretical framework. The use of spirituality in aging within different contexts and observational studies can guide researchers and clinicians to the appropriate resources for supporting and strengthening older adults to age successfully.

Churches and other religious organizations have been shown to enhance personal networks and empower seniors for leadership. By providing support with day-to-day tasks and emotional care, churches play a vital role for aging members in the community and the healthcare setting. The use of the expanded model has the potential to unify faith communities around the task of promoting successful aging (Parker et al., 2002).

Reminded of Havighurst's statement from 1961 that no single theory can account for the variety of meanings that surround successful aging (Martin & Gillen, 2014), there have been limited studies that have utilized this expanded model since it was first introduced in 2002. The current Rowe and Kahn model of successful aging does not account for people who remain engaged with life and have a quality of well-being despite experiencing physical dysfunction. However a new multidimensional model introduced by Young, Frick, and Phelan (2009) captures the ability of older adults to adapt to physical limitation through other domains and can still be deemed successfully aging. What follows will be a discussion of that model.

Multidimensional Model of Successful Aging

Young, Frick, and Phelan (2009) proposed domains that capture the adaptability or ability to compensate for physiologic limitations. In their model, successful aging can be accomplished by an emphasis on the psychological and/or social domains. This model implies a more graded approach to measuring successful aging, one that is less dependent on success in all domains of aging. These researchers emphasize multiple pathways to successful aging or multiple dimensions including physical and functional, social, and psychological (Young et al., 2009).

While there still is no consistency across definitions of successful aging, which includes an extensive list of alternative concepts as previously mentioned, what is congruent are the multiple pathways to successful aging. It is important to emphasize that older adults can experience happiness and well-being by compensating for their physical loss by relying on psychological and social resources regardless of their level of functioning (Hilton et al., 2012).

Young et al., who developed the multidimensional model, postulate another definition of successful aging based on the measurable domains. Successful aging is "a state wherein an individual is able to invoke adaptive psychological and social mechanisms to compensate for physiological limitations to achieve a sense of well-being, high self-assessed quality of life, and a sense of personal fulfillment even in the context of illness and disability" (Young et al., 2009). The purpose of identifying other measurable domains outside of physical function and absence of disease is to recognize other factors that can promote successful aging. The multidimensional approach can help to bridge the gap between the increasing need for healthcare and available resources (Young et al., 2009).

Integrating the three domains; physiological, psychological, and social will now be elaborated upon.

Physiologic domain is measured by two components: the presence of comorbidity, which considers 18 of the most prevalent chronic conditions experienced by older adults; and functional impairment which include seven physical performance variables measured by level of difficulty (Young et al., 2009).

Psychological domain is measured by three components: cognitive function, measured by the Mini-Mental State Examination (MMSE); emotional vitality such as personal mastery, happiness, and low anxiety; and geriatric depression measured by the Geriatric Depression Scale (GDS) (Young et al., 2009).

Sociological domain is defined by two components: engaging with life measured by the degree of interaction in social and supportive relationships; and spirituality or religious commitment is measured by the Spirituality Index of Well-Being (SIWB) (Young et al., 2009).

See Table 2b for an overview of the conceptual and operational definitions related to the multidimensional model referred to in this study.

Table 2 b: Conceptual and Operational Definitions of Model Variables

Variable	Conceptual Definition	Operational Definition
Physiological Domain: Comorbidity	Presence or absence 18 chronic conditions most prevalent in older adults	Angina; myocardial infarction; congestive heart failure; peripheral arterial disease; hip fracture; osteoporosis, osteoarthritis of hands and/or knees and/or hips; rheumatoid arthritis; disc disease; spinal stenosis; stroke; Parkinson's disease; pulmonary disease; diabetes; hypertension; cancer
Functional impairment	Presence or absence of 7 physical performance variables	Standing for long periods; lifting or carrying weights of ~10lbs.; going up and down stairs; walking; stooping/bending/kneeling; using hands and fingers; reaching with either/or both arms

Psychological Domain: Cognitive function	How individuals perceive, register, store, retrieve, and use information	Measurement using the Mini-Mental State Examination (MMSE) or similar tool
Emotional vitality	Presence of a sense of personal mastery	Happiness and low levels of anxiety
Geriatric depression	Changes in mood, behavior, and functioning	Geriatric Depression Scale (GDS) ascertains how older adults feel at the time of interview.
Sociological Domain: Engaging with life	The degree of interaction with the environment and engagement in social activities	Determined by group involvement (neighborhood, community, religious, or other); respect from others; variety in life; receiving and providing help to others
Spirituality	Complex, multidimensional part of the human experience	Spirituality Index of Well-Being (SWIB)

Due to the newness of the model, limited studies have applied the framework. Hilton et al (2012) conducted a pilot study using the quantitative measure of successful aging, and added open-ended questions to determine what it means to age well. The researchers investigated the perceptions of Latinos and how they differ from other cultural groups. Ten themes emerged, with spirituality and transcendence being one of the themes. Their findings suggest Latinos have a rich inner life based on spirituality and family that provides comfort and meaning as they age (Hilton et al., 2012). Similarly, Iwanasa and Iwasaki (2011) utilized a demographic questionnaire, an acculturation and depression scale as well as the use of ten focus groups. The aim was to explore the concept of successful aging among a sample of Japanese Americans. Their findings revealed physical functioning was the most predominant theme, but spiritual beliefs and

practices play a significant role in maintaining one's well-being and ability to cope with stress (Iwamasa & Iwasaki, 2011).

The Multidimensional Model of Successful Aging involves a graded or continuous approach to measuring successful aging. This approach is flexible to allow individuals that may have limitations in one domain to compensate for strengths in the other two domains so that they may still be viewed as aging successfully. When considered by older adults, there are multiple dimensions of successful aging. The multiple dimensions include physical, social, psychological or cognitive functioning as well as spiritual (Iwamasa & Iwasaki, 2011; Young et al., 2009).

A measurement tool is needed to assess the holistic aspects of successful aging from cross-cultural perspectives; however, functional limitations such as visual or dexterity problems in older adults as well as varying levels of literacy may limit the effectiveness of using questionnaires. The multidimensional model can assist researchers and inform professionals in applying research findings to inform evidence-based practice for older adults (Hilton et al., 2012).

According to current population reports by the U.S. Census Bureau (2012), the United States will experience considerable growth in its older population between 2012 and 2050. In 2050, the population aged 65 and over is projected to almost double from 43.1 million in 2012 to 83.7 million. By 2030, greater than 20 percent of U.S. residents are projected to be aged 65 and over with corresponding survivorship rates. These 2012 National Projections of the resident population by age, based on the 2010 Census, will have wide-ranging implications for the country. The changing age structure will affect families and society, both socially and economically (Centers for Disease Control and

Prevention, 2013). A closer review of the current literature on this subset of the population will follow.

Overview of Older Adults

As stated previously, by 2050 it is projected that the population of Americans age 65 and older will grow to nearly 89 million people (Rydholm et al., 2008). According to CDC projections, this number will more than double the number of older adults from 2010 (Centers for Disease Control and Prevention, 2013).

The research regarding community interventions outside of a formalized health care system to support older adults living with and managing chronic co-morbidities is sparse. Living with multiple chronic illnesses, or co-morbidities puts older adults at greater risk for negative outcomes such as hospital admission (Manderson, Mcmurray, Piraino, & Stoles, 2012). Hypertension is one of the chronic illnesses often overlooked for its long-term effect as well as manageability. In a study by Lewis (2011), older adult African-Americans were found to have the highest rates of hypertension and even higher occurrence rates of medication non-adherence compared to white counterparts. Overcoming the barriers to medication adherence in this population as well as others diagnosed with hypertension could be addressed in faith-based community organizations (Lewis, 2011). It is therefore important to understand the coping strategies used by older adults in managing their chronic illness on a daily basis (Loeb, Penrod, Falkenstern, Gueldner, & Poon, 2003) so that nursing interventions within the context of a faith community setting can be utilized to their fullest potential.

With the presence of multiple co-morbidities in older adults, there is an increasing chance of fragmentation or incomplete transfer of information between healthcare

providers for ongoing chronic care management. Care coordinators or patient navigators can assist older adults with managing their chronic disease from a personalized approach. These healthcare workers facilitate safe and efficient transition from healthcare settings and reduce barriers to care transition. Whether in a community setting or hospital-based care system, the majority of these positions require the qualifications of a Registered Nurse with advanced expertise. Services provided include phone support, home visits, liaison with medical and community services, patient and caregiver education, and advocacy for access to appropriate care (Manderson et al., 2012). Manderson et al. (2012) found "when appropriate care or resources are not available in the community, older patients will often remain in higher level care" (pg.114). This lack of community health care resources has an impact on the economy in the healthcare system as well as the psychosocial and functional capabilities of clients (Manderson et al., 2012). Utilizing faith communities as a potential organization to help older adults overcome these barriers is a possibility because the FCN can implement interventions that mirror those of a patient navigator.

The faith community is an ideal setting to provide education and instructional support about disease and illness. Not only are places of worship convenient sites for social support, but they also provide a trusting supportive environment for individuals that mistrust the health care system (Lewis, 2011; White, Drechsel, & Johnson, 2006). Loeb and colleagues (2003) questioned community-dwelling older adults age 55 and older regarding coping strategies for living with chronic illness. They found that relying on spirituality or religion for psychological support for life events was one of the reported coping strategies. Engaging with life through social support was also identified as a vital

component of daily living activities (Loeb et al., 2003). A variety of religious and existential factors appear to contribute to healthy behaviors. When Lawler-Row and Elliott (Lawler-Row & Elliott, 2009) examined the role of religious activity in the health and well-being of older adults, they found achieving a sense of meaning and purpose were critical factors in overall health. Physical and psychological well-being are components of overall health and hence, successful aging.

Faith Communities value health and healing. In fact, these terms are often part of the organization's mission statements. Buijs and Olson (2001) found that faith communities are sites where hope and assistance in coping may be offered within a supportive environment. Having a positive impact on personality development and behavior modification, faith communities can provide a sense of meaning and purpose to life (Buijs & Olson, 2001). FCNs can influence determinants of health through health promotion activities for older adults living with multiple co-morbidities.

Health promotion and disease prevention is the main focus of faith community nursing. When Rethemeyer and Wehling (2004) surveyed 760 faith community members from 19 different congregations regarding the effectiveness of faith community nurses, respondents indicated they benefited from the services provided by their FCN in a variety of ways. Behavioral outcomes identified included receiving needed answers to health questions; obtaining education in the prevention of chronic cardiovascular disease; and benefitting from the ease of contacting the FCN for services. Several services resulting in physical health benefits included frequent blood pressure measurement; diet education; and supportive counseling – all of which have been shown to encourage client self-development resulting in positive health influences (Rethemeyer & Wehling, 2004).

Few studies have described the specific services provided by FCNs for persons with chronic conditions who are members of underserved populations (Monay, Mangione, Sorrell-Thompson, & Baig, 2010). Also, the effectiveness of services in assisting older adults in accessing needed health care has seldom been studied (Rydholm et al., 2008). In a mixed method study by Rydholm et al.(2008), 1,061 documented nurses notes by 75 FCNs provide strong support for the impact of FCNs on the health and well-being of older adults. The researchers identified categories of FCN interventions to include: coping/support/redirection, obtaining assistive devices, finding help for daily living activities, disease self-care guidance, stay at home referral to care agencies, advocacy for vulnerable elders, urgent care access, and end of life concerns. The community support provided by FCNs for older adults and their informal caregivers resulted in cost-savings for individuals, health insurers, and public health care funds. From a healthcare perspective, the services provided by a FCN were shown to promote improved patient outcomes by receiving treatment before the disease progresses to a higher acuity level.

FCNs provide vital services to older adults in the faith community setting and serve to bridge the gap between formal healthcare settings, much like a patient navigator, and the informal community setting. Further research on the linkage between FCNs interventions and outcomes for persons with chronic illness is needed.

Chapter Summary

Since the inception of Faith Community Nursing by Rev. Westberg in 1984, this specialty practice has gained momentum in the United States. A review of the role and specific interventions associated with the specialty practice has revealed the holistic focus

of care for the mind, body, and spirit in the context of faith communities. Despite the limitations and barriers to introducing FCNs, client perceptions validate the services provided as enhancing traditional care services by incorporating spiritual care as well as providing continuity in ongoing community outreach healthcare. Future research is needed to validate the conceptual framework initiated by Bergquist and King (1994) and the development of a research model begun by Dyess and Chase (2012). For purposes of this study, the theoretical framework of successful aging aligns with the interventions of the study sample which were older adults age 66 and older.

The number and proportion of older adults in the United States are growing at an unprecedented rate. By 2050, the U.S Census Bureau projects that the number of Americans aged 65 or older will more than double to 89 million from the most recent census total in 2010 (Centers for Disease Control and Prevention, 2013). Many older adults are living into their 70s, 80s, and beyond and since the beginning of 2011 roughly 10,000 Americans will celebrate a 65th birthday each and every day for the next 20 years. The baby boom generation will significantly change the demographic landscape of the United States. By 2030 one in every five Americans, approximately 72 million people will be an older adult (Centers for Disease Control and Prevention, 2013).

An attempt to define and measure successful aging is an ongoing struggle. The conceptual definition differs based on the objective or subjective perspectives of theorists, researchers, or older adult participants. The core components of the successful aging construct provides a supportive framework for research. The core components of the construct are; avoiding disease and disability, maximizing cognitive and physical function, and engagement with life (Rowe & Kahn, 1997). Various other perspectives

have challenged Rowe and Kahn's conceptualization as missing external factors that prevent or add to successful aging. The missing external factors of spirituality; subjective well-being; and life course perspectives provide opportunities for health promotion and illness prevention.

When Crowther et al., (2002) argued that positive spirituality was a missing component in Rowe and Kahn's original model, they were postulating that this concept should stand alone as an integral part in the framework that defines successful aging. While there has been limited use of the enhanced version by Crowther et al., this should not deter researchers and clinicians from considering the importance of spirituality in supporting and strengthening older adults to age successfully. The multidimensional model, developed by Young et al., (2012) implies a more graded approach to measuring successful aging with less dependence on success in all three domains. They recognize that even in the context of disease and/or disability, adaptive psychological and social mechanisms can compensate for physical limitations to achieve a self-assessed quality of life and sense of well-being. These multiple pathways to successful aging can assist researchers and healthcare professionals.

Diseases such as heart disease and cancer pose the greatest health risks as people age as do other chronic illnesses such as chronic obstructive lung disease (COPD), stroke, Alzheimer's and diabetes. While death is unavoidable, decline and death associated with these leading chronic diseases are often preventable or can be delayed. Multiple opportunities exist to promote and preserve the health of older adults. Public health plays a critical role in advocating for those in need and promoting health aging. Faith community nursing is a sub-specialty that exists in public health. Not enough is known

regarding the interventions of FCNs and how they are contributing to the health and well-being of older adults.

CHAPTER III

RESEARCH DESIGN AND METHODS

Introduction

To examine interventions by Faith Community Nurses (FCNs) and how these interventions align with the multidimensional model of successful aging, the study utilized secondary data analysis. Data were obtained through the web-based Faith Community Nursing/Health Ministries (FCN/HM) Network Documentation and Reporting System developed by the Henry Ford Health System in Detroit Michigan. In this chapter, an overview of the web-based documentation and reporting system data source will be described. A description of the study design, population, data abstraction procedures, protection of human subjects, and statistical analysis methods will also be presented. Cumulative interventions filtered by researcher identified criteria were the focus of this analysis.

Due to the nature of the FCN/HM web-based documentation and reporting system, conducting a secondary data analysis is an appropriate way to address the research questions in this study which are: 1. what is the distribution of interventions provided by FCNs across age groups? 2. In what ways do FCNs contribute to the health and well-being of older adults? 2a. what is the distribution of interventions involving older adults currently reported by FCNs in a large network? 2b. what is the mode of delivery (i.e., individual or group) of interventions targeting older adults? 3. how do the interventions documented by Faith Community Nurses align with the multidimensional model of successful aging?

Design of the Study

Secondary analysis is simply the reanalysis of primary data, usually collected by someone other than the original author and often times for another primary purpose (Shadish, Cook, & Campbell, 2002; Smith et al., 2011). Primary data refers to original raw data gathered by the investigator performing the research. Common sources of secondary data used for analysis include large publicly available datasets such as medical data registries, national or state surveys, and large government-funded datasets (Shadish et al., 2002). Secondary analysis is also appropriate for proprietary datasets (Doolan & Froelicher, 2009) such as the Henry Ford Health System FCN/HM Network Documentation and Reporting System. In regard to this study, the dataset included pertinent variables that have not been analyzed with respect to successful aging. However, secondary analysis has both advantages and disadvantages.

The advantages to using secondary datasets is the availability of large, diverse samples, relevant measures to address the research question, and longitudinal data which can be difficult to collect without incurring substantial costs. In secondary analysis, the costs incurred with primary data collection are avoided. One of the greatest advantages in the analysis of secondary data for an early career researcher, is the revelation of potential epidemiologic trends for future primary data studies (Doolan & Froelicher, 2009). In regard to the current study, the selected dataset has not been previously analyzed with respect to successful aging, which provides a new perspective in the field of faith community nursing and a foundation for future research.

The use of archived data presents practical obstacles. One of the most significant obstacles faced when using secondary data is control. When a researcher gathers primary

data, they can decide what type of data will be gathered, how it will be gathered, and the conceptual framework used for comparison. Other obstacles include data used in a secondary analysis may have been initially collected for different reasons than those of the present study; data may be insufficient to analyze the theoretical variables; missing data may be prevalent; and the methods or accuracy of gathering the data may be unclear or unknown. Unexplained covariates need to be considered or may not be available to identify (Shadish et al., 2002) when using secondary analysis. In conducting a secondary data analysis the researcher is not able to control measurement error which may have been introduced in the development and administration of the questionnaire.

Faith Community Nursing/Health Ministries Documentation and Reporting System

The Henry Ford Macomb Hospitals (formerly St. Joseph's Healthcare) Faith Community Nursing Network began developing its own documentation tools in 1995 using teams of FCN members. Each year, focused teams of FCNs reviewed the literature, including the work of other FCNs, and made adjustments to the documentation tools to meet their needs and the needs of their clients. In 2000, St. Joseph's Healthcare Faith Community Nursing Network was awarded a grant from the Michigan Department of Community Health to develop the Faith Community Nursing/Health Ministries Documentation and Reporting System. Once grant-funding was received, work on the web-based documentation site began in June 2000.

In 2001, pilot testing was completed and documentation using the web-based site began. Based on the pilot tests, the design legibility and utility of the site was refined in June 2002. Other changes ensued throughout 2002 and 2003 such as; the ability to share the site with other Faith Community Nursing Networks; point of service documentation

became available through the use of personal digital assistant (PDAs) devices; and synchronization to the internet through desktops. As the use of wireless access to the site increased, the use of PDAs to document in the system dwindled.

In 2007 and 2009 significant quality improvements were made to the system. A confidential patient numbering system was introduced. Additional functions were added such as the ability to filter and sort cumulative data by criteria (visit type, disease type, age category) for evaluation. In 2012 a system rewrite was released with new features and changes which were more intuitive and user-friendly than the previous versions. New features included the ability to save the form as a draft, and a user-alert when the patient entered already existed in the system. Intuitive changes included data validation and automatic population of an age range when the client's date of birth is entered. In 2014 the North American Nursing Diagnosis Association (NANDA), Nursing Intervention Classification (NIC), and Nursing Outcomes Classification (NOC) systems were added to the Individual Interaction form as the FCN Professional Process Module. However, usage of the Professional Process Module is optional. Designed as an institutionally supported internet-based documentation network, Faith Community Nursing Networks of all denominations and faiths can meet the American Nurses Association professional documentation standards by documenting services rendered to clients in the community setting (American Nurses Association & Health Ministries Association, Inc, 2012).

The Faith Community Nursing/Health Ministries Documentation and Reporting System consists of a patient profile form, individual interaction form, monthly group form, and a variety of cumulative activity reports. The individual user or FCN can input into the patient profile form, the individual interaction form, and the monthly group form

as well as prepare cumulative reports on their congregation filtered by criteria such as visit type, spiritual/emotional/relational issue type, disease type, age category and other criteria.

The patient profile form is an alphabetical listing of the patient's input by the FCN. This form must be populated with demographic data that includes: name, address, gender, date of birth, and member type (member or non-member). Once the required fields are completed, the system assigns a random number to the patient, creating a confidential document for use in data aggregation. The complete patient profile section can only be viewed by the person who inputs the data. Optional fields include denomination, medical condition or concern, emergency contact numbers, advance directives, date of anointing of the sick, ethnicity choices, body mass index (BMI), durable power of attorney, guardianship, insurance code, congregation, race choices, and nursing diagnosis or issue. Fields such as gender, age, member type, ethnicity choices, BMI, insurance code, and race choices automatically populate the Individual Interaction Form. A patient profile form must be added before an individual interaction can be submitted.

The individual interaction form is used to document each patient/client interaction. This form is easily completed by check marks and some of the fields are automatically populated from the patient profile as mentioned previously. The following are key sections of the individual interaction form: demographics; spiritual/emotional/relational; health/wellness; medical conditions; interventions; outcomes and the FCN professional process module containing NANDA, NIC, and NOC.

The group activity form is utilized to document interactions with groups of people. Categories provided to document group interactions are: education/information; support groups; and screenings. The FCN can also utilize the group activity form to document health ministry team activities such as meetings; office hours; preparation time; and professional development education programs.

The cumulative activity reports can export individual interaction cumulative data and group activity data. There are two user types that have the ability to mine reports for the purpose of gathering and reporting statistics, the Faith Community Nurse and the Network Administrator. The FCN has access to five reports which detail the data they have input on the individual interaction and monthly group form, but they can only extract cumulative reports on their own congregation. The Network Administrator is a FCN that oversees a group or network of congregations which consists of individual FCNs and Health Ministry Teams. The Network Administrator can add congregations, add users, email all users or individual regions, and extract cumulative reports on all the congregations in their network for the purpose of gathering and reporting statistics. Data can be exported to an excel file to review individual site activity, evaluate time management, as well as cost savings/avoidance interactions. Network Administrators can track individual network members' use of the system for documentation compliance. They have the ability to filter and sort data based on the interest of those to whom they report such as administration, grantors, and community interest groups. Cumulative documentation can be filtered by zip code, region, denominations, faith, or multiple items of interest such as: problems; disease conditions; interventions; and outcomes. In addition multiple categories can be selected to filter and retrieve sorted data such as the number of

clients/patients in a specific age range grouped with one or more interactions within a selected time frame. Group activity can also be retrieved and reports prepared for estimating community benefit and setting network goals regarding certain target populations. Cost savings/avoidance computations can also be retrieved on individual interactions and group activity. The usual costs for screenings, education and support group activities, as well as nursing visits are calculated based on prevalent fees charged by the healthcare system affiliated with the Network.

The FCN Network at Henry Ford Macomb has been in existence since November 1994. It has been a model for the development of FCN Networks in other states across the country. Currently 11 states use the web-based Faith Community Nursing/Health Ministries (FCN/HM) Network Documentation and Reporting System through subscription membership. The validity of the data entered into the web-based documentation system is based on a mutually agreed upon partnership between the Henry Ford Macomb Hospital (HFMH) Faith Community Nursing/Health Ministry Network (FCN/HMN) and the subscription member (church/congregation/synagogue). Based on the signed written formal agreement between the two parties, the subscription member must have a qualified FCN. Criteria are explicit (see Appendix 1), the FCN must:

- Complete a FCN foundations course
- Provide services no less than 16 hours per month
- Maintain a current license as a registered nurse
- Perform all activities in accordance with the American Nurses Association Standards of Practice and Code of Ethics for FCNs
- Maintain confidential secured records

- Provide periodic and yearly written reports to the Network Administrator
- Be engaged by the congregation/church/synagogue on an at will basis, whether or not compensation is paid

The Henry Ford Macomb Hospital FCN/HM Network shall provide services and supports to the local FCNs as a benefit of membership. Criteria are explicit (see Appendix 2), the benefits of membership include:

- Orientation to the network
- Professional support resources for continuing education and skill development
- FCN foundations course including free or reduced registration fee
- Current Policy & Procedure Manual
- Peer support for goal setting and program development
- Networking opportunities on a local, state, and national level.

The purpose of this study was to examine documented interventions by FCNs within selected Faith Community Nursing Networks and describe how they align with the three domains described in the multidimensional model of successful aging. The sampling design and comprehensiveness of the individual and group interventions provided a point in time opportunity to analyze the variety of interventions and map them to the domains of the multidimensional model to describe the extent to which FCNs were responsive to the health needs of the growing older adult population.

Sample and Setting

The Faith Community Nursing/Health Ministries Network (FCN/HM) Network is a community-based, institutionally supported network of Faith Community Nursing

Networks, Health Ministry Networks, and independent nurses. The network was designed to help its partners meet professional documentation standards and to increase sharing of challenges, successes, and needs in the care of the whole person-spirit, mind, body, and relationships. Membership in the network is accomplished through an annual subscription to the site and services. There are approximately 500 active users of the FCN/HM Documentation and Reporting System. Each of the active users belongs to a network which is overseen by a FCN Administrator. There are currently 17 networks, of which five networks were selected to share data. These 5 networks were selected based on recommendations from the System Administrator that oversees system-wide training, implementation, and oversight of all 17 networks. These five networks were selected due to greater usage compliance, longevity within the system, and size of the network. The five network FCN Administrators were contacted for permission to access their network documentation system for this study. Thus this study utilized the data (study sample) from five networks.

All interventions were examined which includes individual interventions and group activities. Age range groupings are pre-determined in the web-based system. The age groupings are 0-4; 5-13; 14-18; 19-30; 31-50; 51-65; 66-80; 81-90; and 91 years of age and older. All interventions, both individual and group across the age groupings were initially examined to understand the distribution of interventions offered by FCNs. This initial comparison provides information to answer research question 1 (What is the distribution of interventions provided by FCNs across age groups?). The sample in all age groups who received some type of documented intervention, whether individual or

group encounter, was a convenience sample. The analysis of interventions from this sample was based solely on time of entry in the web-based documentation system.

To answer research question 2 (In what ways do FCNs contribute to the health and well-being of older adults?), all interventions, both individual and group, for the age ranges of 65 or less were compared with the same set of interventions pertaining to care recipients age 66 years and older. This comparison provided information to answer research questions 2a (What is the distribution of interventions involving older adults?) and 2b (What is the mode of delivery of interventions targeting older adults?).

The settings for network oversight of documentation are the Henry Ford Macomb Hospitals and St. Joseph Mercy, Michigan; Alegent Health, Nebraska; Memorial Hospital and Health Care Center, Indiana; and Advocate Health Care, Illinois. Permission to access the cumulative data from each of these network sites was granted by the individual Network Administrator. See Appendix 3 for a copy of the academic research access agreement between the researcher and the Network Administrator.

Measures

The individual interaction form, (see Figure 3a, 3b, 3c, and 3d) is the format used for documenting individual interactions between a FCN and a patient/client. This interaction includes assessment, identification of the problem/issue/nursing diagnosis, interventions, and evaluation/outcomes. The Patient Profile automatically populates this form but is de-identified for cumulative reports. Most data can be indicated via check boxes with the option of clicking on several boxes in a section. One exception in the intervention category is the entry for blood pressure measurement. In this field a drop down box is provided to identify a stage of blood pressure reading, e.g. normal; pre-

hypertensive; stage I hypertensive; stage II hypertensive however, customization of data entry is not permitted. As identified in Table 3a, each category in the individual interaction form contains numerous fields that help identify or describe the issue addressed in the interaction. As mentioned, more than one field can be checked as there may be a combination of issues. An example of a combination of issues causing spiritual/emotional/relational concern would be the differing expressions of grief over a recent death is causing relationship strain with a spouse. In categories where "other" is an optional field, a short narrative to describe the type of intervention can be entered. Table 3a contains the list of categories available to enter interactions but documenting in each category is not required with each entry.

The Faith Community Nurse/Health Ministry (FCN/HM) Congregational Activity Summary report contains the cumulative data for individual interactions. To view cumulative individual interaction data, only a date range needs to be inserted. For the purpose of this study, the date range was 01/01/2014 to 12/31/2014, and the categories of spiritual/emotional/relational; health/wellness; and individual interventions were described. After identifying the interactions described above with all age groups, the individual interventions were analyzed for older adult's age 66 years and older in relationship to the multidimensional model of successful aging.

Table 3a: Individual Interaction Categories and Descriptive Terms

Category	**Terms identified by check boxes**
Spiritual/Emotional/ Relational:	Abuse, Depression, Emotional Distress, Grief/Loss, Parenting, Relationship, Spiritual distress, Spiritual Well-being, Stress, Other
Health/Wellness:	Children's Health, Diet/Nutrition, General Health, Infant's Health, Knowledge deficit related to education on health issues, Live Alone, Living Arrangements, Medications, Men's Health, Mobility Altered, Non-compliance, Physical Activity, Safety, Sensory Impaired, Women's Health, Weight Loss/Gain, Other
Medical/Disease Conditions	Cancer, Cardiovascular, Gastrointestinal, Genitourinary, Hypertension, Infectious Disease, Mental Health, Drug/Substance abuse, Musculoskeletal, Neurosensory, Women's Health, Other
Interventions	Active Listening, Arrangement of Meals, Coordination of Support, Empowerment/Advocacy, Managing Chronic Disease, Pain Management, Prayer, Presence, Promoting Understanding, Providing Information, Surveillance, Touch/Hug, Transportation, Other
Contact Initiated by: (who made referral to FCN for intervention/contact)	Case Management, Congregational Staff, Home Care, Health Care Professional, Member, Network, Non-Member, Pastor/Leader, Physician, Other
Referral to:	Case Management, Community Resource, Congregational Resource, ER/ED, Home Care, Hospice, Network, Pastoral Staff, Physician, Other
Underinsured Help:	Dental, Hospitalization, Medication Coverage, Nurse Practitioner, Optical, Physician, Tests, Other
Outcomes:	Knowledge of: (as a result of the intervention, the receiver of care or caregiver has) Options, Resources, Health Behaviors, Coping, Anxiety Control, Participation in Health Decisions, Social Involvement/Support, Acceptance of Health Status, Implements Adherence Behaviors, Wellbeing (Spiritual, Physical, Emotional, Relational) Client's Goals: Met, Unmet, Exceeded Expectation, In Progress Insurance Type: Uninsured-self pay, Uninsured-unable to pay
Notes:	Advanced Care Planning, Cost Savings/Avoidance, Reason for Cost Savings/Avoidance, Diagnostic Related Groups, Nursing Diagnosis

The group activity form is the format used for documenting interactions of the FCN with groups of people or the congregation. Figure 3e reveals the format used for documenting group interactions between a FCN and a group of people or the congregation. Categories as well as descriptions of professional activities for a group of

people are included in Table 3b. The categories for documenting group interactions are: education/information, screenings, and support groups. Appropriate check boxes are provided in the electronic documentation form for each FCN to enter time in quarter hours or hours; numbers participating or contacts, and cost savings/avoidance (use is optional). Customization of data entry beyond time, contacts, and cost savings/avoidance is not permitted.

Table 3b: Group Interaction Categories and Descriptive Terms

Category:	**Description:**
Education / Information	Adolescent/Teen Health, Advanced Care Planning, Cancer, Cardiovascular, Care Giver Support, Children's Health, Community Partnership, CPR/AED, Diabetes, End of Life, Exercise and Activity, Heart Health, Infant's Health, Maternal, Medications, Men's Health, Mental Health, MS/Arthritis, Neurological, Nutrition, Older Adult Health, Parenting Support, Personal Risk Behavior Management, Respiratory/Pulmonary, Safety, Spiritual/Pastoral Care, Spiritual Development, Stroke Risk, Volunteer Ministry, Women's Health, Other
Screenings	Blood Sugar, Blood/Organ Drive, Bone Density, B/P, Cholesterol, Colon, Depression, Fall/Risk Assessment, Flu Shots, Foot Care, Glucose, Health Fait, Hearing, HgA1c, Infant/Child Growth & Development, Mammography, Mental Health, Nutritional, Prostrate, Safety, Skin, Stress/Anxiety, Stoke Assessment, Suicide Prevention, Vision, Other
Support Groups	Adult-Men's, Adult-Women's, Alzheimer's, Cancer Survivors, Care Giver, Diabetes, Divorce Support, Domestic Violence, Exercise and Activity, Grief/Loss, Healthy Lifestyle, Mental Health, Parenting, Smoking Cessation, Spiritual Counseling, Substance Abuse, Teen-Male, Teen-Female, Weight Loss, Other

Again, the Faith Community Nurse/Health Ministry (FCN/HM) Congregational Activity Summary report contains the cumulative data for group interactions. To view cumulative group activity data, only a date range needs to be inserted. For the purpose of this study, the date range was 01/01/2014 to 12/31/2014, and all three of the group

interaction categories were examined and include the hours and contacts. After identifying the interactions described above with all age groups, the group interventions were analyzed for older adult's age 66 years and older in relationship to the multidimensional model of successful aging.

The FCN/HM Congregational Activity Summary report can be sorted by a variety of filtered areas, see Table 3c. Once filtered areas are selected by the user, a date range can be added to export the report. Many charts and graphs can be created to display the targeted data. For this study, the filtered areas included: age; member type; and gender.

Table 3c: Individual Interaction Cumulative Data

Filtering areas:	**Categorical data:**
Ethnicity Choices, Race Choices, Visit Type, Member Type, Age, Insurance Type, Contact Initiated By, Intervention, Blood Pressure, Hemoglobin A1c, Medical/Disease Condition, Erroneous, Gender, Draft, Cost Savings, Paid/Unpaid, FCN Nursing Diagnosis, FCN Nursing Intervention, FCN Nursing Outcomes, Advance Care Planning	Demographics, Spiritual/Emotional/Relational, Race Choices, Ethnicity Choices, Hemoglobin A1C, Blood Pressure, Health/Wellness, Medical/Disease Conditions, Interventions, Contact Initiated By, Outcomes, Insurance Type, and FCN Professional Process Module

Operational definitions of intervention terms listed in Table 3a. are provided by the FCN/HM Documentation and Reporting System Guide (For Non-Administrator Use).

Empowering is defined as providing the client means to act on own behalf. Examples include providing information; empowerment; promoting understanding.

Advocacy is defined as acting on behalf of the client. Examples include surveillance; coordination of support; transportation; arrangement of meals.

Monitoring is defined as scheduled follow-up observations. Examples include monitoring of blood pressure; medications; other.

Blood Pressure is defined as normal = less than 120/80; Pre-hypertensive = 120-139/80-89; Stage I hypertension = 140-159/90-99; Stage 2 hypertension = greater than 160/100.

Figure 3a: Individual Interaction Form

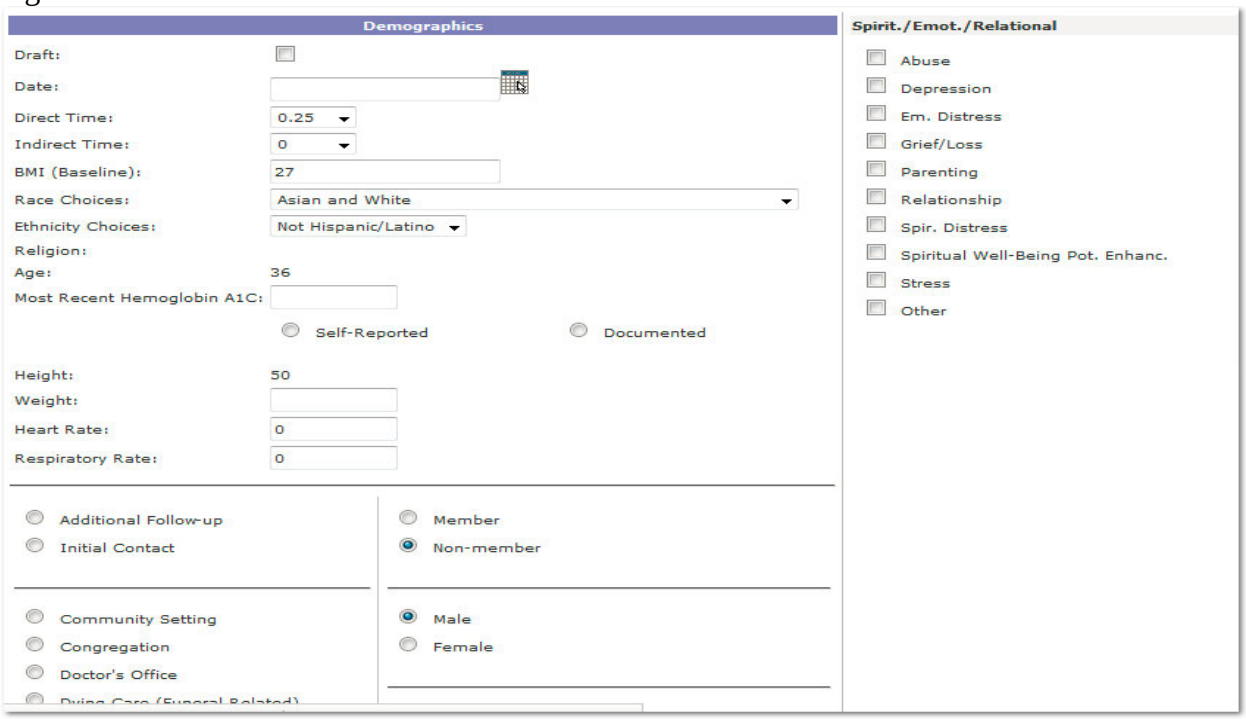


Figure 3b: Continuation of Individual Interaction Form

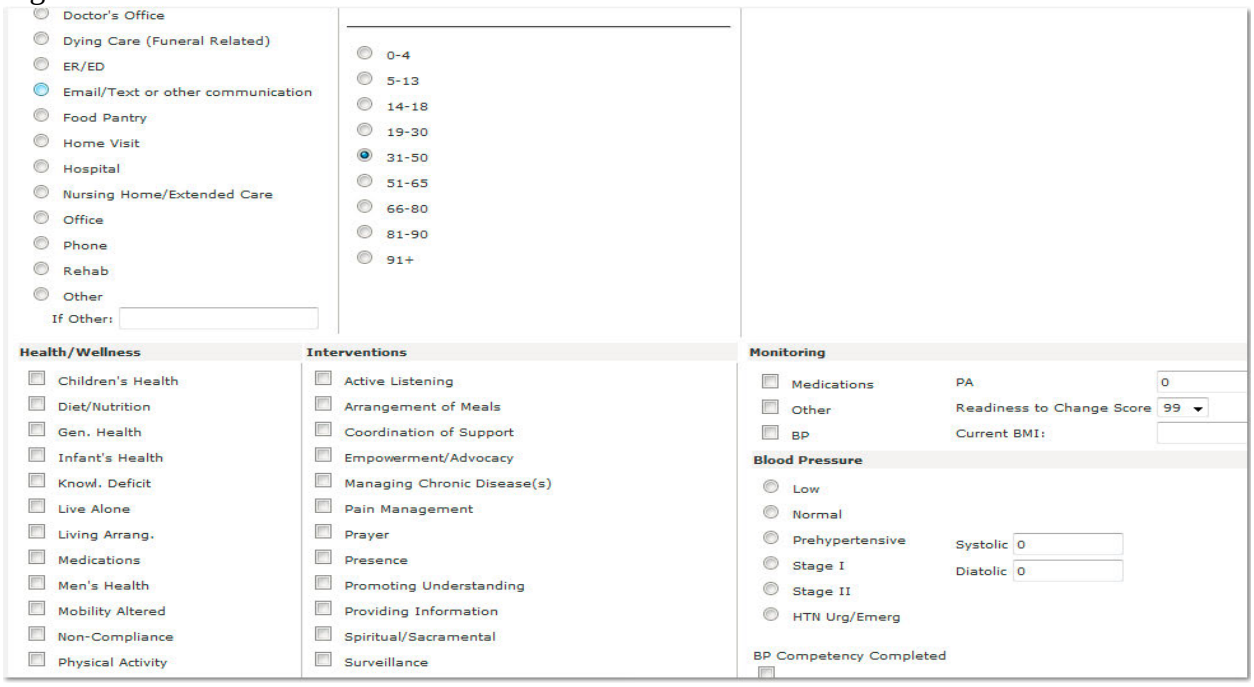


Figure 3c: Continuation of Individual Interaction Form

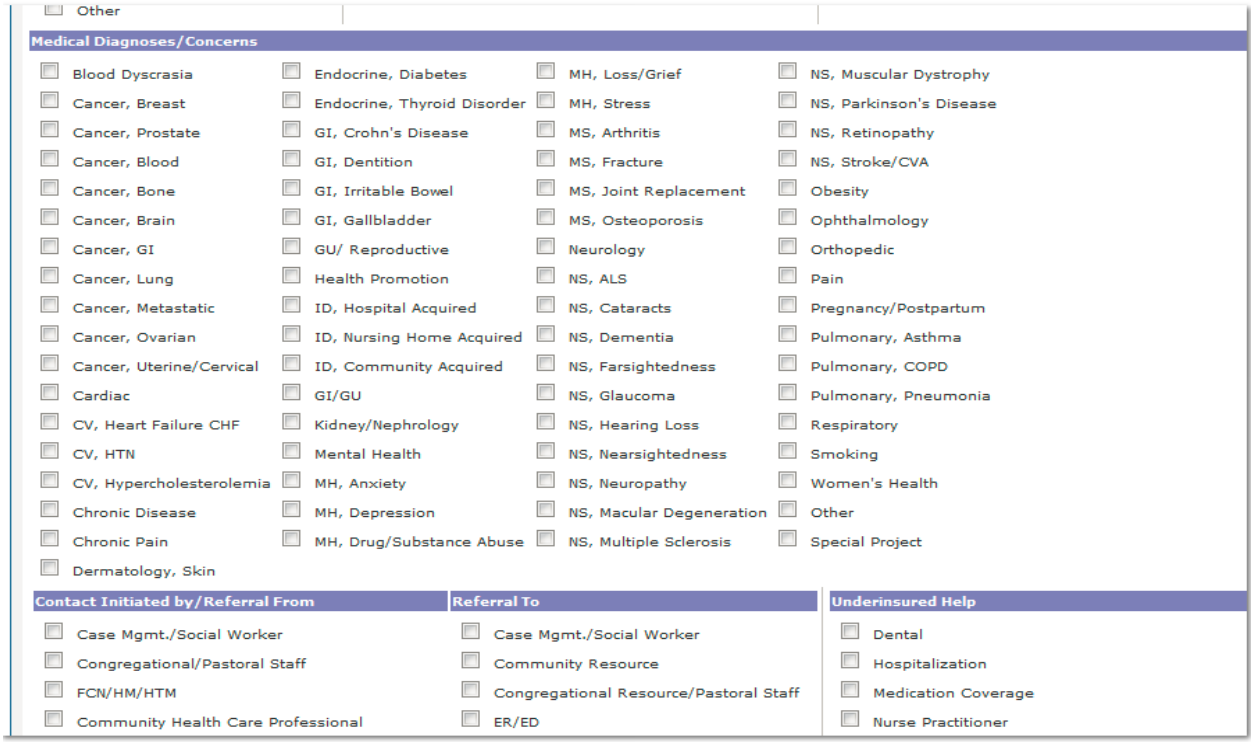


Figure 3d: Continuation of Individual Interaction Form

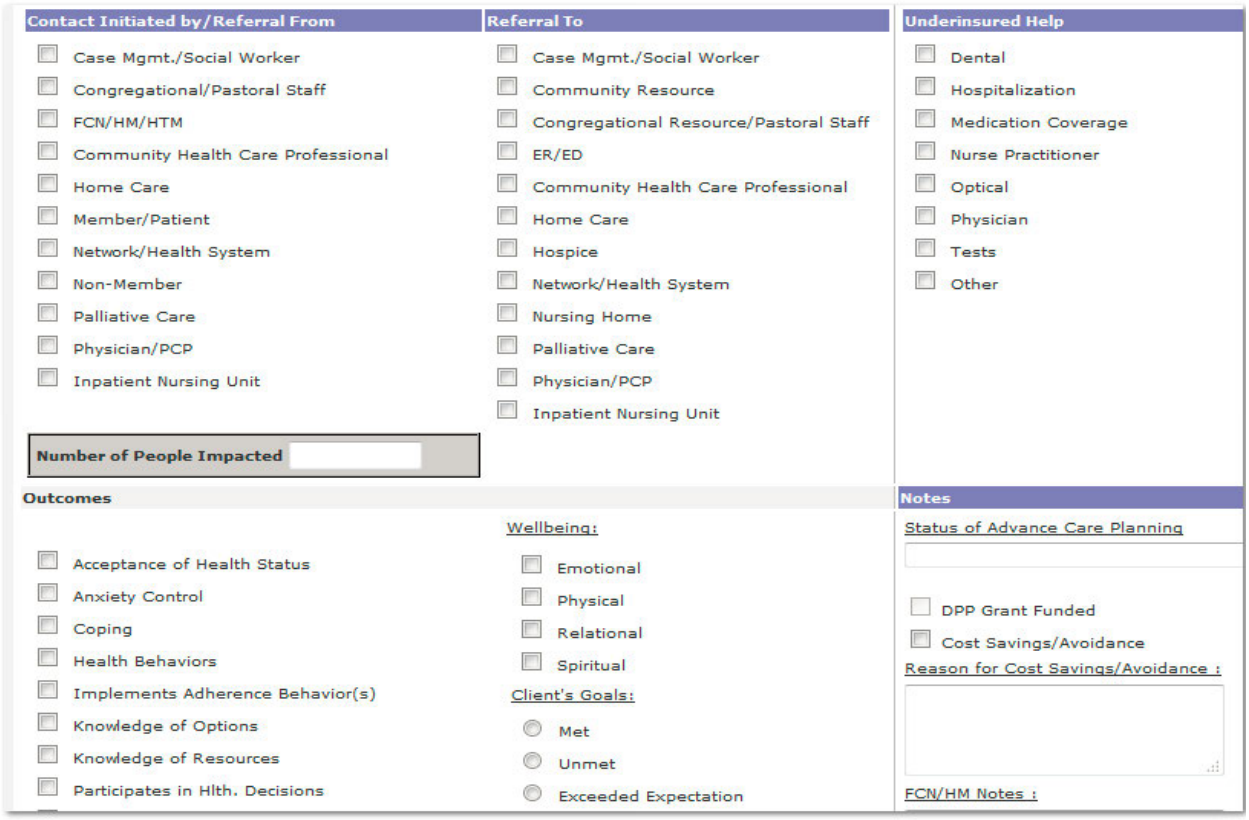
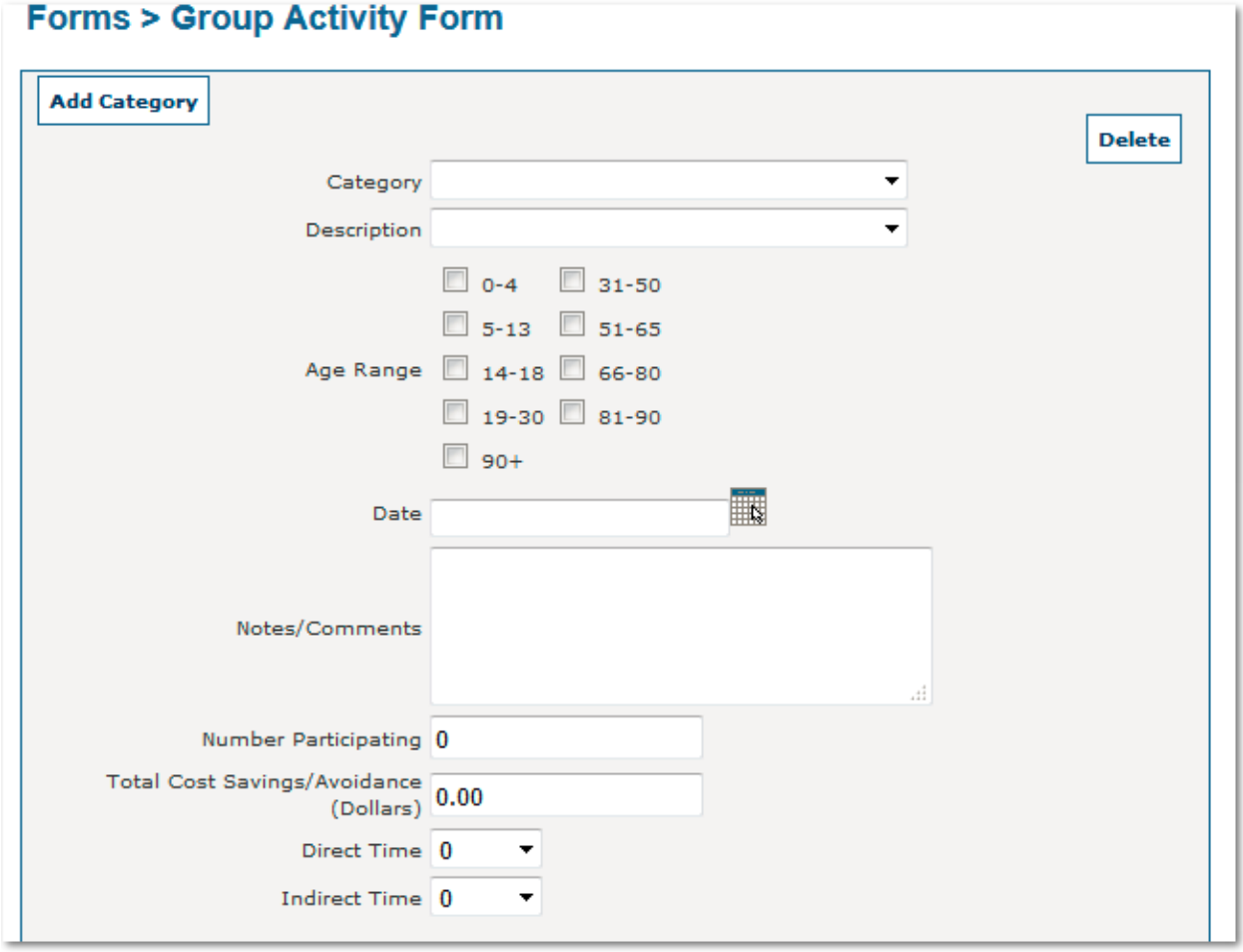


Figure 3e: Group Interaction/Activity Form



Procedures for Data Retrieval

For each of the five networks that agreed to permit access to their data, an academic research agreement was developed by the researcher and signed by both parties. See Appendix 3 for a copy of the agreement. Once Institutional Review Board approval was obtained from The Pennsylvania State University under the expedited review process for the secondary analysis, data retrieval began.

Within each of the five networks, the number of congregations who were active users of the documentation systems was identified. The total number of members per congregation was made known and then the total number of clients in each database was

established. Once the demographics of a congregation was known, then filtering of cumulative data in the congregational activity summary report was extracted. The date range was based on a calendar year. This process was repeated for each active congregation in a network and then progressed to a different network. Since the FCN/HM Congregational Activity Summary report contains both group and individual cumulative interaction data, once each cumulative summary report was extracted, data were transposed to IBM SPSS Statistics Version 22 for analysis. Duration of involvement in actual data retrieval cumulatively for the five networks took approximately 4-6 weeks. Once data in all the congregations within each network were retrieved, coding of interventions to the theoretical framework began.

Protection for Study Participants

This is a secondary analysis of an existing dataset. In the primary dataset, written consent was obtained from the FCN providing care to a client in a faith community setting before entering data into the Documentation and Reporting System. The de-identified data extracted for secondary analysis does not contain the patient name, birthdate, personal identifiers, or the name of the FCN entering the data. Subjects are linked by a numeric identifier known only to the FCN who inputs the data after having personal contact with the individual. It was determined by the Penn State University Office of Research Protection that this research contains non-human subject participants and was therefore exempt from Institutional Review Board approval.

This secondary analysis poses minimal risk to subjects. Since the data were extracted from a cumulative report, no contact with participants was required. The data in the documentation and reporting system was de-identified after the patient profile was

populated by the FCN entering the data. There are identifiers for each of the five networks, but personal numeric identifiers of the clients or the individual FCN documenting the intervention was not necessary for this analysis. No feasible alternative for accessing the required healthcare record data was identified and use of this data was essential to the project.

Data Analysis

Descriptive statistics were utilized to analyze the retrieved data. Before beginning the data analysis, a fit between the research questions and data set were determined. A codebook or manual of operations is one way to determine an appropriate fit (Doolan & Froelicher, 2009). A FCN/HM Documentation and Reporting System Guide for Non-Administrator User and an Administrator Guide 2014 were obtained from the Director of Faith and Community Health at the Henry Ford Health System. The categories of interest were clarified using descriptive terms further operationalized in the user manuals. Also the Henry Ford Macomb Hospitals FCN/HM Network Policies and Procedures manual were provided to support the validity of the partnership agreement. The variables or interventions were determined to be both appropriate and collected with a sufficient level of accuracy based on the level of compliance discussed in the policies and procedures manual. Once the quality of the data set was determined, the sample variables were examined for an appropriate fit to the research question.

To examine research question 1 (What is the distribution of interventions offered by FCNs across age groups?), descriptive statistics, including mean, median, quartiles or stanines, low value, high value, standard deviation, and frequency distributions (relative frequency), were computed to assess the overall sample characteristics. Depending on the

distributions for interval type data, box plots may help to assess the normality of the data distributions for intervention indicators including hours and number of contacts. A comparison between the interventions indicators reported for clients across all age ranges provided a description of all encounters, both individual and group, between the FCN and the patient/client. A median test may be used to compare median values.

To examine research questions 2 a. (What is the distribution of interventions involving older adults currently reported by FCNs in a large network?) and 2 b. (What is the mode of delivery of interventions targeting older adults, individual or group?), descriptive statistics, including mean, median, quartiles or stanines, low value, high value, standard deviation, and frequency distributions (relative frequency), were computed to assess the overall sample characteristics between the cumulative age ranges of 0-65 and the cumulative age ranges of 66 and over. Depending on the distributions for interval type data, box plots may help to assess the normality of the data distributions. A median test may be used to compare median values.

Once an appropriate fit was determined between the first set of research questions and the data set information, concerns regarding missing data were also addressed. While some missing data may exist, the written formal agreement between the Henry Ford Macomb Hospitals FCN/HM Network and the subscription member states that the FCN must document monthly using the network web-based system (See Policy #4 in Appendix). Failure to submit 70% of documentation is cause for termination of the relationship between the two entities (See Policy #2 in Appendix).

To examine research question 3 (How do the interventions documented by faith community nurses align with the multidimensional model of successful aging?) data

mapping of intervention variables to the model domains was conducted using data analyzed for the cumulative age ranges of 66 and over. Upon completion of mapping, it was anticipated that the data findings from research questions 2a and 2b would reveal how FCNs are contributing to the health and well-being of older adults.

Chapter Summary

This chapter has provided an overview of the methodology that was used in the study. An overview of the dataset was discussed as well as the steps to take when completing a secondary analysis of existing data. This was followed by the sample and setting where data input originated. Measures identified in the individual and group activity input reporting forms were discussed including the categories and descriptive terms. The variables that were analyzed based on the research questions were presented which included the reliability and validity of the measures. The data analysis plan was formulated using descriptive statistics. The comprehensiveness of the Documentation and Reporting System made this a relevant source for understanding how interventions by FCNs are impacting successful aging in community-dwelling older adults.

CHAPTER IV

Results

Introduction

This study examined ways in which Faith Community Nurses (FCNs) contribute to the health and well-being of older adults. The first step in this analysis was to determine which faith communities, in each of the five networks, were actively documenting interventions in the system. Once active documentation was noted within a faith community for the year 2014, the cumulative data from the congregational activity summaries were entered into the SPSS system for further analysis. The sample characteristics of each of the five networks, determined through a frequency distribution, are described further in the following section.

To respond to research question 1, the next step was to assess the distribution of each of the intervention variables documented by FCNs across all age groups. The participant characteristics regarding gender, member affiliation to the faith community, and age range distribution were examined as well as group and individual interventions. In understanding the total sample distribution related to interventions, further analysis could then occur regarding research question 2a and 2b specific for older adults related to the distribution of interventions and the mode of delivery.

The final analysis involved mapping (aligning) the findings from research question 2a and 2b to the multidimensional model of successful aging. The results from this mapping further clarifies how faith community nursing interventions are assisting older adults to successfully age and further identifies those areas where interventions could occur for the greater than 60% of the population cared for by FCNs.

Sample Client Characteristics

As previously discussed in Chapter 3, the five Faith Community Nursing/Health Ministries Networks that agreed to participate in this study were selected based on recommendations from the system administrator at the Henry Ford Macomb Hospital (HFMH) Faith Community Nursing / Health Ministry Network (FCN/HMN). The HFMH Faith Community Nursing /Health Ministry Network administrator provides oversight and technical updates to the documentation and reporting system for all network users. Documentation users were considered by this researcher to be an active user if in any one category used in the current data analysis; numerical data had been entered in 2014. Across all five networks, a total of 249 faith communities have access to the FCN/HMN Documentation and Reporting System. For this study, 169 or 68% of the faith communities were active in providing 2014 documentation as shown in Table 4.1.

Table 4.1 Baseline Characteristics of 5 Sample Networks

Network	**Location**	**Active**	**Access**	**% Active**
Advocate Health	Chicago, IL	27	43	63
St. Joseph Mercy Oakland	Pontiac, MI	49	68	72
Catholic Health Initiative	Omaha, NE	56	70	80
Memorial Hospital and Health Care Center	Jasper, IN	12	30	40
Henry Ford Macomb	Detroit, MI	25	38	66
Total:		**169**	**249**	**68**

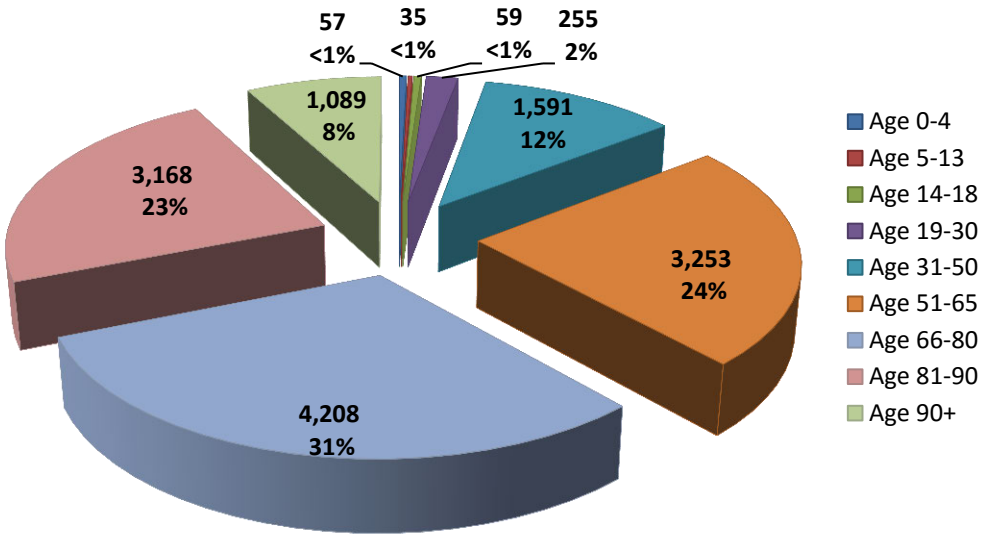
Since documenting the demographic profiles of clients is required, the total numeric value for gender, age-range, and member / non-member affiliation is a valid representation of the sample based on compliance requirements for FCN documentation.

Sixty-six percent of the care recipient clients were female, and 83% of the care recipient clients were members of the faith community where the interaction occurred. The age distribution of the care recipient sample is distributed from newborn to older adult. The age range groupings are pre-determined by the electronic documentation system and automatically filled-in when the client's date of birth is entered by a FCN. Greater than 60% of the care recipient clients were age 66 and older with the age range of 66-80 identified as the largest group of clients receiving care from FCNs (see Figure 4a). Descriptive statistics for the participants profile are summarized in Table 4.2.

Table 4.2 Profile of Care Recipient Sample

Variable	**Description**	**Sum**	**%**
Gender	Female	9115	66.00
	Male	4628	34.00
	Total	13743	100.00
Affiliation	Member	13715	83.00
	Non-Member	2782	17.00
	Total	16497	100.00
Age Range	0-4	57	0.42
	5-13	35	0.26
	14-18	59	0.43
	19-30	255	1.86
	31-50	1591	11.60
	51-65	3253	23.72
	66-80	4208	30.68
	81-90	3168	23.09
	91+	1089	7.94
	Total	13715	100.00

Figure 4a: Age Distribution of Care Recipients



Totals per Age Range
N=13,715

As the table and graph reveal, greater than 30% of care recipients were older adults age 66-80. The distribution of interventions across all age groups and then specific for older adults age 66 and older will be presented according to each of the research questions.

Interventions Provided by FCNs for all Age Groups Combined

To answer research question 1: *What is the distribution of interventions provided by FCNs across age groups*, the data distribution, including hours spent by FCNs on the intervention and the number of contacts encountered during the interaction, is represented by bar graphs. Since a comparison between age groups was not the intent with this research question, a frequency distribution provided the greatest emphasis on the interventions distribution.

Group Interventions

Group activity interventions are described as activities for a group of people or a congregation. The group activity categories used for analysis in this study were education/information, screenings, and support groups. The required documentation fields within these categories, once the descriptive terms are selected, are time and number of participants. Time refers to the amount of time set aside for a class or screening activity or prep time for articles/materials. The number of participants or contacts represents either the number attending the presentation or class as well as the number of handouts taken from display racks or bulletins/newsletters retrieved related to education/information. The number of participants or contacts also represents the number of people screened.

A total of 8,996 hours and 247,525 contacts were documented across all age groups for education/information interventions. There are 31 descriptive terms for the category education/information, these are listed in Table 3b. For all age groups, nutrition education was the most frequently documented group activity by FCNs for the education/information category. Figures 4b and 4c identifies the top five most frequently documented education/information activities based on time spent on the interventions by FCNs and contacts/participants attending the presentation or class, or number of educational handouts/newsletter articles.

Figure 4b: Top Five Group Education/Information Interventions for Time Spent

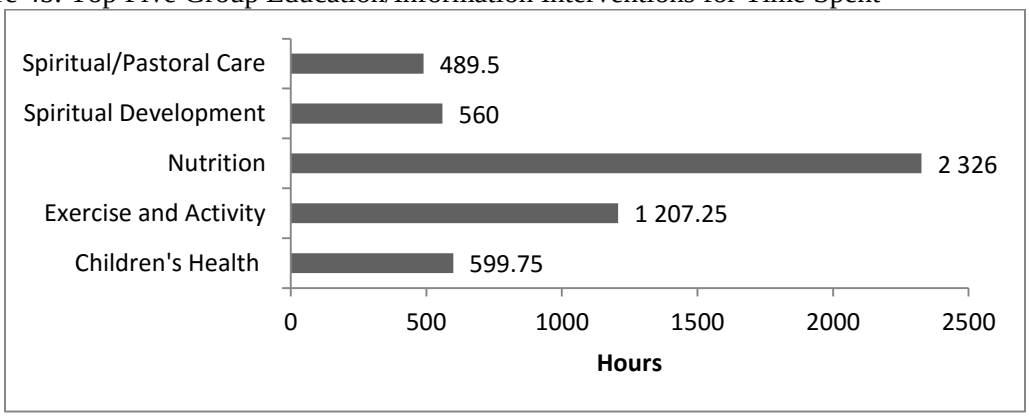
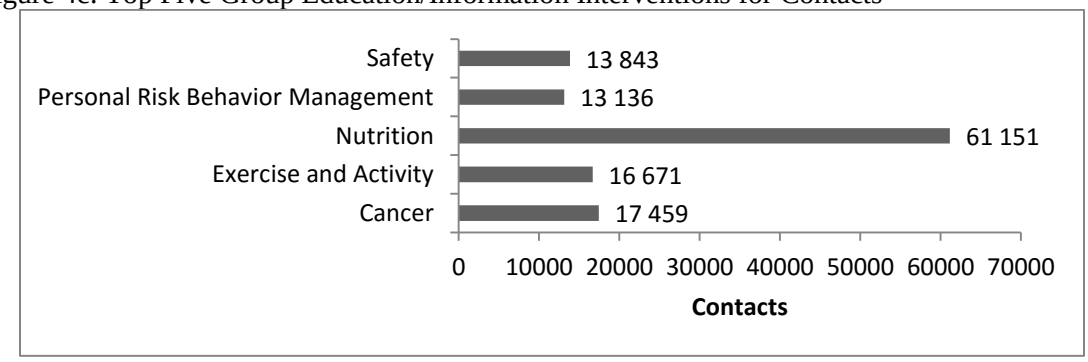
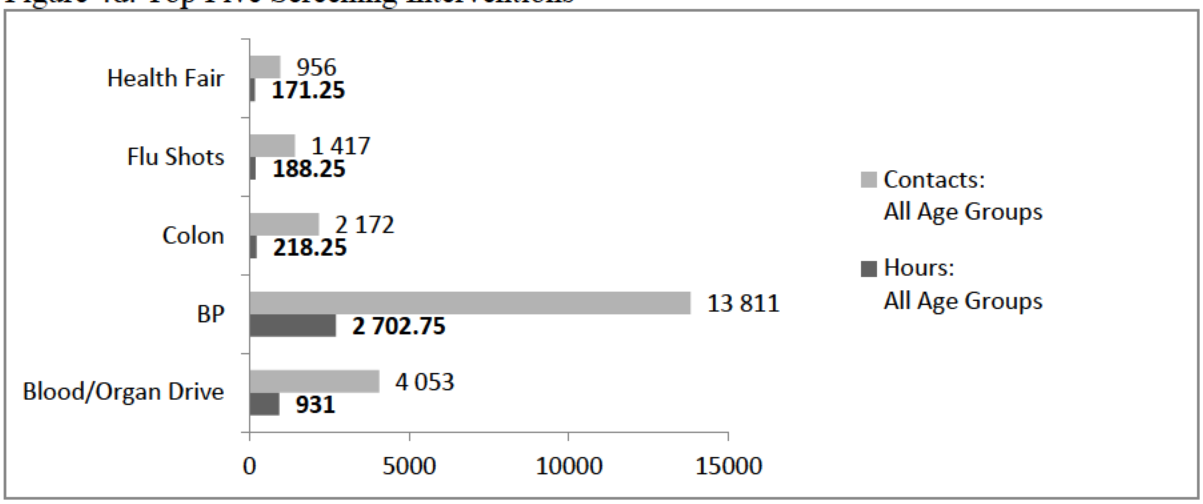


Figure 4c: Top Five Group Education/Information Interventions for Contacts



A total of 4,747.25 hours and 41,467 contacts were documented across all age groups for screening interventions. There are 26 descriptive terms for the variety of screenings provided by FCNs, these are listed in Table 3b. Across all age groups, blood pressure screening was by far the most frequent screening intervention. Greater than 56% of the time consumed by FCNs conducting screenings occurred measuring blood pressure, and 33% of the overall contacts for any of the 26 screening interventions ensued for blood pressure. Figure 4d provides an overview of the five most frequently documented screening interventions.

Figure 4d: Top Five Screening Interventions



When blood pressure is selected as a description, four categories appear where FCNs can enter the number of participants that are in each category. As a screening tool, blood pressure measurement identifies individuals at risk for hypertension. Another important benefit of blood pressure screening is the opportunity to provide support for ongoing hypertension self-management along with referral to a primary care provider for medical management. See Table 4.3 for the distribution of blood pressure findings as a result of screening.

Table 4.3: Distribution of Blood Pressure Categories

Blood Pressure Category	Contacts
Normal	5158
Pre-hypertensive	3519
Stage I	2142
Stage II	640
Total	**11459**

The final category for group interventions is support groups. Described as regularly scheduled meetings on a specific topic, a total of 16,032.5 hours and 92,164 contacts were documented across all age groups for support group interventions. There are 20 descriptive terms for the variety of support groups provided by FCNs, these are listed in Table 3b. Figure 4e reveals the top five support group activities in which FCNs

allocate the most time. More time is spent on exercise and activity support groups than the other 20 interventions for this category. Figure 4f reveals a slightly different distribution for documented support group contacts. Attendance at healthy lifestyle support groups was the most frequently documented intervention (see figure 4f). Surprisingly, time spent by FCNs for care giver support was identified in the top five support groups (see figure 4e) but was not included in the top five support groups for documented participants (see figure 4f). Instead care giver support groups were replaced with substance abuse support groups in the top five support group interventions for documented contacts/participants. While substance abuse support groups were not defined, some of the most common that meet in a faith community setting are Alcoholics Anonymous (AA) and Narcotics Anonymous (Narc-Anon).

Figure 4e: Top Five Support Group Interventions for Time Spent

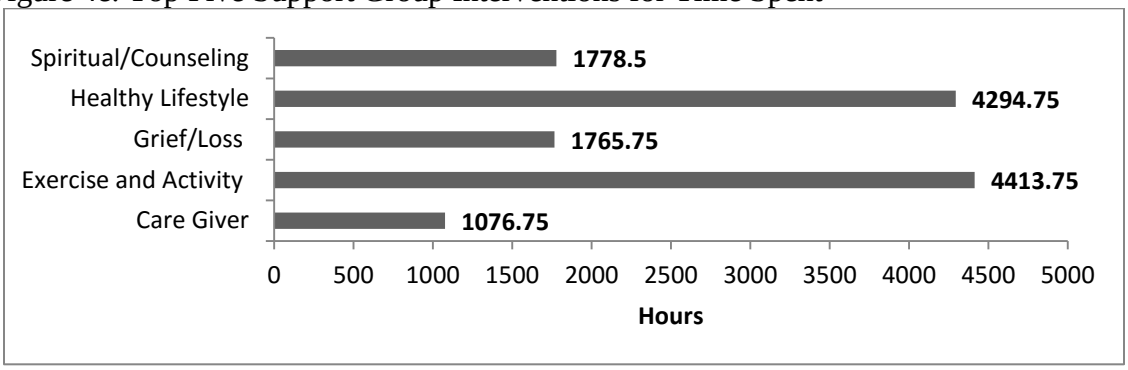
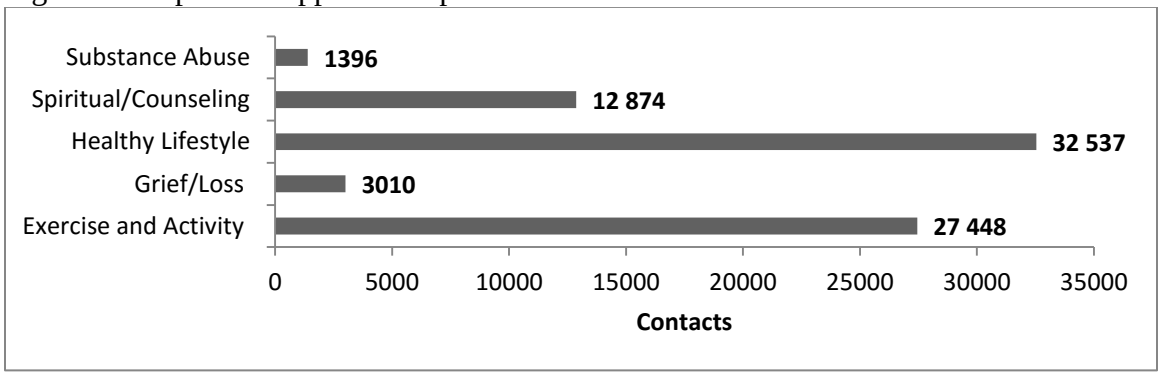


Figure 4f: Top Five Support Group Interventions for Contacts

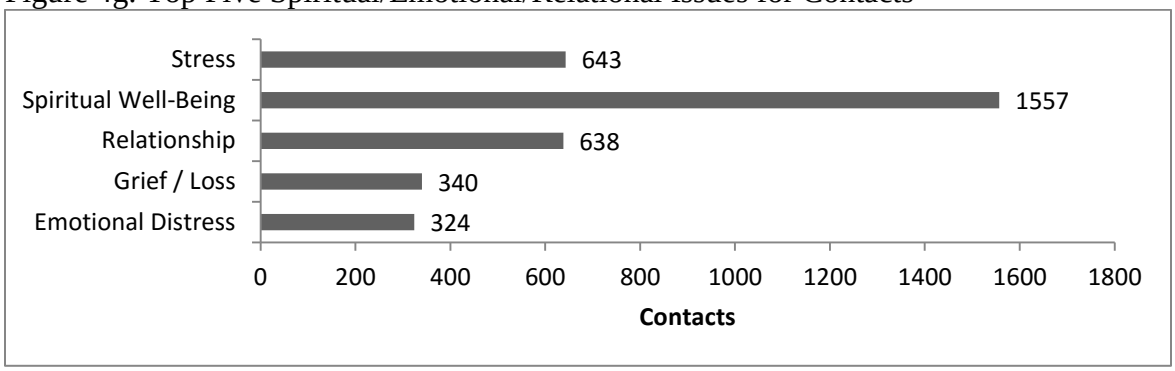


Individual Interventions

Individual interventions are described as interactions with a patient/client/parishioner, and include assessment of a problem/issue/nursing diagnosis or steps taken during the interaction. Table 3a in chapter III contains a list of the individual interaction categories and descriptive terms. The individual interaction categories used for analysis in this study were spiritual/emotional/relational, health/wellness, and interventions. The required documentation field within these categories, once the descriptive terms were selected, were number of participants or contacts. However, more than one item can be checked in a category as there may be a combination of issues. Time spent on individual interactions is not a documentation option.

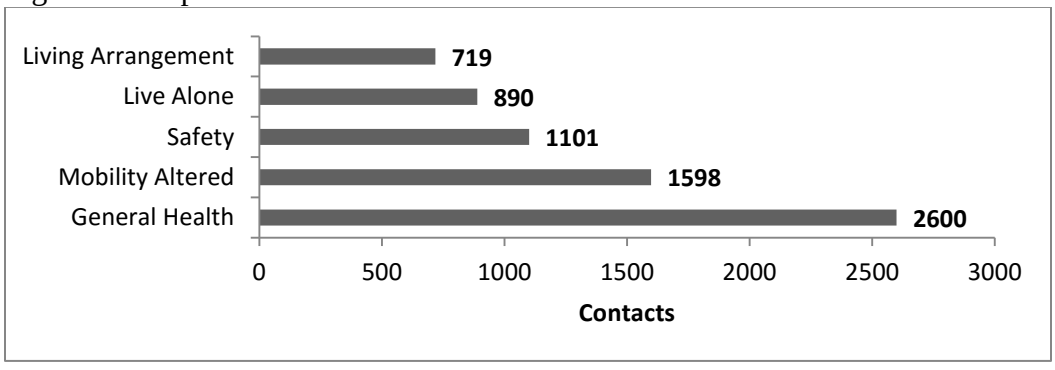
The category of spiritual/emotional/relational provides an opportunity to document issues that were part of the patient interaction. A total of 4,269 contacts were documented across all age groups in this category. There are ten descriptive terms for the spiritual/emotional/relational issues FCNs could identify occurred during an individual interaction, these are listed in Table 3a. The most frequent spiritual/emotional/relational issue documented was spiritual well-being. Defined in the Documentation and Reporting System Guide as "potential for enhancement of well-being", spiritual well-being issues were part of the interaction between FCNs and patients 36% of the time. Figure 4g identifies the top five spiritual/emotional/relational issues most frequently documented during an interaction.

Figure 4g: Top Five Spiritual/Emotional/Relational Issues for Contacts



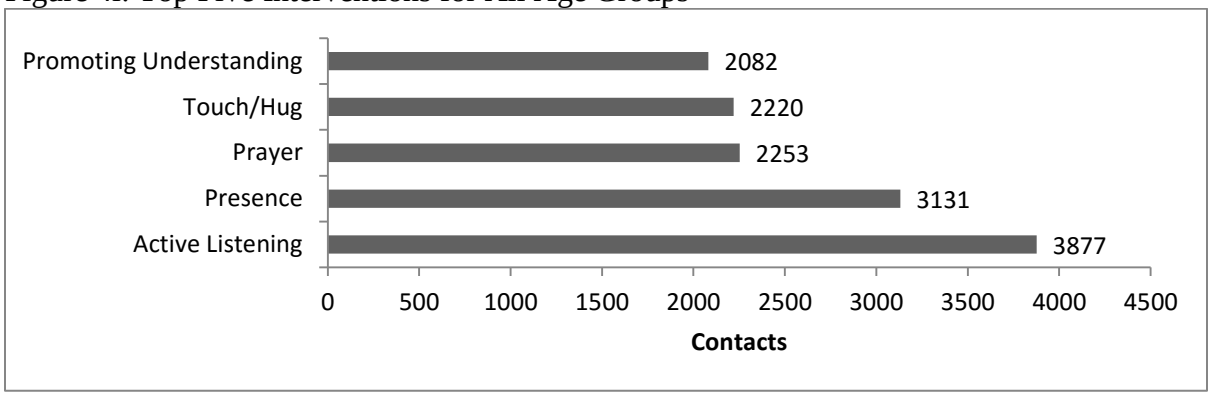
The second category providing an opportunity to document issues occurring during individual interactions is health/wellness. A total of 10,614 contacts were documented across all age groups for health/wellness issues. There are 17 descriptive terms for the health/wellness issues FCNs could identify occurred during an individual interaction, these are listed in Table 3a. Nearly 25% of all contacts involving a health/wellness issue were focused on general health. General health covers a broad range of topics including assessment; education; action plans related to the client's general health; and how to improve health status i.e. use of vitamins, exercise, herbal supplement, recommended immunizations, and standards of care. Figure 4h identifies the distribution of the top five documented health/wellness issues occurring during an individual interaction.

Figure 4h: Top Five Health/Wellness Issues for Contacts

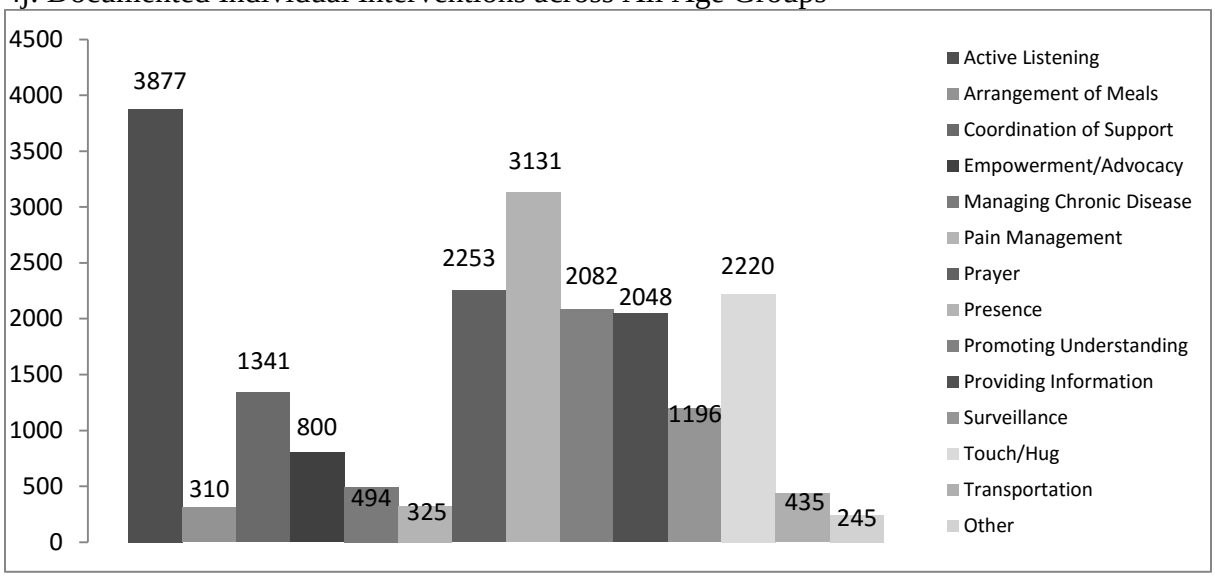


The final individual interaction category used for this analysis was interventions. The 14 interventions identified in Table 3a are interventions most frequently used by FCNs. A total of 20,757 contacts were documented across all age groups related to an intervention. The most frequently documented intervention was active listening. The description for active listening is grouped with the interventions of presence; prayer; and touch/hug and labeled as "intentional presence" in the Documentation and Reporting System Guide. Greater than 55% of all documented intervention fall within this grouping. Figure 4i identifies the top five documented individual interventions across all age groups. Figure 4j identifies the distribution of all individual interventions documented across the age groups.

Figure 4i: Top Five Interventions for All Age Groups



4j: Documented Individual Interventions across All Age Groups



Interventions Provided by FCNs for Older Adults

To identify how FCNs contribute to the health and well-being of older adults, a comparison of the documented interventions specifically involving older adults in the age ranges of 66-80, 81-90, and 91+ years were grouped and filtered into the category of individuals age 66 years and older, while the clients in age ranges of 0-4, 5-13, 14-18, 19-30, 31-50, and 51-65 years were grouped and filtered into the category of individuals age 0-65 years. Documented interventions involving individual's age 0-65 years were compared with documented interventions for individual's age 66 years and older across a total of 169 congregations in the 5 networks. Also analyzed to answer the second research question was the mode of delivery (i.e., individual or group) of interventions that target older adults.

The second research question was divided into two components.

2a: *What is the distribution of interventions involving older adults currently reported by FCNs in a large network*?

2b: What is the mode of delivery (i.e., individual or group) of interventions targeting older adults?

The congregational activity summary reports for each of the five networks were filtered by the two age categories mentioned previously, i.e. ages 0-65 years and ages 66 and older years. To assess the overall sample characteristics between the two age categories, the median was the number that best represented the central tendency due to the extreme ranges. The mean and standard deviation were not calculated due to extreme low and high value ranges. When data were filtered by the two age categories, the summative values for each of the group and individual intervention categories differs when compared with summative totals across all age groups.

Group Interventions

Group education/instruction activities were examined across the five networks comparing older adults with the age group 0-65 years. Given the focus on older adults, the top five group education/instruction activities, for hours or time spent by FCNs on the education/instruction activities, were selected based on those activities most commonly reported for the age group 66 years and older. These education/instruction activities included exercise/activity, mental health, nutrition, spiritual development, and volunteer ministry.

A total 6,357.75 hours were spent by FCNs on group education/instruction activities with older adults, and the time spent by FCNs on nutrition education exceeded all the other education/instruction activities (1,750.25 hrs.). For the age group 0-65 years, FCNs spent more time on exercise/activity far exceeding all of the other education/instruction activities (10,705 hrs.). The predominant education/instruction

activity for total amount of time spent differs between the two age groupings. Interestingly, when median values were analyzed, exercise/activity is the leading activity for both age groups. Also, time spent by FCNs on mental health and volunteer ministry group activities appeared in the top five group education activities, but did not appear in the top five group education activities for contacts/participants (see table 4.5). Table 4.4 reveals the comparison between the two age groupings using measures of central tendency for the time spent by FCNs on education/instruction group activities.

Table 4.4: Top Five Group Education Hours across Five Networks

Group Education	Frequency	Median	Minimum	Maximum
Age 0-65 years				
Thr=17,837.25 hrs.	*Hours*	*Hours*	*Hours*	*Hours*
Exercise/Activity	**10,705**	**203**	**10.50**	369
Mental Health	232	50.50	1	81.75
Nutrition	2,335.50	125.75	9	**1,930.75**
Spiritual Development	617.75	137.25	0	277.50
Volunteer Ministry	280	36.75	0	161.25
Age 66+years				
Thr=6,357.75 hrs.	*Hours*	*Hours*	*Hours*	*Hours*
Exercise/Activity	1,134.25	**199.25**	**13.50**	431
Mental Health	222.25	50.50	1	81.75
Nutrition	**1,750.25**	112.50	1	**1,383**
Spiritual Development	419.50	68.75	0	205.75
Volunteer Ministry	256.50	23.25	0	177.50

Boldface font represents highest value

Given the focus on older adults, the top five group education/instruction activities based on number of contacts or participants attending presentations or classes were selected based on those activities most commonly reported for the 66 years and older age group. These education/instruction activities included cancer, exercise/activity, nutrition, safety, and spiritual development.

A total of 226,470 clients participated in education/instruction activities from the 66 years and older age group. When the cumulative data were compared between the two age categories, nutrition education had more documented contacts then all the other 31

education/instruction categories. In fact, nutrition education contacts were documented more frequently in the 0-65 age group than for those in the 66 years and older age group. When comparing the median value for both age groups, exercise and activity education/instruction was the predominant documented group activity in both age groups. Revealed in the group education contacts, cancer education and safety education were included in the top five education activities (Table 4.5) but were not included in the top five education activities when analyzing documented hours spent (Table 4.4). Table 4.5 reveals the comparison between the two age groupings using measures of central tendency for the contacts or participants attending group education activities.

Table 4.5: Top Five Group Education Contacts across Five Networks

Group Education	**Frequency**	**Median**	**Minimum**	**Maximum**
Age 0-65				
Tc=247,483 contacts	*Contacts*	*Contacts*	*Contacts*	*Contacts*
Cancer	17,159	1,132	0	10,107
Exercise/Activity	15,382	**3,803**	258	6,335
Nutrition	**61,226**	2,149	**266**	**52,801**
Safety	13,809	1,245	131	8,878
Spiritual Development	10,507	855	0	8,056
Age 66+				
Tc=226,470 contacts	*Contacts*	*Contacts*	*Contacts*	*Contacts*
Cancer	17,321	1,343	0	10,108
Exercise/Activity	15,876	**3,937**	**261**	6,301
Nutrition	**49,854**	2,151	16	**41,912**
Safety	13,332	1,247	0	8,855
Spiritual Development	9,658	779	0	7,889

Boldface font represents highest value

Group screening activities were examined across the five networks comparing older adults with the age group 0-65 years. Given the focus on older adults, the top five group screenings activities, for hours or time spent by FCNs, were selected based on those activities most commonly reported for the 66 years and older age group. These screening activities included blood/organ drives, blood pressure, colon, flu shots, and health fairs.

A total of 4,128.75 hours were spent by FCNs on screening activities with older adults. As Table 4.6 reveals, more time was spent on blood pressure screening for both age groups than any of the other top five screening activities. Time spent by FCNs conducting health fairs was included as one of the top five screening activities, but did not appear in the top five screening activities when contacts/participants were counted (see Table 4.7). Interestingly, similarities were evident in all measures of central tendency for blood pressure screening hours.

Table 4.6: Top Five Group Screening Hours across Five Networks

Group Screening	Frequency	Median	Minimum	Maximum
Age 0-65				
Thr=4,266.50 hrs.	*Hours*	*Hours*	*Hours*	*Hours*
Blood/Organ Drive	625.75	177.50	1.25	227
Blood Pressure	**2,556.75**	**458.25**	**63.25**	**1,039**
Colon	203.25	0	0	106.25
Flu Shots	204.75	53.75	6.50	62.75
Health Fair	172	32.25	0	99.25
Age 66+				
Thr=4,128.75 hrs.	*Hours*	*Hours*	*Hours*	*Hours*
Blood/Organ Drive	559	154.50	0.25	221
Blood Pressure	**2,562.75**	**476.75**	**64**	**1,027.75**
Colon	205	0	0	106.50
Flu Shots	189.50	44.50	4	62.75
Health Fair	161.25	32.50	0	88.50

Boldface font represents highest value

When comparing table 4.6 and table 4.7, the highlighted data reveals blood pressure screening, across both age groups, was the largest screening activity documented by FCNs. In fact, minimal difference was noted in amount of time spent by FCNs and number of documented contacts participating in the blood pressure screening activity across all measures of central tendency and measures of dispersion.

Table 4.7: Top Five Group Screening Contacts across Five Networks

Group Screening	Frequency	Median	Minimum	Maximum
Age 0-65				
Tc=38,528 contacts	*Contacts*	*Contacts*	*Contacts*	*Contacts*
Blood/Organ Drive	2,717	583	89	1,162
Blood Pressure	**13,011**	**2,526**	**257**	**4,880**
Colon	2,089	0	0	1,125
Flu Shots	1,442	327	41	580
Safety	3,663	59	0	3,000
Age 66+				
Tc=36,792 contacts	*Contacts*	*Contacts*	*Contacts*	*Contacts*
Blood/Organ Drive	2,302	568	20	982
Blood Pressure	**13,029**	**2,658**	**260**	**4,866**
Colon	2,115	0	0	1,153
Flu Shots	1,433	316	27	574
Safety	3,599	19	3	3,000

Boldface font represents highest value

Support group activity was the final documented group activity examined comparing older adults with the age group 0-65, across the five networks. Given the focus on older adults, the top five support group activities, for hours or time spent by FCNs on support group activities, were selected based on those activities most commonly reported for the 66 years and older age group. These support group activities included care-giver, exercise/activity, grief/loss, healthy lifestyle, and spiritual/counseling.

A total of 13,962 hours were spent by FCNs on support group activities with older adults. When analyzing total time spent by FCNs on the top five support group activities, exercise/activity consumed the most time for FCNs on interventions with older adults compared with health lifestyle support groups for client's age 0-65. However, the median value reveals health lifestyle support groups for both age groups as the predominant activity where FCNs hours were spent. Care-giver support groups appeared in the top five support group activities for time spent by FCNs but did not appear in the top five support

group activities for number of participants or contacts. Table 4.8 reveals the comparison between the two age groupings using measures of central tendency for the time spent by FCNs on support group activities.

Table 4.8: Top Five Support Group Activity Hours across Five Networks

Support Group	Frequency	Median	Minimum	Maximum
Age 0-65				
Thr=14,823.50 hrs.	*Hours*	*Hours*	*Hours*	*Hours*
Care-Giver	956.75	47	0	857.50
Exercise/Activity	3,872.25	211	0	**2,842.50**
Grief/Loss	1,707.75	167.50	0	1,076.75
Healthy Lifestyle	**4,064.75**	**646**	0	1,815.50
Spiritual/Counseling	1,520.25	209	0	752.25
Age 66+				
Thr=13,962 hrs.	*Hours*	*Hours*	*Hours*	*Hours*
Care-Giver	964.25	40.25	0	877.50
Exercise/Activity	**4,077.50**	175.25	0	**3,099.25**
Grief/Loss	1625	151	0	1,064.75
Healthy Lifestyle	3,909.25	**554.50**	0	1,784.50
Spiritual/Counseling	1,540.25	248.75	**17**	715.25

Boldface font represents highest value

Given the focus on older adults, the top five support group activities based on number of contacts or participants attending support groups were selected based on those activities most commonly reported for the 66 years and older age group. These support group activities included exercise/activity, grief/loss, healthy lifestyle, spiritual/counseling, and substance abuse.

A total of 53,947 older adult clients participated in support group activities. The most frequently attended support group by older adults was exercise/activity compared to healthy lifestyle support groups for the 0-65 age group. A new category of support group replaced the care-giver support group in table 4.8 when analyzing documented number of participants. Substance abuse was identified in the top five support group activities attended by older adults. Table 4.9 reveals the comparison between the two age

groupings using measures of central tendency for the number of participants attending support group activities.

Table 4.9: Top Five Support Group Activity Contacts across Five Networks

Support Group	Frequency	Median	Minimum	Maximum
Age 0-65				
Tc=85,445 contacts	*Contacts*	*Contacts*	*Contacts*	*Contacts*
Exercise/Activity	24,989	**1,501**	0	14,119
Grief/Loss	2,928	575	0	1,062
Healthy Lifestyle	**31,277**	1,056	0	**25,647**
Spiritual/Counseling	11,818	1,060	0	8,688
Substance Abuse	1,368	87	0	1,165
Age 66+				
Tc=53,947 contacts	*Contacts*	*Contacts*	*Contacts*	*Contacts*
Exercise/Activity	**25,406**	831	0	15,059
Grief/Loss	2,616	530	0	990
Healthy Lifestyle	20,565	898	0	**15,326**
Spiritual/Counseling	11,621	**914**	**29**	8,577
Substance Abuse	1,253	31	0	1,165

Boldface font represents highest value

Individual Interventions

Given the focus on older adults, the top five spiritual/emotional/relational (SER) issues were selected based on those interactions between FCNs and clients most commonly reported for the 66 years and older age group. These SER issues included depression, grief/loss, relationship, spiritual well-being, and stress.

A total of 2,996 SER issues were documented based on assessment by FCNs for the 66 years and older age group. Spiritual well-being was the most frequently documented SER issue identified by FCNs not only for the older adult age group but also for 0-65 age group. Table 4.10 reveals the comparison between the two age groupings using measures of central tendency for contacts assessed with potential SER issues.

Table 4.10: Top Five Individual Interaction Contacts for SER Issues across Five Networks

SER Interactions	Frequency	Median	Minimum	Maximum
Age 0-65				
Tc=1,568 contacts	*Contacts*	*Contacts*	*Contacts*	*Contacts*
Depression	66	11	0	38
Grief/Loss	93	14	1	60
Relationship	213	58	2	75
Spiritual Well-Being	**497**	**72**	**5**	**333**
Stress	299	58	0	146
Age 66+				
Tc=2,996 contacts	*Contacts*	*Contacts*	*Contacts*	*Contacts*
Depression	205	41	0	107
Grief/Loss	265	13	**0**	143
Relationship	433	23	0	242
Spiritual Well-Being	**1,203**	**111**	1	**763**
Stress	399	82	1	198

Boldface font represents highest value

Given the focus on older adults, the top five health/wellness issues were selected based on those interactions between FCNs and clients most commonly reported for the 66 years and older age group. These health/wellness issues included general health, lives alone, living arrangements, mobility altered, and safety.

A total of 8,534 health/wellness issues were documented by FCNs for the 66 years and older age group. General health issues were the most frequently documented health/wellness issue identified by FCNs for the older adult age group. When individual interactions included health/wellness issues, the broad topic of general health occurred more frequently for both age groups. Table 4.11 reveals the comparison between the two age groups using measures of central tendency for contacts where health/wellness issues were part of the individual interaction.

Table 4.11: Top Five Individual Interaction Contacts for Health/Wellness Issues across Five Networks

Health/Wellness Interactions	**Frequency**	**Median**	**Minimum**	**Maximum**
Age 0-65				
Tc=2,696 contacts	*Contacts*	*Contacts*	*Contacts*	*Contacts*
General Health	**860**	**138**	**3**	**394**
Live Alone	163	21	1	90
Living Arrangements	133	8	0	99
Mobility Altered	256	36	0	**122**
Safety	172	53	1	57
Age 66+				
Tc=8,534 contacts	*Contacts*	*Contacts*	*Contacts*	*Contacts*
General Health	**1,916**	**292**	**2**	**1,185**
Live Alone	757	120	1	391
Living Arrangements	630	67	0	412
Mobility Altered	1,433	185	**2**	652
Safety	988	211	**2**	441

Boldface font represents highest value

Given the focus on older adults, the top five individual interventions used by FCNs were selected based on those interventions most commonly reported for the 66 years and older age group. These individual interventions included active listening, prayer, presence, promote understanding, and touch/hug.

A total of 15,797 individual interventions occurred between FCNs and clients in the 66 years and older age group. Active listening interventions were the most frequently documented individual intervention documented by FCNs for the older adult age group. Comparing both age groups, active listening was the predominant individual intervention. Table 4.12 reveals the comparison between the two age groups using measures of central tendency for individual intervention contacts between FCNs and clients.

Table 4.12: Top Five Individual Intervention Contacts across Five Networks

Interventions	Frequency	Median	Minimum	Maximum
Age 0-65				
Tc=6,117 contacts	*Contacts*	*Contacts*	*Contacts*	*Contacts*
Active Listening	**1,295**	**172**	**26**	**669**
Prayer	602	133	3	315
Presence	881	143	12	455
Promote Understanding	726	112	3	337
Touch/Hug	499	109	1	251
Age 66+				
Tc=15,797 contacts	*Contacts*	*Contacts*	*Contacts*	*Contacts*
Active Listening	**2,808**	287	**23**	**1,557**
Prayer	1,779	199	1	860
Presence	2,431	**310**	5	1,302
Promote Understanding	1,484	141	1	694
Touch/Hug	1,888	250	2	885

Boldface font represents highest value

The distribution of interventions involving older adults were compared with interventions provided to individuals age 0-65. The mode of delivery of interventions were examined through an analysis of group interventions and individual interventions. The final research question in the examination of FCNs interventions in the promotion of successful aging will involve mapping/aligning the individual and group interventions to the multidimensional model.

Aligning FCN Interventions with the Multidimensional Model of Successful Aging

To answer research question *3, How do the interventions documented by faith community nurses align with the multidimensional model of successful aging?*, data findings from research questions 2a and 2b were aligned with the model domains. The multidimensional model, as described in chapter II, emphasizes three domains: physiological; psychological; and sociological as pathways to successful aging. The top

five group and individual interventions have been aligned with each of the domains based on operationalized definitions of the model variables. Also, the explanation of terms provided in the Documentation and Reporting System Guide for the intervention categories analyzed in this study were used to assist with aligning the documented interventions to the model. The interventions appearing in bold font identify the interventions with the most frequent documented hours (hrs.) spent by FCNs in that interaction category and/or the greatest number of participants/contacts (c) attending the presentation/class, screening, or individual interaction.

In the multidimensional model, the physiological domain is defined by two variables; the presence or absence of chronic disease comorbidities; and the presence or absence of physical performance variables to determine functional impairment. The most frequently provided interventions involving older adults that were aligned with the physiologic domain are listed in table 4.13. Interaction categories not found to align with the model were individual spiritual/emotional/relational (SER) issues and individual interventions.

The psychological domain is defined by three variables; cognitive function, defined by how individuals perceive, register, store, retrieve, and use information; emotional vitality, defined by the presence of a sense of personal mastery; and geriatric depression, defined by changes in mood, behavior, and functioning. The most frequently provided group and individual interventions that aligned with the psychological domain are listed in table 4.13. Two interaction categories, group screening activities and individual interactions for health/wellness issues, did not contain interventions that aligned with the model.

The sociological domain is defined by two variables; engaging with life, defined by the degree of interaction with the environment and engagement in social activities; and spirituality, defined as the complex, multidimensional part of the human experience. The most frequently provided interventions that aligned with the sociological domain are represented by each interaction category except group screening activities. Table 4.13 lists the interaction categories and interventions that aligned with the model.

Table 4.13 Alignment of Model Variables with Interaction Categories and FCN Interventions

Multidimensional Model Variable	**Interaction Category**	**Intervention**
Physiological: Disease & Functional Impairment	Group Education	Cancer * Exercise/Activity *** +** **Nutrition * +** Safety *
	Group Screenings	**Blood Pressure * +** Colon * + Flu Shots * + Health Fair * + Safety *
	Support Groups	**Exercise/Activity * +** Healthy Lifestyle * +
	Individual Health/Wellness Issues	**General Health *** Mobility Altered * Safety *
Psychological: Emotional vitality Coping Resilience	Group Education	Mental Health +
	Support Groups	Care-Giver + Grief/Loss * + Substance Abuse *
	Individual SER Issues	Depression * Grief/Loss * Stress *
	Individual Interventions	**Active Listening *** Presence * Promote Understanding *
Sociological: Engaging with life Spirituality	Group Education	Spiritual Development * + Volunteer Ministry +
	Support Groups	Spiritual/Counseling * +

	Individual SER Issues	Relationship * **Spiritual Well-Being ***
	Individual Health/Wellness Issues	Live Alone * Living Arrangements *
	Individual Interventions	Prayer * Touch/Hug *

* = top five documented contacts
+ = top five documented hours invested
Bold font = most frequently reported activity

Chapter Summary

This chapter has provided an analysis of the documented interventions provided by FCNs across five networks retrieved from the Faith Community Nursing/Health Ministry Networks Documentation and Reporting System. An overview of the sample characteristics revealed the gender, member affiliation to the faith community, and the age range distribution of the participants. Each research question was then addressed through separate analysis of the data. The distribution of interventions across all age groups, including group and individual interactions, was conducted to present a broad overview of FCNs interactions with clients. The amount of time spent by FCNs preparing or providing group activities was analyzed as well as the number of participants attending group activities. For individual interactions, contacts or number of participants were analyzed. To examine how FCNs are contributing to the health and well-being of older adults, the cumulative data across the five networks was filtered into two age categories, i.e. ages 0-65 years and ages 66 years and older. Here the group and individual interventions were compared across the five networks to identify the mode of delivery (individual or group) and the interventions that target older adults. In the final phase of analysis, to determine how the interventions documented by FCNs promote successful

aging, the interventions most frequently provided by FCNs to older adults were aligned with the multidimensional model of successful aging.

In the next chapter, a summary of the findings examining the distribution of interventions across age groups are discussed. The distribution of the interventions involving older adults in comparison to the 0-65 age group along with the mode of delivery targeting older adults and how these interventions align with the multidimensional model are offered. The studies limitation and strengths are presented, and recommendations for enhancing the data collection system used for analysis and implications for nursing practice are suggested. To conclude, the next steps in faith community nursing research in the care of older adults is proposed.

CHAPTER V

Discussion

Introduction

The purpose of this study was to examine the distribution of interventions provided by FCNs to determine how these nurses are contributing to the health and well-being of older adults. To summarize the findings, the group and individual interventions provided by FCNs to individuals in all age groups were similar to the interventions provided to older adults. Aligning the frequently provided interventions by FCNs with the multidimensional model of successful aging revealed an association with each of the model domains. It does appear, after data examination when drilling down to specific age ranges, that there is an overestimation of age entries however, this documentation system is widely used, and is the best data set that currently exists to examine cumulative data documented by FCNs. It also provides a significant representation of the interactions that are occurring in faith communities between professional nurses and clients seeking information and support for health promotion and disease prevention.

The following discussion of the summary of findings begins with an overview of the sample characteristics. Attention will then be turned to the interventions provided by FCNs across age groups and then will specifically examine those interventions involving older adults. The alignment with the multidimensional model will be discussed, followed by limitations and strengths of the study. Recommendations for enhancing the data collection system used for analysis as well as implications for nursing practice are offered. To conclude this chapter, strategies to advance faith community nursing practice in the care of older adults is proposed.

Summary of Findings

Sample Client Characteristics

Faith communities provide a trusting, supportive environment and are becoming convenient sites for health and wellness programs (White et al., 2006). In this study, 169 faith communities had active FCN involvement, determined by evidence of documentation, providing some form of health promotion and disease prevention interaction. Of the 13,715 clients across all age ranges receiving care from FCNs in this network, greater than 60% of the clients were older adults age 66 years and older. The literature supports this finding based on a survey given to FCNs regarding the population they serve and the services provided. Ninety-two percent of FCNs reported the majority of clients served were older adults and that caring for people's health concerns and promoting health is a natural outreach of faith communities (McCabe & Somers, 2009).

In this study, large numbers of older adults appear to be attending or participating in group education and support group activities. However, a clear delineation of programs specifically for older adults does not appear to exist. Greater effort could be put forth in offering education programs to promote physical health as well as support groups promoting mental health for this population. A more detailed discussion addressing this issue is presented in an upcoming section of this chapter.

Faith communities touch the lives of a large number of people from all socioeconomic levels throughout all stages of life. Within the 169 faith communities used for this study, approximately 197,736 individuals were identified as members of a faith community in this network. Surprisingly 17% of the clients in this sample were non-members. This finding reveals evidence that faith communities are responding to the

needs of the local community but greater effort could be made on extending outreach to non-members and non-Christian communities. Also reported in the literature, women were found to have higher levels of religious activity involvement than men (Lawler-Row & Elliott, 2009), in this study 66% of the sample were female. To understand what interventions are provided by FCNs across all age groups, the next section will discuss these findings.

FCN Interventions across Age Groups

Across all age groups, Faith Community Nurses are promoting health. Large numbers of people are participating in education and support group activities. The total number of participants attending education/information group delivery activities was 247,525 over a one year time frame in this network. Nutrition education far exceeded the other top five group education interventions for both time spent by FCNs and the number of participants attending group activities. Nutrition and obesity issues are a common health issue addressed by FCNs (McGinnis & Zoske, 2008). As King and Pappas-Rogich (2011) pointed out, activities that promote healthy weight and good nutrition are often provided monthly by FCNs. Promoting a healthier diet and balancing calories consumed with what is burned is in-line with health indicators cited in Healthy People 2010 (King & Pappas-Rogich, 2011).

Support group delivery activities were identified in the literature as an important role of FCNs (Bergquist & King, 1994; McDermott & Burke, 1993; Swinney et al., 2001). The number of participants attending this type of group delivery activity, over a one year time frame in this network was 92,164 with more than 16,032 hours devoted by FCNs to the variety of support group activities identified in the documentation system.

Healthy lifestyle and exercise activity were the predominant support groups attended. According to White et al., social support and positive responses to wellness programs occur through exercise and dialogue related to cardiac health (2006). Providing education and instruction support about disease and illness management through healthy lifestyle support groups such as weight management programs and exercise, and activity support groups through structured group activities provides a trusting supportive environment at convenient faith community sites where social support is fostered (Lewis, 2011; White et al., 2006). As a result of these types of support groups, increased knowledge regarding the warning signs of stroke and heart attack and improved participation in regular exercise can occur (Rethemeyer & Wehling, 2004). Through healthy lifestyle support groups, faith communities are helping participants meet health care needs.

Other support groups revealed in the data analysis findings relate to psychosocial support. Swinney et al. (2001) identified concerns expressed by faith community members in the area of adolescent risk-taking behaviors, spousal abuse, and child abuse. The same faith community members found the psychosocial support needed when they turned to their faith community. The number of participates in attendance at three of the top five support group interventions related to psychosocial support in this study were substance abuse (1,396), grief/loss (3,010), and spiritual counseling (12,874). Interestingly, the hours set aside for support group activities (16,032.5 hrs.) far surpassed the other two group activity categories (education/8,996hrs.; screening/4,747.25hrs.). When time is documented for support group activities, prep time for articles is factored in. Consistent with these findings, a study by McGinnis and Zoske (2008) found that greater than 50% of FCNs time was spent on program development/management.

Frequent blood pressure screenings may also result in positive health influences. A total of 41,467 contacts were documented for screening interventions. More than one third of contacts for screening activities across all age groups occurred during blood pressure screening. Not only health teaching but blood pressure screening provided by FCNs were areas identified by the clients as self-help promoting activities (Wallace et al., 2002). FCNs were viewed as a valuable link in providing continuity of care Previous research supports similar findings (Monay et al., 2010; Rethemeyer & Wehling, 2004). Rethemeyer and Wehling (2004) surveyed 760 faith community members regarding the outcomes of services provided by FCNs. The survey findings revealed frequent blood pressure checks, healthier eating habits and regular exercise participation resulted in a positive influence on participant's health. Monay et al. (2010) concurred that blood pressure measurement, diet education, and supportive counseling by FCNs were providing supportive self-management to low-income individuals who might otherwise have limited access to health services.

Individual interventions provide an opportunity for health/wellness and spiritual/emotional/relational discussions to occur. Across all age groups, the most frequent individual interaction provided by FCNs was interventions, with a total of 20,757 contacts made between FCNs and individuals. The specific individual interventions, listed in order of frequency were active listening (3,877 contacts), presence (3,131 contacts), prayer (2,253 contacts), and touch/hug (2,220 contacts). These interventions are categorized as intentional presence, and represent greater than 55% of all individual interventions for this age group. This is the core of the specialty practice; "the intentional care of the spirit". One reason, supported in the literature, for the

frequency of intentional presence interventions by FCNs, is unrestricted time constraints for interactions with clients allowing for a deeper, more personal encounter (Dyess & Chase, 2012). However, what is unique regarding the role of the FCN, outside the various health care roles of a community health nurse, is the holistic aspect of faith community nursing. As Bergquist and King (1994) elaborated upon, the holistic wellness promoted within the categories of body, mind, and spirit is exemplified in the spiritually mature Registered Nurse who assumes the role of a FCN. McGinnis and Zoske also point out that the spiritual dimension is central to FCNs practice (2008).

Discussions regarding health/wellness issues were part of the individual interaction and 10,614 conversations during individual interactions covered topics related to health/wellness issues. General health was a health/wellness issue most frequently discussed during an individual interaction. Assessing for general health and developing action plans for how to improve health status has been mentioned in the literature as a main element in program development for FCNs (Dyess et al., 2010). In fact, FCNs provide services for adults living with chronic illness by incorporating interventions and multiple layers of caring so individuals can live abundantly despite living with illness (Dyess & Chase, 2010).

Discussions regarding spiritual/emotional/relational issues also occurred as part of the individual interaction with a total of 4,269 conversations during individual interactions. It is not surprising that spiritual well-being was the most frequently occurring discussion between FCNs and clients, since the spiritual dimension of care is central to FCNs practice. As the role of the FCN resides in the unique setting of a faith community, the spiritual care provided by FCNs emphasizes sanctity of the body,

strength in times of grief, a source of self-esteem, and emotional well-being through prayer (Bergquist & King, 1994). Some recipients of FCN care believe that faith and spiritual beliefs are important in maintaining health (Swinney et al., 2001).

FCN Interventions for Older Adults

Filtering the documented interventions into two distinct age groupings provided an opportunity to examine FCNs interventions directed toward older adults. For this discussion, the findings for the age 66 years and older group will be examined by mode of delivery and the frequency of contacts and hours that occur with each category. Keep in mind regarding the sample characteristics, greater than 60% of clients seen by FCNs in this sample were age 66 and older.

Group education/instruction activities were the most frequently provided group activity by FCNs for older adults (226,470 contacts). Nutrition education was the most frequently attended activity by older adults (49,854 contacts) and the education activity where FCNs spent the most time preparing or conducting instruction (1,750.25 hrs.). When comparing nutrition education contacts (61,226) for the 0-65 age group, and time (2,335.50 hrs.) spent by FCNs preparing or conducting instruction for this age group, an interesting discovery begins to emerge. The total contacts for nutrition education across all age groups were 61,151 and time spent by FCNs preparing or conducting nutrition education instruction were 2,326 hrs. A flaw was identified in the cumulative reporting. This puzzling finding may provide evidence of the convoluted nature of the data system for group activity documentation. When participants attend a group activity, the only required documentation is number of participants. So when age is used as a filter to extract data totals, participants may be counted more than once which creates data

slippage. Another intriguing finding was found when examining the data on the network level. When interpreting minimum and maximum values for nutrition education in the age 66 years and older group, one network had as few as 16 contacts in a year for nutrition education compared to another network with a maximum of 41,912 contacts in a year for nutrition education. This is a wide range across the five networks suggesting possible missing data.

Exercise/activity was also noted to have a high rate of frequency for number of contacts (15,876) and time spent (1,134.25hrs.) by FCNs for older adults. If we purely focused on the median value, exercise/activity would be recognized as the most frequently attended group education activity (3,937 contacts; 199.25hrs.) for the age 66 years and older group. An unexpected finding was the amount of hours spent by FCNs on exercise/activity for the age group 0-65 years (10,705 hrs.) compared to the older adult age group. When McCabe and Somers (2009) reported that FCNs devote 50-100% of their time serving seniors, the proportion of hours spent on exercise/activity for the 66 years and older age group is less than adequate. Exercise/activity for older adults is usually done with others, providing a form of social support and engagement with life, a vital component in the daily activities of older adults (Loeb et al., 2003). FCNs do provide disease self-care guidance thereby impacting health and well-being of older adults and their caregivers (Rydholm et al., 2008) and healthy behaviors were noted by Lawler-Row and Elliott to increase with age (2009). However, greater effort could be put forth in offering education programs to promote physical health for older adults such as heart disease and cancer prevention and stroke risk assessment. Overall, when examining

group education/information activities, there appears to be no specific activity focused on older adults.

Documented support group activities for older adults revealed a total of 53,947 contacts and 13,962 hours spent on preparation and/or delivery by FCNs. In this support group category, exercise/activity had the highest amount of older adult participants (25,406) and hours spent on preparation and/or delivery (4,077.50 hrs.). Healthy lifestyle support groups were not far behind in frequency (20,565 contacts; 3,909.25 hrs.). Across all age groups the findings were similar, healthy lifestyle support groups (32,537 contacts; 4,294.75 hrs.) and exercise/activity support groups (27,448 contacts; 4,413.75 hrs.) were the most attended activities in this category.

Regular physical activity is one of the most important things older adults can do to reduces the risk of falls (Centers for Disease Control and Prevention, 2013) still, support groups promoting mental health for older adults was lacking. Topics such as caregiver support, grief/loss, and cancer survivor support groups provided by FCNs could meet the needs of older adults for social interaction exposure by providing opportunities to engage with others. Since a significant proportion of older adults identify with a religious organization, as mentioned in Chapter 1, support groups provided by FCNs in the faith setting could meet the needs of older adults to combat isolation and loneliness. This researcher was expecting to see spiritual development support groups to have significantly more participants in the older adult age group however, that was not found. However, a shift does begin to occur as the spiritual aspect of care for older adults begins to emerge when examining the median value. Spiritual/counseling support groups had the largest median value across the five networks at 914 contacts for the age 66 years and

older group. It is important to note, when examining the minimum value across the five networks, there is at least one network where support group activities are not occurring or are not being documented. Plus, exercise/activity appears as a topic in both education/information and support groups which could lead to a lack of precision when analyzing cumulative findings.

Group screening activities for older adults were provided to 36,792 contacts and 4,128.75 hours were spent by FCNs on screening activities. Blood pressure screening remains the single highest screening activity by FCNs for older adults as well as across all age groups. This is an encouraging finding since the National Report Card on Healthy Aging for older adults age 65 and older reveals 94% of older adults are diagnosed with high blood pressure and taking prescribed medication (Centers for Disease Control and Prevention, 2013). It is important to note that FCNs are also providing flu vaccines and colorectal cancer screening, some of the preventive care and screening indicators for older adult health recommended by the CDC.

When examining the summative values of group activities across the five networks, hours spent on education/information activities reveals greater than a two-fold increase in frequency with the age 0-65 group compared to age 66 years and older group (see table 5.1). However, when examining the total number of contacts comparing the two age groups, rates of occurrence were similar. This is an intriguing finding. It is unknown if the hours spent by FCNs on exercise/activity, an identified category in both education/information activities and support group activities, is disproportionally higher for the age 0-65 group in education/information group activities, could be related to a more diverse selection of exercise/activity options as there is a lack of standardization in

defining this category. Does this lack of clarity create inaccuracy in cumulative reporting or are participants counted more than once? This discrepancy related to this broad topic remains a limitation of the data set.

Comparing the summative values of the two age groups across the five networks for screening activities reveals minimal differences (see Table 5.1). However, summative support group hours, which include preparation time for meetings, reveal a slight increase in time spent for the 0-65 age group (14,823.50hrs.), and a significant increase in contacts for support groups in the same 0-65 age group (85,445). The environment within the faith community includes a natural support group setting, much like an extended family or caring individuals (Bergquist & King, 1994). This should be fostered for all age groups, especially older adults who often list social support as one of their most significant needs (McCabe & Somers, 2009).

Table 5.1: Summative Values across Five Networks for Group Activities

Group Activity	**Age 0-65**	**Age 66+**	**Difference**
Hours:			
Education/Information	17,837.25	6,357.75	11,479.50
Screening	4,266.50	4,128.75	137.75
Support Groups	14,823.50	13,962	861.50
Contacts:			
Education/Information	247,483	226,470	21,013
Screening	38,528	36,792	1,736
Support Groups	85,445	53,947	31,498

When examining individual interventions, conversations regarding spiritual/emotional/relational (SER) issues and health/wellness issues often occur as part of the individual interventions and were reported in the documentation. The findings from each of these documentation categories will be discussed as they relate to older adults.

For older adults age 66 years and older, 2,996 contacts included conversations related to a SER issue. Spiritual well-being was the most frequently reported SER issue (1,203 contacts) for older adults compared to the 0-65 year age group (497 contacts). Loeb et al. provided a broad overview of coping strategies used in older adults to manage chronic disease in their day-to-day experience (2003). One category in which coping strategies emerged was relying on spirituality and religion. Participants noted that relying on spirituality and religion provided the psychological support to see them through life events (Loeb et al., 2003). McCabe and Somers (2009) also reported that spiritual support was a need of older adults met by FCNs. The findings revealed from this current study of the documentation system suggest spiritual needs were being addressed during individual interactions between FCNs and older adults more often than the comparison age group.

Health/wellness conversations were part of the individual interaction between FCNs and older adults with 8,534 contacts compared to the 0-65 year age group with 2,696 contacts. General health was the most frequently occurring conversation (1,916 contacts). The Documentation and Reporting System Guide used by FCNs as a reference for documentation input defines the general health issue as assessment, education, and action plans related to improving the health status i.e. use of vitamins, exercise, herbal supplements, recommended immunizations, and standards of care. While this is a broad explanation of the term general health, the CDC recognizes health education for older adults as an important indicator of health aging. Altered mobility is also a frequently occurring health/wellness conversation with older adults (1,433 contacts) compared to the 0-65 year age group (256 contacts). Described in the Documentation and Reporting System Guide, altered mobility is the assessment by the FCN of mobility, weight-bearing

status, and the use of assistive devices, i.e. cane, walker, wheelchair. Reducing the proportion of older adults who have moderate to severe functional limitations as a determinant of healthy aging is a specific *Healthy People 2020* objective (Centers for Disease Control and Prevention, 2013). While conversations between FCNs and older adults are occurring regarding health/wellness issues, greater effort could be made to engage this ever-growing population living with chronic disease in health promotion and disease prevention to promote successful aging.

The final interaction examined in this study was individual interventions. More than twice the amount of individual interventions occur with older adults, age 66 and older (15,797 contacts) compared to the age group 0-65 years (6,117 contacts). Active listening is the most frequently occurring intervention between FCNs and older adults (2,808 contacts). Here, the unique specialty of faith community nursing begins to become evident. Not only active listening interventions but also individual interventions of presence (2,431 contacts), prayer (1,779 contacts), and touch/hug (1,888 contacts) were frequently occurring with older adults. Examining the median value, the intervention of presence occurred more often with older adults (310 contacts), again revealing the salient feature of unrestricted time restraints. As McCabe and Somers (2009) point out, 95% of in-home visits are taking place with older adults, and 74% of FCNs report spending 30-60 minutes per visit. One of the core processes of FCN practice identified by Dyess and Chase (2012) is the opportunity FCNs have to enter the private world of another with no time constraints for the interaction leading to a deeper more personal encounter. The interventions reflect the multiple layers of caring provided by FCNs for social and spiritual support.

While the number of individual interventions were low when compared to group activities, this could reflect the small number of FCNs that have completed educational preparation to assume the role. Currently there are approximately 12,000 faith community nurses. As information and knowledge regarding this specialty practice increases, hopefully so will the number to meet the needs of the nation's 46.2 million older adults.

Alignment of FCN Interventions with the Multidimensional Model of Successful Aging

FCNs play a key role in promoting successful aging because of their holistic approach to providing health care services in the community. These nurse have an opportunity to significantly improve the quality of life for older adults, however identifying their holistic approach to the care of older adults has been loosely defined due to the lack of a theoretical framework to define their work. Aligning the interventions targeting older adults to the model domains captures the potential of FCNs to tailor interventions focused on health promotion and disease prevention to improve the well-being of older adults.

The physiological domain in the multidimensional model was defined by the presence or absence of chronic disease as well as functional impairment. This domain is being addressed by group education activities aimed at providing information regarding nutrition and exercise/activity to improve physical health. Physical activity can prevent many of the health problems that come with aging and older adults at risk for falling should exercise to improve or maintain balance. High blood pressure is a major risk factor for cardiovascular disease, and is the leading cause of illness and death in older

adults (Centers for Disease Control and Prevention, 2013). Screening for high blood pressure serves a vital need for detection of individuals with undiagnosed disease as well as management between medical visits for medication effectiveness and lifestyle modification adherence. Support groups and individual interactions addressing general health/wellness issues are also assisting older adults to maintain or improve their physical health status.

The psychological domain in the multidimensional model was defined by cognitive function, emotional vitality, and resilience. This domain was being addressed by group education and support groups aimed at aspects of mental health however, more could be done. While there does not exist a clear delineation of programs specifically for older adults, greater effort could be put forth to promote mental health for this age group. Many older adults suffer with mental distress due to grief following the loss of loved ones, care-giving challenges and depression or substance abuse (Centers for Disease Control and Prevention, 2013). Support groups for caregivers and cancer survivors could meet not only mental health needs but the social interaction exposure needed to combat isolation and loneliness. Emotional and social support was strong predictors of well-being. The interventions provided by FCNs can help to identify older adults with mental distress and provide recommendations to available community programs to improve mental health.

The sociological domain in the multidimensional model was defined by the degree of engagement in social activities and the presence or absence of spirituality. This domain was being addressed by group and individual interventions aimed at social engagement through volunteer ministry opportunities and spiritual development through

education, support groups, and individual interactions. The supportive environment present in faith communities provide a positive influence as groups of people share values and beliefs in relation to the spiritual dimension (Buijs & Olson, 2001). Also church membership was found to be a significant contributor to a sense of meaning and purpose for older adults (Lawler-Row & Elliott, 2009). FCNs appear to be meeting holistic needs in the non-traditional health care setting similar to nurse navigators practicing in traditional settings.

When mapping FCNs interventions to the model domains, the cluster of activities and individual interventions do map to the model domains, which suggests FCNs are contributing to the health and well-being of older adults. However, when the data tables were examined for group activities there is an overestimation of contacts when the data was drilled down to age ranges. Overall, when examining data across the five networks, FCNs are providing a variety of interventions to assist older adults to successfully age. The one exception was the descriptive term blood/organ drive. The screening intervention, blood/organ drive, did not align with any of the model domains due to the nature of the event which is usually implemented by the American Red Cross to meet the physical needs of the local community and may be organized by FCNs.

Study Limitations and Strengths

The individual interaction form used by FCNs for documenting interactions with clients includes some required information such as age range, gender, member type and insurance type that must be completed for electronic documentation submission. However, many of the categories that describe the type of interaction, i.e. spiritual/emotional/relational, health/wellness, and interventions, all used in this analysis

as well as outcomes of care that describe the result of the intervention are not required for successful submission of the interaction form. This becomes a study limitation related to missing data. Although it has been described throughout the study that this is an initial examination, further research on the effects of FCNs interventions on improving outcomes of persons with chronic illness may be difficult to determine due to this slippage of data.

Another limitation exists when documenting in the group activity form. When an optional group activity category is selected i.e. education/information, screenings, and support groups, a variety of description options can be selected for the group activity. The required fields for completing documentation, once the description is selected, are number of participants in attendance and the time set aside for the activity/class. When analyzing cumulative data from the group activities, standardization of definitions for the descriptive terms prevents consistency in documentation across users. For example, in the education/information category some of the description options are self-identifying i.e. adolescent/teen health, CPR/AED, diabetes. Inconsistency exists when descriptive terms such as caregiver support, exercise and activity, and parenting support are description options found in both the education/information category and the support group category. A similar lack of clarity exists with the descriptive term of safety which appears on both the education/information category and the screenings category. Standardizing definition of descriptive terms would inform the user of the documentation system to enhance accuracy in cumulative reports and to better target prioritizing needed care.

The strengths in this study were evidenced by the descriptive findings. Large numbers of older adults appear to be attending or participating in group education

activities and support groups. While there does not exist a clear delineation of group programs specifically for older adults, more than 60% of recipients of FCN care are older adults age 66 and older. Supportive programs help to alter aspects of community life through social engagement as well as help maintain a sustained healthy lifestyle. Social support networks combat loneliness, depression, unhappiness, poor self-rated health, and increased care needs. Healthy lifestyles include participating in screening programs. Individual interventions were an area where spiritual care needs are being met. Perhaps this is an area where greater workforce effort could exist. FCNs provide vital services to older adults in the faith community setting. The variety of services provided are a testimony to the needs that exist among clients to gain knowledge regarding health care information. In seeking information, older adults can make informed decisions about their health management.

Implications for Practice

FCNs are providing vital services to older adults in the faith community to promote health and educate about disease prevention. FCNs enhance other traditional health care services by educating and empowering clients and their families regarding knowledge of chronic disease management and prevention. Caring for people's health concerns and promoting health is a natural outreach of faith communities, but collaborating with formal social service agencies to improve accessibility to community services for older adults is needed. Faith communities touch the lives of a large number of people from all socioeconomic levels and are one setting where holistic health services for adults living with chronic illness can be provided. But as evidenced by the findings and discussion regarding the documented interventions across five large faith community

networks, FCNs still have a long way to go with education and instruction efforts to assist older adults in the area of health promotion and disease prevention regarding chronic disease management to help lessen the burden on traditional health care settings. To advance the practice of faith community nursing, dissemination of findings from this study will help to inform and advance research in this specialty practice. Collaboration across health care institutions and the community settings where health management can be supported is imperative to enhance quality of life for older adults in the promotion of successful aging.

Recommendations for Enhancing Documentation

Two areas where documentation enhancement is suggested as a result of this data analysis are documentation of group activities and the definition of terms listed in the three group activity categories analyzed for this study. Since group activities were the most frequently documented mode of delivery for FCN interventions, the precision of the documentation affects the cumulative reports used for network administrators and community benefit reporting.

Since the input provided in the group activity form reports number of participants and time by FCNs set aside for the group activity or preparation time, the age accuracy of the target audience participating in the group activity is an approximation at best. If age ranges were an option to estimate the specific audience in attendance, more precise reporting could occur for reporting and planning of future events.

More troublesome, when analyzing the group activity data, is the replication of descriptive terms that occur across group activities. For example, cancer is a descriptive term in the education/information category and cancer survivors is a descriptive term in

the support group category. The description of cancer is clear for each group activity category, but care giver is a confusing descriptive term. Care giver support is a descriptive term that appears in the education/information category however, care giver is the descriptive term in the support group category. It is difficult to analyze results and their meaning when the term is inconsistent in the two categories. Similar cross-over of terms exists with parenting support (education/information) and parenting (support groups). Perhaps if definitions were listed after the descriptive terms, a more precise understanding of the interventions could occur with more accurate reporting.

Future Research

The Faith Community Nursing/Health Ministries Documentation and Reporting System not only assists FCNs to meet professional documentation standards, but the web-based system assists the users in preparing reports for community benefit reporting and grant writing. The documentation site integrates a number of reporting variables that was not examined in this study. Future studies could evaluate referral rates as a result of blood pressure screenings when findings are outside the normal range for blood pressure. Monay et al., (2010) called for further research on the effects of services provided by FCNs to clients with elevated blood pressure on improving outcomes as well as services provided to persons with chronic conditions in underserved populations. Future studies could examine insurance coverage of participants receiving care from FCNs and the frequency and types of services provided by FCNs to each identified group.

Due to the ever increasing pressure to reduce health care costs and increase quality (Bensink et al., 2013), an economic evaluation of the cost effectiveness of implementing faith community nursing in local communities would provide important

information for decision makers in the business of health insurance. Incorporating cost effectiveness analysis alongside the frequency distribution of interventions provided by FCNs would provide a number of benefits. Included in these benefits would be the effectiveness of the interventions for improving the health of the client population under study, the value provided by using nurses in the faith community setting. The impact of financial investments by stakeholder organizations in forming partnerships between health care systems and local faith communities to provide continuity of care, especially for vulnerable populations, could have far-reaching positive gains for both the health care consumer and the health care provider.

Chapter Summary

Faith Community Nurses are providing interventions focused on health promotion and disease prevention with the intentional care of the spirit. The majority of client's receiving care from FCNs were older adults however, a variety of interventions, both group and individual, were occurring across all age groups. While these nurses are doing a tremendous job providing care, more could be done to target care specific for older adults. As the population continues to age, so does the risk of developing chronic disease. Other strategies to promote and manage health are needed to support healthcare for this growing population. The expertise of faith community nursing care is one strategy to help meet this need.

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Appendix A

HENRY FORD MACOMB HOSPITALS

FAITH COMMUNITY NURSING/HEALTH MINISTRY NETWORK
POLICY #1

Title: **NETWORK/CONGREGATION MEMBERSHIP**

Policy: Membership in the Henry Ford Macomb Hospital (HFMH) Faith Community Nursing/Health Ministry Network (FCN/HMN) is a mutual partnership in which the ultimate responsibility for the Faith Community Nurse/Health Ministry remains with the church/congregation/synagogue.

Definition: Faith Community Nurse –
The term Faith Community Nurse (FCN) refers to a registered nurse.
This nurse is:

1. Spiritually mature
2. Has three years of nursing experience
3. A member of a church/congregation in good standing
4. Licensed as a registered nurse in the State of Michigan
5. Well organized and has a passion for health ministry

Lead Health Minister -
The term "Lead Health Minister" (LHM) refers to an individual who is not a registered nurse and leads the Health Ministry.
This individual is:

1. Spiritually mature
2. Experienced in teaching, health counseling or volunteer work and church ministry
3. A member of the church/congregation in good standing.
4. Well-organized and has a passion for health ministry

Procedure: In order to obtain membership in the FCN/HMN the church/congregation must:

1. Be located in Macomb County, or have 30% of it's membership who resides in Macomb County
2. Have a written formal agreement with qualified Faith Community Nurse/nurses or Health Minister, which includes:

   a. Successful completion of a Faith Community Nurse or Health Minister foundations course within one year of membership
   b. Provision of services no less than 16 hours per month
   c. Maintenance of current licensure as a registered nurse or other licensed professional in the State of Michigan
   d. Performance of all activities in accordance with the American Nurses Association Standards of Practice and Code of Ethics
   e. Exclusion of acts of invasive procedures except by signed consent of participating parties

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f. Referring all conditions that he/she is not licensed or skilled to treat to the appropriate persons or agencies
g. Working collegially with members of the ministerial team
h. Maintenance of confidential secured records; records will be given to others only with written permission of the client's signature/representative signature
i. Actively working to increase the professional skill needed in the Faith Community Nurse/Health Minister's practice
j. Provision of periodic and yearly written reports to the Congregation and the FCN/HMN
k. Maintenance of diligent use of the means of grace in providing whole person health care to parishioners in continuation of the healing mission of Jesus Christ or their faith tradition
l. Actively seeking to continue spiritual growth and development through Bible study, prayer, personal devotions, regular attendance at worship and/or communion
m. Attendance at a minimum of 50% of the FCN/HMN support group meetings per year or other FCN/HMN events (conferences, workshops, retreat, committees, etc.)

3. Sign a formal written agreement with the HFMH Faith Community Nursing/Health Ministry Network. Each formal written agreement may be individually negotiated.
4. The following criteria must be included in the formal written agreement: (additional documents in Policy #16).
   a. Terms
   b. Termination
   c. Obligations of the Parties: Network/Congregation
   d. Compensation
   e. Miscellaneous Conditions
   f. Personnel Policies
   g. Selection of Faith Community Nurse or Lead Health Minister
   h. Compliance with Laws
   i. Indemnification (no refund)
   j. Independent Contractor
   k. Notice
   l. Inclusion of all Terms and Conditions in Writing

Ameldia Brown, M.Div, RN Date
Director, Faith & Community Health

Karen Standfest, RN Date
Vice President Patient Care Services & Chief Nursing Officer

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Next Review: August 2013

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FAITH COMMUNITY NURSING/HEALTH MINISTRY NETWORK
POLICY #3

Title: **BENEFITS OF MEMBERSHIP**

Policy: Congregations shall benefit from their relationship with the FCN/HMN through services and supports provided for their Faith Community Nurses, Lead Health Ministers and Health Ministries.

Procedure: Benefits of HFMH FCN/HMN membership shall include:

1. Orientation to the network
2. Foundations for FCN or HM course available
3. Free or reduced registration fee for foundations courses
4. Current Policy & Procedure Manual provided
5. Continuing education opportunities
6. Peer support
7. Web-based documentation system
8. Resources:
   a. Professional support
   b. Learning Resource Center
   c. Community referrals
9. Networking opportunities on a local, state and national level
10. Goals setting and program development support
11. Skill development
12. Starter kit (see addendum section)
13. Yearly performance appraisals
14. Ongoing ministry support

Ameldia Brown, M.Div, RN Date
Director, Faith & Community Health

Karen Standfest, RN Date
Vice President Patient Care Services &
Chief Nursing Officer

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Appendix C

Lina Hixson, MN, RN
Doctoral Candidate
College of Nursing, the Pennsylvania State University
LBH145@psu.edu

September 11, 2015

Nancy Durbin, MS BSN RN-BC
Faith Community Nurse
Director, Faith Community Nurse Ministry & Faith Community Nurse Support Network
Advocate Health
Downers Grove, IL
Nancy.durbin@advocatehealth.com

To Whom It May Concern;

I, Nancy Durbin, on behalf of Advocate Health Care, authorize, Lina Hixson, Doctoral Student Nurse Researcher, College of Nursing, and the Pennsylvania State University, access to the **De-identified documentation data** contained within the Faith Community Nursing/Health Ministries Documentation and Reporting System, Henry Ford Health System for academic research only.

The researcher, Lina Hixson, agrees to not release any individualized or personalized health information that may link a specific individual to the data contained in the electronic reporting system. The intent of the data analysis is to view the content from a group perspective and not as individualized entries.

The health network is aware that the grouped data has the potential to be used for academic presentations and research papers. If used, the health network will be acknowledged as part of the process.

This authorization will remain in effect for no more than 3 years from date of signing to allow time for thorough data retrieval.

Advocate Health Care Representative

Lina Hixson, Researcher

Curriculum Vitae
Lina B. Hixson, Ph.D., RN

email: lina.hixson1@gmail.com

Education/Training

Institution	Degree	Year(s)	Field of Study
The Pennsylvania State University	PhD	2016	Nursing
Duquesne University	MSN	2006	Nursing Education
Carlow College	Certification	1996	School Nursing
La Roche College	BSN	1990	Nursing
OVGH School of Nursing	Cum Laude Diploma	1981	Nursing

Academic Positions

Instructor in Nursing – Waynesburg University, Waynesburg, PA 2014-present
Adjunct Nursing Instructor - Wheeling Jesuit University, Wheeling, WV 2013
Instructor in Nursing - West Liberty University, West Liberty, WV 2009-2012
Adjunct Nursing Instructor - Community College of Allegheny County 2005-2014
West Mifflin, PA
Part-time Classroom Lecturer and Clinical Instructor LPN Program 2006-2009
Western Area Career & Technical Center, Houston, PA

Professional Employment Positions

Staff Nurse, Progressive Medical-Surgical Unit – Per Diem 2006-2007
Jefferson Regional Medical Center, Pittsburgh, PA
Certified School Nurse - Ringgold School District, Monongahela, PA 1998-2009
Emergency Room Staff Nurse – Per Diem-Canonsburg General Hospital 1996-2000
Staff Nurse – CCU, Pediatrics - Allegheny General Hospital, Pittsburgh, PA 1984-1992
Staff Nurse – Central Medical Center & Hospital, Pittsburgh, PA 1982-1984
Staff Nurse – New Graduate - St. Clair Hospital, Mt. Lebanon, PA 1981-1982