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Competency-Based Nursing Education and the Future of Nursing: Where the Faith Community Nurse Fits In

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Cover Page Footnote

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Introduction

The role of the faith community nurse (FCN) has long been embedded in caring for the community as well as the individual, and functions as a critical link in the continuum of care. The focus is not on "illness" care, but on health promotion and disease prevention from a whole-person health perspective. That whole-person health perspective is interpreted as mind-body-spirit health and aligns with one of the core functions of the FCN, *intentional care of the spirit* (ANA & HMA, 2017). Two national nursing landmark reports, both published in 2021, provide guidance and relevance for faith community nursing practice.

First, the American Association of Colleges of Nursing (AACN) *Essentials: Core Competencies of Professional Nursing Education* (2021) provides a blueprint for educationally and experientially preparing nurses for practice. The 10 domains introduced in the document define the competencies necessary to accomplish this. These competencies detailed in each domain are "designed to be applicable across four spheres of care (disease prevention/promotion of health and wellbeing, chronic disease care, regenerative or restorative care, and hospice/palliative/supportive care), across the lifespan, and with diverse patient populations. While the domains and competencies are identical for both entry and advanced levels of education, the sub-competencies are scaled from entry into professional nursing practice to advanced levels of knowledge and practice. Any nursing program curricular model should guide the learner to achieve the competencies" (AACN, 2021, p. 1).

Second, *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* is the third in a series of "future of nursing" reports published by the National Academies of Medicine (NAM), building on the previous two nursing reports. The first report, *The Future of Nursing: Leading Change, Advancing Health* (2011), strongly recommended strategies to "strengthen the capacity, education, and critical role of the nursing workforce. It emboldened nurses to play a significant role in improving health care for people, families, and communities around the world" (FON, 2011, pp *ix-x*). The recommendations align with the practice role of FCNs in health promotion and disease prevention. The second nursing report, published in 2016, *Assessing Progress on the Institute of Medicine Report The Future of Nursing*, focused on "efforts to create a more diverse workforce and expand ways of working with others in and outside of the health system and have served to foreshadow the importance of nurses as key stakeholders in achieving health equity in the United States and globally" (FON, 2021, pp. ix-x).

AACN Essentials: Four Spheres of Care and the FCN Role

Traditionally, nursing education has used acute care settings for most clinical education experiences. Given the complexities of the healthcare system and the needs of Americans, "it is becoming increasingly evident that the future of healthcare delivery will occur within four spheres of care**, 1) disease prevention/promotion of health and well-being,** which includes the

promotion of physical and mental health in all patients as well as management of minor acute and intermittent care needs of generally healthy patients; **2) chronic disease care**, which includes management of chronic diseases and prevention of negative sequelae; **3) regenerative or restorative care**, which includes critical/trauma care, complex acute care, acute exacerbations of chronic conditions, and treatment of physiologically unstable patients that generally requires care in a mega-acute care institution; and, **4) hospice/palliative/supportive care** which includes end-of-life care as well as palliative and supportive care for individuals requiring extended care, those with complex, chronic disease states, or those requiring rehabilitative care" (Lipstein, et al, 2016 and AACN, 2019, cited in AACN, 2021). The nursing workforce needs to prepare nurses to work in diverse settings—including community settings—and those settings must be open to providing the clinical training experiences that nursing students need. The focus of nursing interventions in an illness model unfortunately is still needed, but providing health-promoting interventions that prevent disease or reduce risk are increasingly necessary.

New graduates must demonstrate entry-level competencies through practice experiences with individuals, families, communities, and populations across the lifespan and within each of these four spheres of care. Graduate-level (both master's- and doctoral-prepared) registered nurses, including Advanced Practice RNs (APRNs) are needed in primary care, and must demonstrate the advanced-level nursing education sub-competencies and appropriate specialty/role requirements and competencies (AACN, 2021, p.17).

Jones and colleagues (2022) advocate for mapping population health in the nursing curriculum. This requires academic and practice partners to shift from the distinct focus on "individual holistic needs to a framework that emphasizes social and structural determinants of health, both in didactic education and clinical training" (p. S237). They also recommend greater commitment to 3-way community–academic–practice partnerships to develop a professional nursing workforce equipped for collaborative practice in settings outside of the hospital—in the community—leading to a broad and sweeping impact on population health (Jones et al., 2022).

Educational Preparation of FCNs

The preferred educational preparation for a FCN is a baccalaureate degree in nursing (BSN) with licensure as a registered nurse (RN) in the state where they practice, and for Advanced Practice RNs (APRNs) or graduate-level prepared RNs, minimally a master's degree. A trend has been observed to be evolving over the last several years where FCNs are pursuing a Doctor of Nursing Practice (DNP) degree, with a phenomenon of interest in the faith community. Both RNs and APRNs should have some academic didactic and praxis that includes community- and population-focused care, and clinical experiences outside the hospital. While programs—notably faith-based schools of nursing—include faith community nursing as a variation of community or public health nursing in educational programs, there is an opportunity for more programs to include this in the curriculum. It is a specialty practice of nursing that bridges a gap in the continuum of acute care to the community and is a potential source of clinical site placement for student nurses in the context of the *four spheres of care*.

FCN training courses offer the potential to address competency-based education in the curriculum. Whether FCN training is denomination-specific or is offered through academic-

practice partnerships using the *Westberg Institute Foundations of Faith Community Nursing* curriculum (Westberg, 2019) there is potential to overlay the AACN Essentials, domains, and competencies to the curriculum as it is delivered. This can benefit nurses entering the specialty practice by ensuring their education is competency-based and role-specific.

The Future of Nursing 2020-2030 Report and the FCN Role

The Future of Nursing (FON) 2020-2030 report defines health inequities as "systematic differences in the opportunities that groups have to achieve optimal health, leading to unfair and avoidable differences in health outcomes" (2021, p. 3). The FON reports "growing evidence of a clear association between inequities in both health and access to health care and social determinants of health (SDOH), which are the conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (2021,p. 3). The report clearly delineates the role of nurses to lead change, and prioritize improving health care quality and access, while also improving health equity.

Ross (2018), Vice President for Healthy Communities at Providence St. Jude Medical Center in Fullerton, CA describes how nurses are effective in the neighborhoods where they learn, pray, work, and live to improve the health of their communities. Ross, along with other organizational and community partners and residents, has "transformed a low-income neighborhood with high levels of crime, no community services, failing schools, substandard housing, and disengaged residents into a vibrant community with improved infrastructure, local health and social services, improved housing, thriving schools, engaged residents and a new sense of hope." (Ross, para. 1). Ross further describes simple, yet effective strategies where nurses can make an impact in their workplace, schools, faith communities, neighborhoods, and even in changing policy through advocacy. The premise is that if every nurse took one action to improve their community today, positive change would occur. While the author does not specifically speak to the role of FCNs in their perspective, these are all areas where FCNs have made and continue to make improvements in the health of their communities. The FCN Scope and Standards provided guidance for this (ANA & HMA, 2017).

Faith Community Nurse Scope of Practice

FCNs, based on their scope and standards of practice, serve to promote whole-person health across the lifespan and prevent or minimize illness within the context of a faith community and the broader community (ANA & HMA, 2017, p. 1). In this role the FCN improves access to healthcare and facilitates health equity for individuals and families, while using evidence-based practice to promote health as wholeness of the faith community and its constituents.

In a position statement on evidence-based practice (EBP) supported by the Westberg Institute, Knighten (2019) states "The faith community nurse (FCN) supports, applies, and engages in evidence-based practice" (p. 1). Since evidence is defined as research (external evidence) and non-research (internal evidence coming from quality improvement studies, EBP

application from research translated to practice, opinions from subject matter experts, and clinician experience [Knighten, 2019]), it is incumbent upon FCNs to disseminate their findings and experiences through publications and presentations, so that other FCNs may utilize the evidence in their practice.

Evidence-Based Examples of Impact Made by FCNs

The following curated evidence from the literature serves to illustrate the impact made by FCNs that occur in three of the four AACN spheres of care and address the FON health equity goals. The areas explored are preventing hospital readmission, extending access to healthcare, promoting health in high-risk communities, and palliative care ministry.

The *County Health Rankings and Roadmaps* (2020) recommend faith community nursing as a strategy in their "action to improve health toolkit". They identify that FCNs focus primarily on health promotion, chronic disease management, and injury prevention, but also often function as personal health counselors, patient navigators, and health or community advocates. The strategy suggests that faith community nursing promotes health behaviors and improves health outcomes by facilitating screenings, providing health education and counseling, making referrals, and providing support and follow-up after discharge from the hospital, particularly in minority and underserved and under-resourced populations. The County Health Rankings and Roadmaps (2020) further posit that faith community nursing may prevent readmission to the hospital, though more evidence is needed.

Post-Discharge Follow-up to Prevent Hospital Readmission. Three articles demonstrate evidence and support the idea that FCNs can effectively facilitate care transitions. Ziebarth (2015) conducted a systematic integrative review of 62 articles to provide underpinnings for the Faith Community Nurse Transition Care Program (FCNTCP). The program, a collaboration between the Church Health Center and the International Parish Nurse Resource Center in Memphis, TN, aimed to improve the patient's transition from the hospital to home by partnering with the faith community. FCNs promoted whole person-health to provide transitional care, facilitate the discharge experience, engage patients in their own care, and eliminate unnecessary hospital admissions.

The review laid the foundation for a research study that aimed to describe FCN transitional care and interventions. This resulted in a prospective descriptive analysis conducted by Ziebarth & Campbell (2019) on de-identified intervention data obtained from FCNs' documentation of transitional care. The aim of the study was to: (1) describe transitional care implemented by FCNs using a standardized nursing language—Nursing Intervention Classification (NIC) and (2) compare transitional care interventions implemented by FCN's to evidenced-based transitional care interventions in published research. A total of 1,556 interventions were documented; out of the 554 possible nursing interventions, 40 were reported to have been used frequently. A list of 32 NICs described the majority of transitional care interventions provided and documented by FCNs, encompassing seven domains in order of frequency: (1) behavioral, (2) health system, (3) safety, (4) physiological-basic, (5) family, (6) physiological-complex, and (7) community (Ziebarth & Campbell, 2019).

Strait et al. (2019) reported the outcomes of an evidence-based practice Congregation Transition of Care (CTOC) program intended to decrease 30-day readmission rates in faith-based communities with the use of a FCN and volunteer faith-based registered nurses (VFB-RNs). The goals were to evaluate the implementation of the program (formative); and the effectiveness of the VFB-RN role in a CTOC program, as measured by discharge phone calls, post-discharge primary care provider (PCP) visit, participants' program completion, and 30-day readmissions to the hospital (summative). The findings demonstrated the effectiveness of the FCN and VFB-RN model, with 98% (43) participants receiving discharge phone calls within 72 hours of discharge and 93% (n=41) at 30 days. Ninety-three percent made their PCP visit within 30 days of discharge, and only one participant (2.4%) was readmitted to the hospital within 30 days (Strait et al., p. 163). FCNs are uniquely equipped to facilitate trusted relationships with community members throughout the transition from the acute hospital to home and reconnect patients with their PCP post discharge.

Palliative Care Ministry. Palliative care for hospitalized persons with serious, life-limiting illness has experienced increased utilization in recent years; however, home-based or community-based palliative care could reduce the number of acute care episodes. Palliative care can provide resources and support for those with life-limiting and life-threatening health conditions who wish to continue disease-targeted treatments, as well as those for whom treatment is no longer an option to achieve cure (Knighten, 2022). With the older adult population growing, the need for care in the home is increasingly necessary.

Lentz (2018) poses the question: "What if palliative care was not hospice, hospital, or community-based, but *faith-based"*? Lentz presents a *Palliative Care Doula* (PCD) model, which is a faith community ministry. A team of nurses led by a palliative care expert provides holistic (mind-body-spirit) care, support, advocacy, and education for community-based persons who are not eligible for or ready to choose hospice (p. 114). There are eight important components of a palliative ministry: (1) goals-of-care discussions with patients and/or family; (2) understanding of disease progression; (3) support and assistance in communicating needs, such as when formal palliative care services are needed or refused; (4) hospice eligibility or ineligibility (due to preference for aggressive treatment); (5) communication gaps in healthcare; (6) bridging care gaps; (7) regulatory issues and insurance barriers for general health, palliative, and hospice care; and (8) understanding complex medical management and care coordination (Lentz, 2018). Holistic care is provided in the context of the palliative care ministry, which supplements pastoral care. Clients may be obtained from the prayer list for people who are ill or homebound. The author presented case studies to demonstrate positive outcomes and concluded that the palliative care ministry permits congregants to experience quality of life, honors their desires, supports their faith, and addresses goals of care.

Extending Access to Healthcare and Promoting Health in High-Risk Communities. A faith-based nursing initiative in a Midwest urban area described by Balint & George (2015) served about 40 community members from three parishes and surrounding neighborhoods, covering three square miles. The health ministry outreach program was developed through a partnership between the Catholic Archdiocese, who provided resources, and a private endowment fund designated for FCN and health ministry services. The FCNs provided basic

health promotion and prevention services, screenings, spiritual support, and social support for referrals four days per week, for underserved and homeless clients. They also provided maintenance and safety interventions for people with multiple chronic co-morbid conditions, such as congestive heart failure (CHF), hypertension (HTN), diabetes, and mental health and/or cognitive issues. These patients have limited access to regular primary care resources and many of those "using the faith-based outreach centers are often the poorest of the poor and the economic impact on their access to healthcare services and resources" (p. 36) is seen in the quality of their health. The whole person (mind-body-spirit) care provided by the FCNs has positively impacted countless recipients; a case study illustrates the impact in one patient situation.

Shannon et al. (2022) conducted an integrative review of 48 articles to "identify recommendations to implement culturally congruent and spiritually connected approaches to health promotion in at-risk faith communities" (p. 228). Key search terms included "health promotion" combined with "faith nursing" and "parish nursing" were used to ensure a focus on nursing interventions. Evidence on minority or at-risk populations were prioritized (without focus on one specific racial or ethnic population) to investigate diverse approaches to health promotion. "Nursing interventions were categorized as *faith-placed* (when the faith organization was used by the nurse to test an intervention, *faith-based* (where the selected health program was integrated into the faith community's ministry), or *collaborative* (when the intervention included a combination of both features)" (p. 229). The design was integral to determining the impact on perceived effectiveness of the nursing intervention. Results of the review consistently demonstrated the impact FCNs can have on the health outcomes of at-risk populations by the regular incorporation of health education and supportive interventions.

Thematic analysis revealed five themes that were consistent across real and perceived effectiveness of the health promotion interventions: (1) trusted resource and social support, (2) access to underserved populations, (3) faith leadership endorsement, (4) level of faith community involvement, and (5) FCNs' focus on providing health education and support through the lens of faith-related nursing care (Shannon et al. (2022). The review concluded that FCNs are in a uniquely advantageous position to support faith-based efforts to promote healthier lifestyles. "Collaboration between nurses and faith leaders may create effective partnerships that bridge the physical and spiritual health gap, resulting in consistent faith-centered approaches to health promotion" (p. 234).

Conclusions

The two important landmark nursing reports discussed previously have had significant impact on the profession of nursing, creating lenses through which to view professional competency-based nursing education and the role nurses play in addressing health disparities, issues of inequity, quality, and safety. While these documents apply to nurses, nursing education, and nursing practice in general, the potential application to faith community nursing as a specialty is clear. The scope and standards of faith community nursing practice align with competency-based nursing education and the *Future of Nursing* imperatives, issuing a clear call for FCNs to create community partnerships, collaborate with academic colleagues, engage, and act.

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