ABSTRACT
In this state-funded study of the impact of faith community nursing, 1,061 notes regarding 713 older adults were retrieved from 75 faith community nurses. Critical contacts were mapped using the Data, Interpretation, Action, Response, and Yield (DIARY) charting format. DIARY notes revealed that disabilities were seemingly avoided when reluctant older adults were coaxed to access care before their illnesses escalated. The nurses solicited help from blended networks, procured assistive devices, cued family members, made environments safe, reengaged those who were despairing, calmed those who were anxious, facilitated recovery aftercare, advocated for those who were neglected, and helped caregivers navigate end-of-life decisions.
A ccording to the Federal Interagency Forum on Aging-Related Statistics (2004), the current U.S. population of 36 million people age 65 and older will surge to 71.5 million by the year 2050. When the older segment of the population shifts from 1% to 20%, the numbers of older adults will surpass the numbers of children in some parts of the country (U.S. Census Bureau, 2005). When the older adult population doubles, health care will become more difficult to obtain.

Hiller and Barrow (1999) credit “the graying of America” (p. 7) to the reality that individuals born between 1946 and 1964, members of the Baby Boomer generation, are growing older. People are living longer. Birth rates are declining (Kane, Ouslander, & Abrass, 2004). According to a MetLife Mature Market Institute report in 2001, family caregivers are currently providing 80% of all long-term care services; their services are valued at $306 billion per year, more than twice what is being spent in nursing home and paid home care combined (Arno, 2006).

Recognizing the need to support informal caregivers of older adults in the community, the Metropolitan Area Agency on Aging in Minnesota launched a 2-year exploratory project entitled Supporting Seniors Across Systems (SSAS). The intent of the project was to strengthen existing faith-based support networks that older adults use informally, while enhancing communication between these networks and other quasi-formal and formal helping systems. The intent was to better equip elderly caregivers and at-risk older adults with liaison coaches, helpers, and people of first call.

Funding for the project was obtained through the Minnesota Department of Human Services and the Medica Foundation, financial stakeholders in eldercare and illness prevention. Equipping caregivers and older adults with relationship-driven support systems and people of first call made sense to them. The Department of Human Services is Minnesota’s Medicaid agency. It funds eldercare systems change initiatives through an appropriation from the state legislature. The Medica Foundation is a private organization affiliated with Medica, a health insurance carrier operating in Minnesota, North Dakota, South Dakota, and Wisconsin. The mission of the Medica Foundation is to fund community-based initiatives and programs that improve the health of Medica’s customers and remove barriers to health care access in the greater community. As a grant partner, the Medica Foundation provided the in-kind and cash match required by the Department of Human Services to fund this proposal.

The evaluation component of the project was the Parish Nurse Effectiveness Study. The purpose of the study was to capture the access concerns faced by community-dwelling older adults, the actions faith community nurses take to address those concerns, costs that might be avoided through such interventions, and the observable differences of these nurses’ actions related to quality of life. The investigators were charged with two questions:
- How do faith community nurses support quality of life in older adults and caregivers?
- What value does faith community nursing bring to acute or long-term health care cost prevention?

The Data, Interpretation, Action, Response, and Yield (DIARY) approach to data collection was used to explore these questions (Rydholm, 1995). The DIARY tool provided a connection between faith community nurse interventions and theoretical cost savings.

**NURSING IN FAITH COMMUNITIES: RESPONSE TO A GROWING NEED FOR CARE**

The term *parish nurse* gained visibility under its champion Reverend Granger Westberg, PhD, in 1985. Westberg, a hospital chaplain, began to study the role of nurses as medical interpreters with pastoral hearts in the 1950s. His book *Nurse, Pastor, and Patient* (Westberg, 1955) conveys an understanding of healing as both an art and a science. He recognized the value of advocates who were medically and relationally bilingual. He understood reluctance to seek help in times of need, fear of the medical system, and the need for trusting liaisons to formal care. He saw congregations as an ideal place for bridge-work to occur. Westberg made it his life’s work to lift up the needed role that nurses in congregations played as intercessors. When Westberg’s book *The Parish Nurse: Providing a Minister of Health for Your Congregation* (1990) was published, it affirmed nurses who had been serving people in their congregations for years as informal consultants. Congregants who were alert to what was happening quickly grasped the need to formally acknowledge the role.

**Faith community nurses typically serve congregants across the age continuum, but older adults tend to be the first to approach them for assistance.**

Faith community nursing is the term now accepted by the American Nurses Association (ANA) for parish or congregational nursing. Faith community nursing is recognized by the ANA as a specialty area of practice requiring active RN licensure but not certification. Because it is a rapidly growing, autonomous kind of practice, completion of a standardized 36-hour faith community...
The number of currently practicing faith community nurses is estimated to be close to 10,000 (D.L. Patterson, personal communication, September 28, 2007). Standardized preparation is currently offered through 104 institutions of higher learning within the United States in partnership with the International Parish Nurse Resource Center in St Louis, Missouri. It is essential to complete this preparation.

Sometimes faith community nurses are also asked to attend clinical pastoral education or lay ministry preparation classes offered by their denominations or allied health care systems. Few volunteers are held to such rigors, yet faith community nurses often serve congregations for little or no pay. Because they must earn incomes elsewhere, their attentions are often diverted from the work they feel called to do.

Older adults comprise approximately 13% of the population, yet they account for 37% of medical expenditures in the United States (Centers for Medicare & Medicaid Services, 2004). As the graying of America continues, a proportional surge in health care expenditures is expected. Older adults will be discharged from the hospital earlier with functional limitations. Many adults with disabilities will rely on social service agencies and faith communities for assistance. Disability prevention will become more important.

Maintaining older adults’ independence in the community has been shown to save public assistance expenditures, promote well-being, and enhance quality of life. Independence is best sustained through a network of formal and informal supports (Smith et al., 2000). Ideally, faith communities augment community-based entities, such as living at home, block...
nurse programs, in-home health care, adult day services, transportation services, medication management assistance programs, friendly visiting, telehealth, and telemedicine. To discern the occurrence of such links and the impact of faith community nurses on community-dwelling older adults, the SSAS Parish Nurse Effectiveness Study was launched.

METHOD
Design
This mixed method study used both quantitative and qualitative strategies to attempt to discern the nature and impact of faith community nurse interventions on community-dwelling older adults. After a rigorous informal networking effort to capture all potential participants, the known 200 faith community nurses practicing in metropolitan Minnesota and the surrounding central and northeastern counties were invited to participate in a “no obligation” preparation session through a letter of invitation. The preparation session was offered in the form of a DIARY charting workshop for two free continuing education credits. A description of the study was included in the workshop objectives. The preparation session was offered 13 times in an effort to engage all potential contributors. Half of the faith community nurses in the metropolitan area (N = 101) were able to attend at least one of the sessions.

Sample
Participants were informed that the goal of the project was to obtain a total of 1,000 case notes regarding their most significant older adult contacts. Contributors would receive a $20 stipend per note submitted. Yields (portion of the DIARY) were not required for remuneration. Instruction was provided on data collection and how to uphold confidentiality in the reporting process. Provisions for confidentiality were delineated in a letter of understanding. All participants were invited to sign the letter of understanding, which added that they were in no way to be regarded as employees of the state, but that they were bound, as RNs, to abide by the Faith Commu-

Figure 1. Charting by exception form for symptom disregard. ©1995, Laura Rydholm, MSN. Reprinted with permission.
nity Nursing: Scope and Standards of Practice (ANA & Health Ministries Association, 2005). All but 2 of the 101 workshop participants signed letters of understanding.

Data Collection

Data was then collected using the DIARY charting process. Notes were contributed by 76% (n = 75) of those who signed the letter of understanding. The DIARY format (Rydhom, 1997a) was used for the reporting process. DIARY charting is a derivation of the FOCUS (data, action, response) charting system developed by Lampe (1985). It was launched in 1994 to capture data for the federally funded Area on Aging project 309-95. DIARY charting guidelines for narrative notes are shown in the Sidebar on page 20.

The nurses participating in this study submitted DIARY notes regarding recent eldercare experiences. They were given the option of using either a narrative format or charting by exception. The charting by exception method used four forms, listing concerns, interventions, or outcomes that were commonly reported in a previous study. It entailed selecting the form that best fit the situation and checking off the applicable descriptors from those listed. The researchers referred to the charting by exception forms as the DIARY tool. The prior study from which the tool was gleaned was Agency on Aging project 309-95 (Rydhom, 1997b). During the orientation sessions, all participants practiced sharing their stories using both narrative and selection formats. They were encouraged to submit stories in the manner they preferred, allowing the researchers to determine a favored approach. The majority favored charting by exception.

The first form in the DIARY tool pertained to symptoms warranting immediate intervention, such as syncope, sentinel headaches, chest pain, progressive infections, dyspnea, necrotic lesions, renal failure, and warning signals of cancer. This form focused on the reasons older adults were hesitating to seek formal care, why they were disregarding their symptoms, and how symptoms were being brought to the attention of the parish nurse. Nursing interventions targeted the self-imposed barriers to access.

The second form pertained to matters of self-care. It focused on the ways in which the nurses helped older adults and caregivers learn to manage the lifestyle modification and technical care aspects of chronic illness.

The third form focused on functional concerns pertaining to remaining at home and learning to adapt with disabilities. It focused on connecting older adults with formal, informal, and blended support systems and adaptive equipment. Primary outcomes pertained to reducing risk and sustaining functional independence. Efforts to troubleshoot the causes of isolation were part of the safety form, although the causes were often psychosocial.

The fourth form pertained to psychosocial and spiritual concerns, such as worry, despair, demotivation, and uncertainty, and the nurse’s actions in the realms of calming, values clarification, and remotivation. Caregiver stress and vulnerable adult concerns were encompassed in this form, but these were noted as safety concerns when they were urgent. A variation of this form addressed recovery support for individuals who were addicted or self-medicating. An example of the first form of the tool, pertaining to symptom disregard, is shown in Figure 1.

The forms listed concerns, actions, and outcomes commonly reported by rural parish nurses in a prior, federally funded collection of parish nurse DIARY notes (N = 1,800). Taxonomies for the DIARY tool were gleaned from the collection (Rydhom, 1995) and were published in a peer-reviewed journal in 1997. Intervention terms were consistent with the Nursing Interventions Classification (NIC) taxonomy that was emerging at the time (McCloskey & Bulechek, 1996). NIC language arose from this Iowa Project. It needs to be stated that great work has been done to create language for what nurses do under the auspices of The University of Iowa. Because that phraseology was perplexing to many of the nurses in this study, the phraseology of faith community nurses themselves was used to capture the data. In qualitative research, it is important to avoid categorizing data into language that participants do not understand.

The work of the North American Nursing Diagnosis Association (NANDA), NIC, and Nursing Outcomes Classification (NOC) teams is nationally recognized and worth considering in any replication of this study, but participants would need to be adept in the use of the language. The taxonomies continue to evolve, but they are presently well delineated in NANDA, NOC, and NIC Linkages: Nursing Diagnosis, Outcomes and Interventions (Johnson et al., 2006).

Participants understood that they could cite a concern without attaching an intervention or outcome, and they were encouraged to be honest. They were told that remuneration would not be dependent on outcomes. Narrative boxes allowed the nurses to add text when descriptors were lacking. The majority of participants found the lists to be adequate but shared additional history and outcome data in the text boxes. The

Faith community nurses function as listeners, health counselors,... liaisons to referral resources,...advocates, and faith-health integrators.
Unspoken needs of elders
recognized by parish nurses

END OF LIFE NAVIGATION
- Five Wishes forms assistance
- Discernment/values clarification
- Palliative care coaching

HELP FINDING
- Formal, informal & blended
- Meals
- Grocery shopping
- Transport
- Laundry
- Housekeeping
- Personal care
- Bill paying
- Chores
- Med pickups

SELF CARE GUIDANCE
- Hypertension
- Diabetes
- Heart/Lung
- Chemo/radiation
- Post-op
- Other (arthritis)

STAY AT HOME REFERRAL
- Hospice
- Home Care
- Senior Linkage
- Assisted living
- Chore services
- Meals on wheels
- Financial assistance

Figure 2. Overarching categories of concerns and interventions reported by faith community nurses.

tool allowed participants to document several concerns, interventions, and outcomes simultaneously. This complicated the quantification process but expanded the database.

The tool offered an opportunity to capture and quantify recurring interventions without drawing attention to specific actions. The nurses using the tool were invited to add concerns, interventions, and outcomes to the lists; however, this rarely occurred. A comprehensive examination of the reliability and validity of the DIARY tool is yet to be accomplished, but these nurses found the tool to be user friendly.

Initially, many of the nurses chose to submit their stories in narrative form. As they grew accustomed to using the DIARY technique, they shifted to using the DIARY tool. Eventually 1,061 notes were obtained. One nurse submitted notes electronically. The other 74 submitted handwritten notes by U.S. mail. All notes were then coded, and only the authors knew the actual names of the care recipients being referred to in the notes. The authors also signed their names in code.

Data Analysis
When nurses used the DIARY tool, their reports became quantifiable, and this was of great interest to the administrative audience that funded this study. Approximately two thirds of the notes were submitted in a ready-to-quantify form, but the remaining third, the narrative notes, needed to be translated into the DIARY tool format. Those notes were translated into the DIARY tool format by the researcher who developed the tool using prior methodologies (Rydholm, 1997b). This needed to occur for all data to be included in the SPSS version 11 tally.

The nurse participants were telephoned when clarity was needed regarding a narrative comment or when help was required to discern which descriptor needed to be emphasized. Through this translation process, “pearls” were gleaned about how the DIARY tool should be ex-
panded or refined for future use, but the tool remained unaltered in Microsoft Access™ during the quantification process.

Completed, handwritten checklist forms were then entered into identical forms in a Microsoft Access database by an outside transcriber whose work was double checked for accuracy. After the narrative notes were translated into the DIARY tool format, all of the reports could be quantified together. The sums of all marked descriptors were tallied and then examined using SPSS. The SPSS analysis was completed by a quantitative researcher. The quantitative analysis was performed, in part, to determine how quantification would work logistically. It worked, but the tallies revealed the need for further descriptive clarity.

A secondary analysis was performed. This time, the analysis was done by the primary investigator (Rydholm, 1997b). In this analysis, both open and axial forms of coding were used (Strauss & Corbin, 1998). Using the language of the nurses themselves and terms that administrators could understand, notes were summarized in a line-by-line manner. Key concerns, interventions (broadly then specifically defined), resolutions, and one-sentence descriptions about what occurred were entered sequentially into rows using Microsoft Excel®. Every row held a story, but concerns, interventions, resolutions, and sentence descriptions fell into separated lists or columns. The columns grew as the stories were entered. Columns made it possible to sort, block, and count similar encounters.

After the story descriptors were entered, the lists of concerns and interventions were explored for repeated themes. As themes were identified, descriptors were tweaked so similar scenarios would share the same identifiers. After the shared identifiers were in place, the data could be sorted. After sorting occurred, stories about like concerns or similar interventions appeared together in blocks. The findings were best viewed by sorting the data by broad intervention first, specific intervention second, and concern third. During each sorting process, a short description of what had happened, the concern, the intervention, and the resolution line for each note remained intact. The trailing one-sentence descriptions ensured nothing was being lost in the sorting process. As shared descriptors were folded in, the raw data were revisited. Telephone calls were made to the nurse contributors to ensure that points of emphasis remained true to their intent whenever there was a question. Corrections were made as a result of the dialogue.

After distinct categories of concerns and interventions emerged in the sorting process, the number of entries within each category could be tabulated for descriptive purposes. This ensured that lead categories warranted the emphasis they were being given. The final overarching categories are shown in Figure 2. The 1,061 notes were analyzed five times in the redesignation and re-sorting process before these categories were claimed. In other words, the categories emerged; they were not predesignated.

At the end of the process, the original data were again reviewed to ensure nothing had been lost or contrived in the sorting process and to confirm that the identifiers

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**TABLE 1**

**DEMOGRAPHIC DATA**

<table>
<thead>
<tr>
<th></th>
<th>Initial Notes (n = 713)</th>
<th>Further Notes (n = 348)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notes Written (N = 1,061)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Older adults served</td>
<td>713 (100%)</td>
<td>126 (100%)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>457 (64)</td>
<td>89 (70)</td>
</tr>
<tr>
<td>Male</td>
<td>200 (28)</td>
<td>35 (28)</td>
</tr>
<tr>
<td>Not cited</td>
<td>56 (8)</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Trait</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frail</td>
<td>582 (82)</td>
<td>28 (22)</td>
</tr>
<tr>
<td>Lives alone</td>
<td>419 (59)</td>
<td>62 (49)</td>
</tr>
<tr>
<td>Poor</td>
<td>307 (43)</td>
<td>46 (37)</td>
</tr>
<tr>
<td>Caregiver</td>
<td>210 (29)</td>
<td>27 (21)</td>
</tr>
<tr>
<td>Diabetic</td>
<td>174 (24)</td>
<td>28 (22)</td>
</tr>
<tr>
<td>Disabled</td>
<td>430 (60)</td>
<td>70 (56)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;60</td>
<td>15 (2)</td>
<td>5 (4)</td>
</tr>
<tr>
<td>60 to 69</td>
<td>138 (19)</td>
<td>27 (21)</td>
</tr>
<tr>
<td>70 to 79</td>
<td>213 (30)</td>
<td>28 (22)</td>
</tr>
<tr>
<td>80 to 89</td>
<td>232 (33)</td>
<td>49 (39)</td>
</tr>
<tr>
<td>≥90</td>
<td>49 (7)</td>
<td>15 (12)</td>
</tr>
<tr>
<td>Uncertain</td>
<td>66 (9)</td>
<td>2 (2)</td>
</tr>
</tbody>
</table>

*a Older adults served.

*b Older adults served more than once.
served well as descriptors. The nurse participants were invited to review the distilled versions of their notes. Some did; some did not. Those who did concurred with the summaries, stating that the qualitative analysis portrayed their experience well. At the conclusion of the sorting process, the Microsoft Excel tables were taken back to the research team for review. The results were tabulated and graphed (Figure 2).

**FINDINGS**

**Qualitative Analysis**

The reported attentions of the faith community nurses were evenly divided into three realms, which can be seen in Figure 2. One third of the notes pertained to urgent attention, one third pertained to functional support, and one third pertained to psychosocial support. The urgent care portion was related to escalating medical concerns and concerns of vulnerable adults. The functional support portion involved self-care coaching; links to formal, informal, and blended support systems; and procurement of assistive devices. The psychosocial support portion included calming, remotivation, values clarification, support team coordination, and end-of-life navigation. Some psychosocial-spiritual care reports regarding caregiver support stories were relegated into the functional support tier during this process. Similarly, some vulnerable adult reports floated into the urgent attention category in the secondary analysis. Finally, interventions targeting functional support for sustaining independence became more clearly defined.

**Demographic Data**

Demographic data on the faith community nurse participants were analyzed using measures of central tendency. There were 713 care recipients (patients) represented in the 1,061 encounters. The majority of care recipients were women between the ages of 70 and 89. Those who were visited most repeatedly were apt to be women, ages 80 to 89, frail (by subjective assessment), physically disabled, and living alone (Table 1).

The 75 nurses who contributing notes in this study tended to be in their late 50s or early 60s. More nurses older than age 70 (n = 5) contributed stories than did nurses younger than age 50 (n = 4). Their denominational affiliations paralleled denominational demographics for Minnesota. Fifty-one percent were Evangelical Lutheran Church of America or unspecified (Missouri Synod) Lutheran (n = 38); 20% were other Protestant (i.e., United Church of Christ, Methodist, Presbyterian, Episcopal) (n = 15); 20% were Catholic (n = 15); 9% were Evangelical/conservative (i.e., Baptist, Evangelical Covenant, Evangelical Free, Pentecostal, Reform, Wisconsin Evangelical Lutheran Synod, Orthodox) (n = 7). No male nurses participated in the study. All participants were Christian and Caucasian. Nurses who contributed more than 10 notes to the study were apt to be paid to work an average of 20 hours per week. There were two prolific contributors who were volunteer nurses. Most of the notes came from nurses who were being reimbursed by their congregations for their service. There were a few unpaid contributors from rural outskirt settings.
SAMPLE NARRATIVE DIARY NOTE RELATED TO NURSING INTERVENTION SAVING LIVES AND MONEY

<table>
<thead>
<tr>
<th>Initial Note</th>
<th>Further Note</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data</strong> Care recipient: “Can you take me to the ED? I’m afraid to drive. I’m bleeding from my urinary tract infection.”</td>
<td><strong>Data</strong> Carrying laundry up from the basement less than 3 weeks after renal surgery.</td>
</tr>
<tr>
<td><strong>Interpretation</strong> Nurse: High risk for an accident or fall? Altered tissue perfusion? Unwilling to call 911.</td>
<td><strong>Interpretation</strong> High risk for injury (fall/postoperative bleeding).</td>
</tr>
<tr>
<td><strong>Action</strong> Drove her to ED where they initially wanted to change her antibiotic and send her home. Advocated for further testing due to severity of bleeding. Waited 5 hours with her in the ED.</td>
<td><strong>Action</strong> Coordinated laundry assistance through volunteer parish network.</td>
</tr>
<tr>
<td><strong>Response</strong> They discovered a bleeding renal tumor, which was promptly excised.</td>
<td><strong>Response</strong> Accepted congregational help with chore assistance three times per week for 1 month.</td>
</tr>
<tr>
<td><strong>Yield</strong> Reduced risk of blood loss or related trauma. Early intervention for cancer.</td>
<td><strong>Yield:</strong> Isolated older adult reconnected with support. Risk reduction during postoperative phase.</td>
</tr>
</tbody>
</table>

Quantitative Analysis

The quantitative analysis entailed an SPSS tally of the charting by exception (DIARY tool) forms after they were transcribed into Microsoft Access. This tally reflects the work reported by the faith community nurses. Because one third of the records (the narrative DIARY notes) needed to be translated into the charting by exception format before they could be included in the tally, there was an interpretive component to this analysis. The translator was the author of the forms (Rydholm, 1997b).

In the SPSS analysis, psychosocial-spiritual concerns emerged as the predominant focus. These were captured in fourth form reports \( n = 418, 40\% \). Concerns addressed included grief, loss of meaning, loss of purpose, guilt, regret, feelings of inadequacy, feelings of vulnerability, worry, anxiety, helplessness, loss of hope, despair, decisional conflict, impaired adjustment, caregiver fatigue, frustration with self or others, interpersonal tension, anger, abuse, neglect, exploitation, loss of serenity, and need for end-of-life support. All of these conditions are somehow embraced in the evolving Iowa Project language of nursing diagnoses, interventions, and outcomes endorsed by the ANA (Johnson et al., 2006).

Nurses regularly related efforts to help people who were anxious or angry with cognitive restructuring when these were perceived as matters of ineffective coping. Anxiety and worry were the most pervasive psychosocial concerns, yet they received less documented attention than the various forms of despair. The nurses focused much of their attention on despair (hopelessness) related to grief and life transitions. Despair often resolved with de-isolation in grief-related reports, but nurses were advocates for the pharmacological treatment of depression.

Interventions targeting caregiver support, vulnerable adult intercession, recovery aftercare teamwork, and end-of-life navigation were also included in these reports. Some of the reports indicated a breadth of intervention in which many emotional needs were being simultaneously addressed. For this reason, the sum of percentages in Table 2 exceeds 100%.

The second largest group of stories pertained to signs and symptoms warranting concern or signs of escalating illnesses capable of resulting in lasting disabilities or death. These were the first form reports \( n = 265, 25\% \). Reported interventions focused on fears of expense, of being diagnosed, of being sentenced to a life change, of losing autonomy, of being devalued, of being regarded as ignorant, or of being considered a pest. These barriers were at the root of most reported access delays. Most of these scenarios could be coded into Iowa Project language using the terms of ineffective coping or denial, but the term symptom disregard was helpful to narrow the focus.

For all conditions, the most common reasons older adults were not addressing their medical needs early included reluctance to bother their physicians (sometimes for fear of being reprimanded), naiveté related to signs and symptoms, and stoic independence. In these cases, the nurse’s response was apt to be more oriented toward advocacy than information. Seventy-five percent of the cited interventions fell into the category of advocacy. Education was cited as a component of intervention in less than 50% of the cases. Lack of insurance was only cited in 2 cases (1%), further suggesting that the primary barriers to help seeking were psychosocial in nature. In most of the cases reported, the older adult sought urgently needed medical care and had new treatments prescribed as a result of nurse advocacy. In these stories,
nurses noted that they accompanied the older adults to physician specialist appointments, sat in ED waiting rooms for up to 5 hours, responded to telephone calls from distraught first responders, made repeated follow-up telephone calls, and escorted people to the front door of the health care facility. Significant yields were reported in these stories (Table 3).

Stories pertaining to frail older adults who were ignoring symptoms of impending strokes, heart attacks, heart failure, renal failure, respiratory failure (hypoxemia/acidosis), dehydration, sepsis, third-degree wounds, amputation, cancer progression, falls, abuse-related trauma, nerve damage related to untended fractures, and medicine toxicity were considered from a cost–risk-reduction perspective in the qualitative analysis. These were easily linked to standard reimbursements for diagnosis-related groupings from a cost-avoidance perspective. If the nurses were right about the differences their interventions made, they may have saved the Medicare system more than $3 million. Some of these estimates (n = 60) flowed from potential injuries, which may or may not have occurred as a result of falls, but most were grounded in escalating illness scenarios. A DIARY note of this nature is presented in the Initial Note portion of the Sidebar on page 26.

Concerns related to functional safety (14%), illness self-care deficits (9%), depression linked to isolation (8%), and detrimental lifestyle habits (4%) comprised the remaining 35% of the stories, respectively (Table 4). Efforts to address these concerns may well have had cost-saving implications, but these outcomes pertained more to risk reduction than disease interruption. Extraneous community-based influences made estimating cost savings seem inappropriate. These efforts could readily be translated into Iowa Project language (Johnson et al., 2006).

Efforts to address functional safety focused on reducing the risk for falls. Faith community nurses assisted with construction of ramps and, when appropriate, facilitated relocation to assisted living facilities. One nurse brought an electric blanket to an older adult whose furnace was awaiting repair. The nurses facilitated the use of assistive technologies and procured low-vision resources. One nurse created a pictorial speed-dial emergency call system.

The nurses facilitated the completion of tasks such as housekeeping, yard chores, meals, delivery of prescription refills, transportation, medical appointment accompaniment, respite, and personal care. This was done in part to resolve safety concerns and in part to sustain the older adults’ independence and facilitate illness recovery. The Further Note portion of the Sidebar on page 26 contains a narrative DIARY note of this nature.

Illness self-care deficits were resolved when nurses consulted with formal and family caregivers to address medication mismanagement and other therapeutic regimen-related safety concerns. They provided care and care management informally by merging formal and quasi-formal services. They taught older adults how to check their blood glucose levels and manage chronic symptoms. The faith community nurses updated public health nurses, found financial assistance for medications, facilitated access to veterans affairs benefits, and helped institute palliative plans of care, including care teams.

Efforts to address isolation facilitated the resolution of safety concerns, depression, and intoxication progression through reintegration. Most of these efforts targeted reasons for withdrawal, which included feelings of vulnerability and/or inadequacy, lack of transportation, and the need for assistive devices. In their efforts to address detrimental lifestyle habits, the nurses served as accountability partners for people who were struggling to abstain from smoking or from foods contraindicated in their chronic illness states.

**TABLE 4**

<table>
<thead>
<tr>
<th>Nature of Older Adults’ Concerns*</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial–spiritual</td>
<td>40</td>
</tr>
<tr>
<td>Signs and symptoms warranting care</td>
<td>25</td>
</tr>
<tr>
<td>Functional safety concerns</td>
<td>14</td>
</tr>
<tr>
<td>Illness self-care deficits</td>
<td>9</td>
</tr>
<tr>
<td>Depression linked to isolation</td>
<td>8</td>
</tr>
<tr>
<td>Detrimental lifestyle habits</td>
<td>4</td>
</tr>
</tbody>
</table>

* Caregivers exhibited all concerns listed.

**DISCUSSION**

This study provides strong confirmation that the interventions of faith community nurses significantly affect the health and well-being of older adults and caregivers and that these interventions likely result in health and long-term care cost savings for individuals, health plans/insurers, and publicly funded health and long-term care programs. Still, it must be remembered that avoided events could only be perceived, not observed.

Faith community nurses demonstrated their ability to persuade older adults to take action, and they proceeded to ensure timely and appropriate care to prevent strokes, heart attacks, pulmonary edema, intubation, sepsis, and other debilitating illnesses. Some of the most compelling data indicate that the interventions of faith community nurses probably interrupted the progression of illnesses or disabilities in situations in which older adults with precarious medical conditions were reluctant to contact their physicians. Nurses intervened in situations where older adults may not have realized their signs and symptoms merited assessment and treatment, but the data suggest that denial and fear, more than lack of understanding, were the reasons. Reports of cases of late access that resulted in
hospitalization and surgery were in the minority, but these were the most striking stories of symptom disregard. In these cases, permanent disabilities, which might have resulted in nursing home placement, were probably avoided when medical treatments or surgeries occurred sooner than they otherwise would have. Data regarding mundane or unsuccessful encounters were limited.

Older adults’ reluctance to contact their primary care physicians may be attributed to cultural characteristics of stoicism in this generation. Further statistical analyses can be performed to isolate common attributes among the older adults who were reluctant to contact their primary care physician due to fear of expense, of being diagnosed, of being sentenced to a life change, of losing autonomy, of being devalued, or of being labeled as ignorant or a pest. Such issues have broad implications for individuals of all ages at risk for late access to care. Cultural influences at the roots of health disparities were visible in these findings.

Faith community nurses demonstrated effectiveness in encouraging and sustaining changes in lifestyle habits. They served as accountability partners (support systems) for older adults striving to lose weight, exercise more, stop smoking, and abstain from alcohol or excessive use of pain medications. The nurses’ success in health promotion and wellness interventions should be recognized and expanded, as it will be increasingly critical to preventing and managing chronic illness.

The actions of the faith community nurses in this study indicate they were aware of community-based long-term care services. They serve an important role in identifying needed services and arranging for their delivery. Faith community nurses appear to be adept at connecting older adults to a wide array of informal and formal home and community-based services, including congregation-based helpers, respite providers, transporters, meal makers, friendly visitors, exercise groups, prayer circles, and purpose groups.

Nurses who participated in this study willingly learned a new charting system and documented their interventions, knowing their data would be shared with the project’s funding sources and others interested in the topic. As state and federal policy makers and health systems increasingly seek to control health and long-term care costs, consideration should be given to sustaining and expanding their role.

The benefit of using the narrative version of DIARY charting was that it prompted the users to think methodically and with some intentionality about the differences their involvements made in situational outcomes. The DIARY charting system is valuable as a learning tool for self-discovery, articulation, edification, and redirection. In the arena of research narrative, DIARY charting offers a way to capture data without first filtering it through the lens of a specified language. In this and its previous study, the lack of a filter facilitated the translation of findings into a language that other disciplines could understand. It was through the attempt to translate that the most crucial discoveries were made. Nurses mediate and collaborate in a multidisciplinary manner. The ability to translate roles into terms that can be understood by other stakeholders is important in collaborative practice. Using a taxonomy can thwart collaboration. The DIARY narrative format could be used by non-nurse care providers to relate their role in a situation. Conversely, checklists of terms can bring to mind the awareness of happenings that might not have otherwise occurred to care providers who are trying to tell their story. Charting by exception using taxonomies has merits.

CONCLUSION

The findings of this study demonstrate the remarkable success of faith community nurses in bridging care between the informal, faith-based system and the formal, acute health care system. This role will become increasingly valuable as the older population increases dramatically and chronic diseases become more prevalent. The
impact of faith community nursing will increase as the population ages and more community-dwelling older adults rely on both formal and informal services to maintain independence. This study provided a glimpse into the nature of faith community nursing and its impact on the quality of life of older adults.

These findings reveal implications for the future of nursing beyond the faith community nurse role. It is crucial to recognize that these nurses, who were willing in many cases to work for coffee, were driven by caring convictions. They used Newman’s shared praxis approach to care. Being in the right place at the right time and possessing nursing wisdom helped, but they knew the people they were serving, and that is what made the difference.

REFERENCES


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