Improving Knowledge of Christian Clergy in Rural Communities Through an Evidence-Based Educational Approach to Increase Support of Black Parishioners Seeking Guidance for End-of-Life Decisions

Sonja Hill

Radford University School of Nursing

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Hoffert, Darleen Digitally signed by Hoffert, Darleen Date: 2023.07.27 19:19:09 -04'00' | 7/27/23

Dr. Darleen Hoffert
Primary Investigator/Committee Chair | Date

Marjorie Young Digitally signed by Marjorie Young Date: 2023.07.28 11:22:43 -04'00' | 7/27/23

Dr. Marjorie Young
Committee Member | Date

Samantha Wilkinson Digitally signed by Samantha Wilkinson Date: 2023.07.28 11:29:23-04"00' | 7/27/23

Dr. Samantha Wilkinson
Committee Member | Date

Abstract

Christian clergy report a lack of education has led to decreased confidence when guiding Black parishioners regarding end-of-life (EOL) care planning. Black parishioners value advice from clergy on issues related to the EOL care process. The aim of this study was to strengthen the knowledge and confidence related to EOL care planning and spiritual directives in Christian clergy from rural Black churches in Southeastern Virginia for improved guidance of parishioners. The effectiveness of an educational webinar for enhancement of the knowledge and confidence levels of Black clergy was examined in this study. To meet the needs of clergy related to knowledge deficits in EOL care, an educational intervention was developed based on the transformative earning theory. Volunteer participants meeting inclusion/exclusion criteria completed a pre- and post-survey combined with an educational webinar related to EOL care, including the development of a spiritual directive. The knowledge and confidence levels of participating clergy were evaluated using a combination of multiple choice (knowledge) and Likert Scale (confidence) questions in pre- and post-surveys required to be taken with the educational webinar. Paired t-tests were used to statistically analyze the scores from the pre- and post-surveys. The findings of the project indicated there was a statistically significant change in knowledge and confidence levels of Black clergy following their participation in an educational webinar (knowledge = $P < .001$; confidence = $P < .001$). Further research is required to explore a definitive correlation between the increased knowledge and confidence of clergy, and increased access to EOL care by Black parishioners.

Keywords: spirituality, end-of-life care, care planning, African American, Black, clergy, church, Christian, spiritual directive, hospice, palliative care, knowledge, confidence

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Chapter 1: Introduction

Improving Knowledge of Christian Clergy in Rural Communities Through an Evidence-Based Educational Approach to Increase Support of Black Parishioners Seeking Guidance for End-of-Life Decisions

Black clergy play a significant role in providing guidance to their parishioners. Throughout the years, the Black clergy has played a pivotal role in offering valuable feedback and guidance during challenging circumstances. Black parishioners seek guidance from clergy when facing spiritual challenges but clergy report lacking knowledge on hospice and end-of-life (EOL) care planning required to assist the parishioners adequately (Exline et al., 2013; Sanders et al., 2017). Of the Black beneficiaries enrolled in Medicare and eligible for hospice services in 2019, only 40.8% took advantage of the available care, representing an opportunity for significant improvement in care utilization (Dillon et al., 2012; Enguidanos et al., 2011a; Jackson et al., 2000; *NHPCO*, n.d.). Despite the documented benefits of hospice care, very few Black patients participate in services or care planning for management of a terminal condition beyond the point of conventional treatment due to spiritual conflicts (Balboni et al., 2016; Exline et al., 2013; Johnson et al., 2016). The lack of hospice service utilization and EOL care planning results in uncontrolled pain, ineffective therapies, and increased medical costs while dying in hospitals (Burrs, 1995; Enguidanos et al., 2011; Koss, 2018; Jackson et al., 2000; Pittman, 2018; Winston et al., 2005).

The reluctance to seek EOL care treatment options among Black patients of the Christian faith is rooted in foundational spiritual beliefs such as seeking hospice treatment represents a lack of confidence in God (Burrs, 1995; Fitchett et al., 2020; Rhodes et al., 2012). Faith, beliefs, spirituality, and family influence are the primary impetuses guiding Black parishioners when discussing EOL decisions with spiritual leaders (Fitchett et al., 2020; Koss, 2018; Townsend et al., 2017). Clergy in Black Christian churches often receive requests from parishioners to provide guidance regarding EOL healthcare decisions due to the congregational respect, trust, wisdom, and knowledge of a spiritual leader (American

Cancer Society, n.d.; Baruth et al., 2013; Harmon et al., 2018; Jacobs, 2008; Ramirez et al, 2019; Rowland & Isaac-Savage, 2014; Sloan et al., 2016). When there is a lack of direction coming from a spiritual leader, Black parishioners frequently report feelings of spiritual stress as well as disappointment (Exline et al., 2013). Clergy support and involvement in parishioner education helps to alleviate the uncertainty Black patients and families experience when dealing with hospice care and the transitions across healthcare settings at the EOL (Ramirez et al., 2019; Rowland & Isaac-Savage, 2014; Van Scoy et al., 2018).

The education of clergy is encouraged regarding aspects of the EOL decision-making process (Baruth, 2013; Lindholm, 2018; Parker, 2021; Rowland & Isaac-Savage, 2014). The faith-based influence has a positive impact on the health of congregation members (Harmon et al., 2018; Parker, 2021). Many clergy members are not confident in discussing or providing education regarding EOL care (Koss, 2018; McDonnell & Idler, 2020; Sanders et al., 2017; Van Scoy et al., 2018). Clergy believe learning about EOL care should be a required element of pastoral care training and many clergy members are aware more education is needed (Koss et al., 2018; Lloyd-Williams et al., 2006; McDonnell & Idler, 2020; Van Scoy et al., 2018). Due to lack of training and knowledge, clergy have a desire to improve parishioners' awareness of EOL care but are unsure of the most effective approach to transmit information (Koss, 2018; McDonnell & Idler, 2020; Sanders et al., 2017). Giving clergy an opportunity to receive EOL care training assists with closing the gap on the underutilization of hospice services by Black parishioners while addressing spiritual concerns (Koss et al., 2018; Lloyd-Williams et al., 2006; McDonnell & Idler, 2020; Van Scoy et al., 2018).

Significance

The unique perspective of the Doctor of Nursing Practice (DNP)-prepared nurse allowed for identification of a spiritual care gap experienced by Black Christian parishioners in rural churches of Southeastern Virginia (Sloan et al., 2016; Williams et al., 2012). The spiritual care gap was found to be rooted in clergy knowledge deficits related to EOL care processes and the use of a Spiritual Directive

(Bazargan et al., 2021; Rhodes et al., 2017). A population-specific educational training is necessary to address the knowledge needs identified in the clergy (Harmon et al., 2018; Ramirez et al., 2019). The development of a spiritual directive provides healthcare team members clear preferences outlined by the patient to be followed as part of the EOL treatment plan embodying the holistic approach of nursing (Bazargan et al., 2021; Rhodes et al., 2017).

Anticipated direct benefits of the educational intervention for clergy include progression toward reducing the identified spiritual care gap of Black Christian patients, and increased patient participation in EOL planning (*American Association of Colleges of Nursing,* n.d.; Moran et al., 2019). An indirect benefit is the potential for an additional DNP project for a future student. The project could evaluate the impact of the education intervention on increasing the enrollment rates of Black parishioners within churches of participating clergy.

Purpose

The purpose of this DNP project is to evaluate whether an evidence-based educational intervention using a spiritually guided approach for clergy in rural communities of Southeastern Virginia:

- increases knowledge regarding hospice services;
- increases understanding related to the development of the Spiritual Directive; and
- improves clergy confidence in educating parishioners to ease care transitions for Black patients facing a terminal illness.

Theoretical Framework

Overview

The transformational learning theory will be utilized to develop an educational curriculum for Christian clergy using religious contexts with a spiritual approach concerning hospice and EOL care planning (Mercer, 2006; *Transformative Learning Theory*, 2022). Transformative learning theory is an effective theory outlining how a person's beliefs, feelings, and behavior are altered during the learning process (Pilli, 2004; *Transformative Learning Theory*, 2022). The transformative learning theory

developed by Jack Mezirow in 1978 utilizes deep, useful, and constructive learning through past and new experiences (Brock, 2010; Pilli, 2004; *Transformative Learning Theory*, 2022). The premise of the theory is to incorporate previously gained information, along with prior experiences and knowledge, into newly obtained information (Brock, 2010; Pilli, 2004; Transformative Learning Theory, 2022). The transformative learning theory outlines necessary steps individuals must undergo when learning new information (Mercer, 2006; Pilli, 2004; *Transformative Learning Theory*, 2022).

Types of Learning

There are two types of learning within the transformational learning theory: communicative and instrumental (*Transformative Learning Theory*, 2022, pp. 1–2). The purpose of communicative learning is to allow learners an opportunity to voice needs, feelings, and desires (Meneely, 2015; Mercer, 2006; *Transformative Learning Theory*, 2022). Instrumental learning is concerned with task- or problem-oriented activities for the evaluation of learning (Transformative Learning Theory, 2022). During the webinar, session clergy will utilize communicative learning to stimulate discussion pertaining to hospice care (Harmon et al., 2018; Johnson et al., 2018; Rhodes et al., 2017). A pre- and post-survey will be required as part of the educational curriculum for instrumental learning (Cipriano-Steffens et al., 2021; Pentaris & Christodoulou, 2021).

Essential Components of the Transformative Learning Theory

Learning and transformation within an environment can be facilitated by three essential components of the transformative learning theory: critical reflection, rational disclosure, and centrality of experience (*Transformative Learning Theory by Jack Mezirow*, n.d.). Additional clarification is provided for each of the three essential components as follows:

- Critical Reflection
    - Thinking critically on experiences changes people's perspectives.
    - This approach deepens self-awareness.
- Rational Disclosure
    - This theoretical component pertains to transforming experiences.

- Centrality of Experience
    - This component describes life experiences. In Mezirow's transformative learning theory, such experiences include what people do and believe in (*Transformative Learning Theory by Jack Mezirow*, n.d.).

Principles of the Transformative Theory

The three dimensions of learning include psychological, persuasive, and behavior (*Transformative Learning Theory*, 2022). Utilizing each dimension of learning determines how one understands information (*Transformative Learning Theory*, 2022). Each component is necessary for people to be able to think for themselves in order to learn effectively (*Transformative Learning Theory*, 2022). Learners must establish individualized meaning and interpretations as a substitute for society or culture mandating personal thoughts and feelings (*Transformative Learning Theory*, 2022). "Clergy use their knowledge to raise awareness of events and situations outside of human experience which are related to Christian faith, and to provide tools for researching and examining these occurrences in order to affect their life experiences" (Meneely, 2015, p. 89; Mercer, 2006). As seen in Figure 1, all components within the three dimensions of learning are exemplified in this DNP study.

Psychological Dimension. Individuals make independent interpretations of information learned through the psychological dimension (*Transformative Learning Theory*, 2022). Clergy members will utilize the psychological dimension by applying and interpreting the spiritual approach to hospice care.

Persuasive Dimension. In the persuasive dimension, learners use personal experiences to guide decisions (*Transformative Learning Theory*, 2022). Clergy use knowledge to integrate transformed learning using established Christian experience to support parishioners needing spiritual guidance and education (Meneely, 2015; Mercer, 2006).

Behavior Dimension. The behavior dimension allows participants to change behavior to impact actions (*Transformative Learning Theory*, 2022). Clergy members need to understand how to communicate information regarding to parishioners (Sanders et al., 2017). The behavior dimension of

learning is evidenced by an impactful change in the way clergy guide parishioners to a better understanding the EOL care process and hospice services (Meneely, 2015, p. 89; Mercer, 2006).

Transformative Learning Phases According to Mezirow

Transformative learning employs 10 common transformational phases:

1. Disorienting dilemma – When a person's current meaning structure does not match an experience in the past and results in unsettled (*Transformative Learning Theory by Jack Mezirow*, n.d.).
   - Project application: Providing an educational webinar, clergy can identify the lack of knowledge gained from previous experience through the pre- and post-test.
2. Self-examination – Learners conduct an examination of their own ideas and comprehensions and consider the ways in which their own experiences are relevant to the present predicament (*Transformative Learning Theory by Jack Mezirow*, n.d.).
   - Project application: Clergy recognizes the need for additional education.
3. A critical assessment of assumptions – Past assumptions must be evaluated, analyzed, and validated (Transformative Learning Theory by Jack Mezirow, n.d.).
   - Project application: The clergy will reflect on their prior knowledge of EOL, while also considering any new information.
4. Recognition others have shared similar transformation – The awareness of the transition process is shared, and others have had analogous experiences.
   - Project application: Once clergy learn additional education, information can be used to educate parishioners.
5. Exploration of new roles or actions –The individual can seek new roles that are compatible with new skills (Transformative Learning Theory by Jack Mezirow, n.d.).
   - Project application: This project will allow clergy to accept taking on a new role to educate parishioners.
6. Development of a plan for action – Strengthen faith in one's convictions and

knowledge (Transformative Learning Theory by Jack Mezirow, n.d.).

7. Project application: Clergy will plan to take the webinar to increase their knowledge in hospice care.

8. Acquisition of knowledge and skills for implementing the plan – Individuals grow and change their viewpoint and begin to plan a course of action after an awareness of one's previous ideas may have been incorrect or misdirected (Transformative Learning Theory by Jack Mezirow, n.d.).
    - Project application: Clergy will attend the webinar to gain knowledge about hospice care.

9. Trying out the plan – This stage individuals carry out further plans for transformational learning, and it is here true learning takes place (Transformative Learning Theory by Jack Mezirow, n.d.).
    - Project application: Clergy will take a pre- and post-test.

10. Development of competence and self-confidence in new roles – In this stage of transformational learning, an emphasis on exploration and trying to make sense of all the various ways in which new things have changed (Transformative Learning Theory by Jack Mezirow, n.d.).
    - Project application: Examining clergy pre- and post-test scores to obtain understanding.

11. Reintegration into life on the basis of new perspectives – This phase involves gaining knowledge and skills (Transformative Learning Theory by Jack Mezirow, n.d.).
    - Project application: Clergy will take the information gain and educate parishioners.

Hypotheses

- ***H(o):*** An evidence-based educational intervention using a spiritual approach will not provide the knowledge necessary for clergy to confidently educate parishioners on EOL care options founded in the Christian faith in rural communities of Southeastern Virginia.

- H(a): An evidence-based educational intervention using a spiritual approach will provide the knowledge necessary for clergy to confidently educate parishioners on EOL care options founded in the Christian faith in rural communities of Southeastern Virginia.

Variables

Independent Variable

The independent variable (IV) is an evidence-based educational intervention using a spiritual approach to provide the knowledge necessary for clergy to confidently educate parishioners on EOL care options inclusive of hospice and the development of a spiritual directive.

Dependent Variable

The dependent variable (DV) is increased confidence and knowledge of clergy when educating and facilitating EOL care planning with parishioners.

Definitions

- **Clergy** – A group of individuals ordained to serve in a Christian church in pastoral or sacerdotal capacities (*Dictionary.Com*, n.d.)
- **Chaplain –** An individual who assists people in the process of changing what can be changed and coping in a positive and peaceful manner with what cannot be changed using the provision of spiritual support (*Dictionary.com*, n.d.).
- **Spiritual Approach** – A way for individuals to engage in self-exploration and apply their findings to a wide range of situations and challenges (*A Spiritual Approach - The Janki Foundation*, 2017).
- **Hospice –** A specialized type of care that is focused on improving the quality of life for persons who are suffering from an advanced, life-limiting illness as well as their caregivers (*American Cancer Society*, n.d.; Birnbaum & Kidder, 1984; Jacobs, 2008).
- **End-of-life (EOL) Care –** The assistance and medical attention provided during the period just preceding death (*End of Life*, n.d.; Gómez-Vírseda, 2019; Van Scoy et al., 2018).

- **End-of-life Planning Process** – Time when psychological, medical, social, and spiritual support for the patient and family can improve the patient's quality of life but are not expected to cure the underlying disease or stop the progression toward death (*End of Life*, n.d.; Van Scoy et al., 2018; White et al., 2002).
- **Parishioners –** A member of a church who is under the spiritual supervision of a spiritual leader or minister (Johnson et al., 2019; Ramirez et al., 2019; Rowland & Isaac-Savage, 2014).
- **Spiritual Directive –** Instructions a person has written down specifying what kind of spiritual care they would like to receive at the end of life in the event they lose the ability to communicate their preferences verbally.
- **Spirituality –** Describes one's relationship with divine grace (Johnson et al., 2019; Ramirez et al., 2019; Rowland & Isaac-Savage, 2014). It is entirely dependent on one's connection to and commitment to various modalities of encountering transcendence in one's life (Feldmeier, 2016; Morgan Consoli et al., 2018; Soroka et al., 2019).
- **Religiosity –** Beliefs and feelings that make up religion (*End of Life*, n.d.; Van Scoy et al., 2018; White et al., 2002).

Summary

The transformative learning theory provides the foundation for utilizing an evidence-based, educational intervention to provide knowledge necessary for Christian clergy to confidently educate parishioners on EOL care options in rural communities of Southeastern Virginia (Enguidanos et al., 2011a; Parker et al., 2021; Pilli, 2004). Black parishioners are committed to their faith believing God is in control, and EOL care is not required if God's will be followed creating unique educational challenges (Enguidanos et al., 2011; Johnson et al., 2019; Parker et al., 2021). Black parishioners have a higher rate of religious affiliation, but a limited understanding of hospice care, resulting in lower enrollment rates (Enguidanos et al., 2011a; Johnson et al., 2018; Parker et al., 2021b). Educational curriculum within churches has often been successful in fulfilling the spiritual needs of Black parishioners, especially given the enormous power and influence from clergy (Baruth, 2013; McDonnell & Idler, 2020; Ramirez et al.,

2019a; Rowland & Isaac-Savage, 2014). Parishioners are more likely to engage, understand, and have better outcomes when interacting with clergy (Harmon et al., 2018; Jacobs, 2008; Parker et al., 2021b).

Clergy are well respected in the Black community and play a significant role when guiding decisions of Black parishioners (Jacobs, 2008; Parker et al., 2021; Rowland & Isaac-Savage, 2014). Clergy report not having official training in EOL care (Bazargan et al., 2021; Rhodes et al., 2017; Sloan et al., 2016). Because of the educational gap, clergy lack confidence in guiding parishioners in EOL decisions (Bazargan & Cobb, n.d.; Rhodes et al., 2017; Sloan et al., 2016). As a result of receiving educational training in combination with established parishioner relationships, clergy will have a solid foundation upon which to speak with parishioners about hospice care and the development of a spiritual directive as part of the EOL planning process (Harmon et al., 2018; Jacobs, 2008; Parker et al., 2021b).

Chapter 2: Integrated Review of the Literature

Overview

Using the electronic databases ProQuest and Google Scholar, a literature search to obtain peer-reviewed articles on education in Black faith institutions related to end-of-life care was executed. The search terms included were “health education,” “African American,” “Black,” “faith-based,” “education program,” “hospice,” “community-based,” “race,” and “church,” among others. Inclusion criteria for the literature review included grey literature and scholarly peer-reviewed articles written in English and published between 2000 and 2021. The original search returned 323 results from ProQuest and 457 results from Google Scholar. Articles were removed if not adequately related, too broad, too old, or were found to be duplicates. After sorting and categorizing the evidence into an evidence matrix (Appendix A), 86 articles were identified as applicable to this project. A search was also performed for the term “spiritual directive,” but no results were returned. The following themes were identified by using the evidence matrix:

- Clergy Lack Knowledge and Confidence Related to End-of-Life Planning Options
- Clergy Impact on Decision Making
- Religious Beliefs Impacting End-of-Life Decisions

- The Value of Educational Curriculum in Black Christian Churches to Improve Participation in EOL Hospice Care
- Hospice-related Education

Clergy Lack Knowledge and Confidence Related to End-of-Life Planning Options

Strong Support

"There is evidence that minorities with advanced illness may be unaware of their options…the lack of knowledge and misconceptions about EOL care have been blamed for low levels of hospice enrollment among these groups" (Bazargan & Cobb, n.d., p. 106). The evidence presented supports the clergy of Black parishioners play a vital role in education on a variety of topics including EOL care. (Harmon et al., 2018; Rowland & Isaac-Savage, 2014; Sloan et al., 2016). Understanding the attitudes, motivations, and obstacles of clergy when addressing health education concerns in congregations is critical (Harmon et al., 2018; Johnson et al., 2019; Ramirez et al., 2019b; Rowland & Isaac-Savage, 2014). Jacobs (2008) and Lindholm (2018) showed clergy act as a leader for parishioners and are receptive to opportunities for growth. However, Harmon (2018) and Johnson (2018) showed clergy are not well-versed in EOL care and the decision-making process surrounding it.

Despite religion being identified in some research as a determinant of the participation in EOL options by Black parishioners, other studies indicate a lack of education and understanding exists regarding EOL options by clergy who provide the guidance and education to Black parishioners (Bazargan et al., 2021; Harmon et al., 2018; Rhodes et al., 2017; Sloan et al., 2016). Evidence shows clergy need formal education on EOL care (Harmon et al., 2018; Johnson et al., 2018). Educational opportunities for clergy regarding the EOL care process are limited (Harmon et al., 2018; Johnson et al., 2018). When clergy are equipped with an educational foundation in EOL care, they are better able to incorporate knowledge into sermons and help parishioners individually make decisions on EOL care (McDonnell & Idler, 2020; Sloan et al., 2016). Improving the knowledge of Christian clergy in Black churches will provide the clergy with an opportunity to educate the parishioners on the spiritual teachings

of the Bible in the context of some EOL care options available (Gad et al., 2022; Harmon et al., 2018; Koss et al., 2018; Sloan et al., 2016). If clergy are able to have a solid understanding of what is required to educate parishioners on EOL care, then parishioners will be able to make informed personal decisions (Lindholm, 2018; Ramirez et al., 2019; Rowland & Isaac-Savage, 2014).

Challenges

When clergy do not possess the knowledge and confidence in educating parishioners regarding EOL care, inconsistencies in parishioner education can develop (Williams et al., 2012). Ramirez et al. (2019) revealed clergy indicated church leaders were not opposed to discussing certain topics from the pulpit, although the Bible has a lack of relevant scripture related to EOL decisions, presenting a barrier for clergy.

Clergy Impact on Decision Making

Strong Support

The evidence supports the positive influence of clergy in educating parishioners on health-related topics, including those associated with the end-of-life (Harmon et al., 2018; Rhodes et al., 2017; Rowland & Isaac-Savage, 2014). Clergy openness to new initiatives is critical because personal acceptance by clergy influences the reactions of the parishioners (Ramirez et al., 2019; Williams et al., 2012). Clergy assistance with spiritual care planning is linked to increased well-being, optimism, and hope near the end-of-life for Black parishioners (Ramirez et al., 2019; Rhodes et al., 2017; Robinson, 2016; Soroka et al., 2019). Clergy believe sermons and other personal forms of Christian education can guide parishioners on EOL decisions (Rowland & Isaac-Savage, 2014). McDonnell and Idler (2020) and Sloan et al. (2016) used a cross-sectional survey to establish parishioner beliefs about EOL care as well as prospective demand for faith-based EOL services and found 93% of parishioners would be open to education by clergy related to EOL care. Engaging clergy will provide continuing, individual support for personalized EOL care education (Sloan et al., 2016).

Challenges

Lindholm (2018) found several clergy members prefer using sermons as a means of aiding

parishioners in making EOL decisions. The sermon is an indispensable part of the religious experience and Black parishioners place a significant amount of importance on hearing sermons as part of religious practices (Harmon et al., 2018; Johnson et al., 2018; Ramirez et al., 2019). The concentrated character of the clergy, sermons carry a significant amount of weight (Harmon et al., 2018; Johnson et al., 2018; Ramirez et al., 2019). The use of sermons to discuss EOL care maintains attention and parishioners put what they've heard into practice within their lives (Harmon et al., 2018; Johnson et al., 2018; Ramirez et al., 2019).

Rowland et al. (2014) found many pastors believe educating parishioners about EOL is not necessary. The clergy also cited financial constraints as one of the most important reasons why clergy historically does not provide health education initiatives; however, personal meetings with parishioners allows for a minimal-cost option (Rowland & Isaac-Savage, 2014).

Religious Beliefs Impacting End-of-Life Decisions

Strong Support

Approximately 80% of the adult, Black population in the United States believe religion is extremely important (Johnson et al., 2019). Religion and spirituality are vital for Black Christians when dealing with serious and life-threatening illnesses or conditions (Bazargan et al., 2021; Boucher & Johnson, 2021; Enguidanos et al., 2011a; Exline et al., 2013; Hall et al., 2016; Lorenz et al., 2005; Ornstein et al., 2020; Rhodes et al., 2012; Soroka et al., 2019). For various reasons rooted in history, society, and even religion, Black parishioners have a deep-seated mistrust of the healthcare system (Rhodes et al., 2017; Rowland & Isaac-Savage, 2014). "After being brought from Africa during the slavery movement, Black Christians formed a strong spiritual foundation based on the belief that God is in control of everything and no good thing will be withheld" (Burrs, 1995, p. 16; Parker, 2021; Rhodes et al., 2012). Black parishioners believe God is merciful and endowed with miraculous powers, which can aid in the recovery of the sick and the extension of lives (Burrs, 1995; Soroka et al., 2019; Winston et al., 2005). Most Black parishioners believe God can heal regardless of how grim the medical prognosis (Burrs, 1995; Soroka, 2019; Winston, 2005). Ramirez et al. (2019), Rhodes (2017), Robinson (n.d.), and

Soroka (2019) focused on showing the impact of religious beliefs on the EOL care decisions of Black parishioners. Black parishioners who receive appropriate spiritual care have a higher quality of life and an improved ability to cope (Ramirez et al., 2019; Rhodes et al., 2012; Robinson, 2016; Soroka et al., 2019).

Challenges

Consideration and acceptance of EOL services may appear to be in conflict with parishioners' most deeply held beliefs despite the doctrinal teaching to the contrary (Burrs, 1995; Winston et al., 2005). The spiritual view of Black parishioners of a welcomed death is frequently incompatible with the goals of some EOL care services, which are to alleviate the physical, psychological, and spiritual suffering possibly accompanying the end of life (Burrs, 1995; Johnson et al., 2018; Soroka et al., 2019). Black parishioners who are reluctant to seek hospice care do so because they fear losing faith in God or having their religious beliefs clash with those of their loved ones (Burrs, 1995; Rhodes et al., 2017; Soroka et al., 2019). Many members of the Black Christian community believe suffering is a gift from God intended to put faith to the test (Burrs, 1995; Rhodes et al., 2017; Soroka et al., 2019). Burrs (1995), Soroka (2019), and Winston (2005) showed Black parishioners' beliefs support both illness and death are God's will with neither being necessarily affected by medical intervention. Soroka (2019) showed to provide effective EOL care education, more spiritual support in EOL care options must be backed up by evidence-based research (*American Academy of Hospice and Palliative Medicine*, n.d.).

Limited Knowledge Related to End-of-Life Care Exists in Black Christian Churches

Strong Support

An assessment of both qualitative and quantitative data identified a lack of awareness and knowledge about EOL care services as key reasons contributing to minority communities' underuse of EOL services (Bazargan et al., 2021; Boucher & Johnson, 2021; Harmon et al., 2018; Ornstein et al., 2020; Rhodes et al., 2012). For instance, low levels of hospice participation among these populations has been blamed on a lack of understanding and misconceptions regarding EOL care (Bazargan et al., 2021; Boucher & Johnson, 2021; Ornstein et al., 2020; Rhodes et al., 2012). The lack of interest in EOL care options available has been a direct effect of the prevalent distrust in the healthcare system based on

erroneous information (Harmon et al., 2018; Johnson et al., 2018; Rhodes et al., 2012; Van Scoy et al., 2018).

Education related to EOL care is not provided to the Black population in sufficient quantities (Johnson et al., 2018; Johnson et al., 2009; Rowland & Isaac-Savage, 2014; Townsend et al., 2017). There is a critical need for EOL care education in Black churches (Bazargan et al., 2021; McDonnell & Idler, 2020). Johnson (2009) and Ornstein (2020) provided an example indicating 19% of older Black parishioners denied hearing of hospice even though hospice treatment has been widely available throughout the United States for many years (Johnson et al., 2009; Ornstein et al., 2020). Of those who were aware of hospice services, approximately 8% participated while the others reported a lack of knowledge about the services offered (Bazargan et al., 2021; Boucher & Johnson, 2021; Dillon et al., 2012; Enguidanos et al., 2011; Jackson et al., 2000; Ornstein et al., 2020; Rhodes et al., 2017).

Challenges

Koss (2017), Rhodes (2017), and Soroka (2019) reported many Black parishioners do not seek knowledge about EOL care options because they rely on their faith, beliefs, and spirituality to guide their decisions. Rowland and Isaac-Savage (2014) identified a challenge for clergy, citing parishioners' lack of interest in receiving health education by clergy due to limited space or time in church. There have been no investigations into the relationship between church leaders and members' perception of the value of health-related education within the church (Harmon et al., 2018; Johnson et al., 2019; Ramirez et al., 2019; Rowland & Isaac-Savage, 2014).

Overall Summary of Literature

Bazargan and Cobb (n.d.), Ornstein (2020), Rhodes (2012), and Boucher and Johnson (2021) generally identified the discrepancy in EOL care utilization among ethnic minority communities as a complicated and multifaceted issue with multiple interconnected constraints. The evidence supports parishioners are receptive to education presented from clergy because of the trust and respect clergy are granted within the church (Baruth et al., 2013; Harmon et al., 2018). Black parishioners rely on faith, beliefs, and spirituality to make decisions, including those related to EOL care. The role of clergy

allowsfor an advantageous position to educate parishioners. However, clergy indicate a lack of educational opportunities are available related to EOL care topics. The effective use of an evidence-based educational intervention for clergy on EOL care will provide the knowledge necessary for clergy to provide guidance and support to parishioners during each personal journey.

Chapter 3: Methodology

Design

To examine clergy knowledge about EOL care and spiritual directives, these were the steps of the project:

1. Reviewed the 100 Black Churches website for clergy who preside in a rural community who pastor over a church in Southeastern Virginia.
2. Once the sample was selected, an Excel spreadsheet was developed to track the participants and their information applicable to the study (Appendix B).
3. Each identified clergy member was contacted via email (Appendix C) and telephone (Appendix D) stating the purpose and requesting participation in the project. Participants were given the project requirements.
4. The distribution of the educational webinar was scheduled for April 2023, following approval by the Institutional Review Board (IRB; Appendix E). The webinar was accompanied by a pre- and post-survey (Appendix F), which consisted of two 5-point Likert Scale questions and eight multiple-choice questions.
5. Using Qualtrics, the link to the surveys and educational webinar were emailed in April 2023.
6. Participants had 2 weeks to complete the webinar and surveys.
7. Data collected from Qualtrics was calculated using a quasi-experimental design to determine if the webinar increased knowledge and confidence of the clergy.

Project Sample

Sample Access

The target population included Christian clergy serving Black churches in rural areas of specified

Southeastern Virginia counties.

Sample Recruitment

Recruitment of clergy took place for 2 weeks prior to the implementation of the educational intervention. Clergy were recruited from Black churches within Southeastern Virginia. Participants were selected from the 100 Black Churches website, which is a listing of Black churches. The participants were identified during the recruitment period by the student researcher when contacting churches via email or telephone listed on the 100 Black Churches website (*Black-Owned Churches Directory - Find Black-Owned Churches*, n.d.). Clergy were contacted through the directory to confirm whether the church self-identifies as a Black church. Once identified, clergy were invited to join a webinar about EOL care. All willing volunteers identified meeting the inclusion and exclusion criteria were invited to participate in the educational intervention. For those who were willing to participate, the Excel spreadsheet used to track the participants and their information applicable to the study was completed (Appendix B).

Inclusion and Exclusion Criteria

A requirement for eligibility was the clergy member must preside over a Christian church in a rural community primarily serving Black parishioners in the identified counties of Southeastern Virginia to include Accomack County, Charles City County, Gloucester, Powhatan County, James City, King and Queen, King William, York, Isle of Wight County, Matthews County, and Norfolk County. The clergy member was also required to have high-speed internet access. All churches identified as being a religion other than Christianity, including non-denominational churches, were excluded from this project. Churches who did not self-identify as a Black church were excluded. All churches located in any county other than the identified counties were excluded.

Protection of Human Subjects

Institutional Review Board. Data was used and collected for educational purposes as part of the DNP project. The study was approved under Expedited Category 7: Research is on individual or group characteristics of behavior (including, but not limited to research on perception, cognition, motivation, identity, communication, cultural beliefs or practices, and social behavior) or the research employs

survey, interviews, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies by Radford University's Institutional Review Board on April 20, 2023.

Methods Used to Protect Subjects. All participants were assigned an individual identifier code to ensure the participants were de-identified on all study documents. The spreadsheet containing the participants' information and assigned identifier codes will be stored in Radford University's encrypted One-Drive document storage system for 3 years. After 3 years, the data will be permanently deleted from the One-Drive document storage system.

Risks and Benefits of Participation in Project. There was no identified risk for participants. The benefits of participation included:

- increased receptivity,
- provided guidance and support to parishioners,
- increased confidence in EOL care for discussion with parishioners, and
- increased knowledge.

Instrument

Operational Definitions/Variables

- The independent variable (IV) is an evidence-based educational intervention using a spiritual approach to provide the knowledge necessary for clergy to confidently educate parishioners on EOL care options inclusive of hospice and the development of a spiritual directive.
- The dependent variable (DV) is increased confidence and knowledge of clergy when educating and facilitating EOL care planning with parishioners.

Measurement

Pre- and post-surveys are useful instruments for demonstrating an increase in knowledge when questions are answered in a random order (Davis et al., 2018; Shanko, 2020). Learners are likely to be more responsive to a topic being taught if a pre-survey covers all significant elements of information covered throughout the webinar (Davis et al., 2018). An instrument to measure the specific knowledge

presented in this study was not identified, requiring one be developed. The pre- and post-surveys for this study were created from the evidence identified during the literature research. The surveys utilized measured clergy's knowledge and confidence as it related to guiding parishioners regarding EOL care and the development of a spiritual directive using a combination of multiple-choice and Likert Scale questions.

Survey Administration

Pre- and Post-Surveys. The pre- and post-surveys and educational intervention were delivered via a virtual format with 10 duplicated questions. The pre- and post-surveys were given using eight multiple-choice questions to assess knowledge and two 5-point Likert Scale questions to assess clergy confidence. The educational intervention was delivered in the form of a 23-minute webinar via a virtual format (BigMarker, 2017). The pre-survey was given immediately prior to the educational webinar to identify the clergy members' level of understanding of EOL care and the associated process to include the use of a spiritual directive. Immediately following the completion of the educational webinar, a post-survey was required via a virtual format to obtain the certificate of completion. Participants were required to complete all components during one session.

Reported Measurement Reliability

Surveys have been used since the 1800s to identify a wide range of information from many individuals (Roopa & Rani, 2012). Sir Francis Galton pioneered the use of surveys and questionnaires to collect data on human groups and was the first to apply statistical approaches to study individual variations and transmission of intelligence (Roopa & Rani, 2012). Test-retest reliability is a valuable tool for evaluating the validity of pre- and post-surveys (Kim et al., 2022; Melnyk & Fineout-Overholt, 2019; Roopa & Rani, 2012). To conduct a reliability test, a survey is first given to a sample of respondents ("pre-survey") prior to an intervention followed by the same survey ("post-survey") being given to the same sample post-intervention (Roopa & Rani, 2012). Once completed, each answer is evaluated and measured against the previous responses (Roopa & Rani, 2012).

Validity

Construct validity refers to how well a test or measure assesses what it is supposed to be assessed (Kim et al., 2022; Melnyk & Fineout-Overholt, 2019; Roopa & Rani, 2012). Following the conclusion of the post-survey, the construct validity was applied to the data gathered from the pre- and post-survey in order to determine whether the questions and answers constitute a valid instrument, which was utilized for the purpose of enhancing clergy knowledge (Kim et al., 2022; Melnyk & Fineout-Overholt, 2019; Roopa & Rani, 2012).

Level of Measurement of the Data Obtained

The collected data obtained after statistical analysis using a paired t-test was ordinal. Surveys consisted of eight multiple-choice questions to assess knowledge developed based on evidence identified during the literature research. There were also two questions pertaining to the confidence levels of clergy members asked using a 5-point Likert Scale (Kim et al., 2022; Melnyk & Fineout-Overholt, 2019). The point designation placed the individual responses in an order that determined the level of confidence in relation to EOL care and the development of a spiritual directive (Kim et al., 2022; Melnyk & Fineout-Overholt, 2019). Because quantitative data for this project comes from survey questions and is ordered from most relevant to least relevant, it was reasonable to use ordinal data for this project (Kim et al., 2022; Melnyk & Fineout-Overholt, 2019).

Scoring and Interpretation

Multiple Choice Questions. Each survey consisted of eight multiple-choice questions to assess knowledge developed based on evidence identified during the literature research. Six of the multiple-choice questions only had one correct answer for a total of six possible points. Two of the multiple-choice questions instructed the participant to “select all that apply” for a total of nine possible points. One point was awarded for each correct response. The participants did not receive a point if they answered a question incorrectly. The maximum attainable score for each of the surveys was 15 points with the possible range being 0-15 (Kim et al., 2022; Melnyk & Fineout-Overholt, 2019).

Likert Scale Questions. The pre- and post-surveys had two Likert questions each to evaluate confidence. Participants selected from a range of 1-5, represented as 1-strongly agree, 2-disagree, 3-

neutral, 4-agree, and 5-strongly disagree (Kim et al., 2022; Melnyk & Fineout-Overholt, 2019). Specific questions to be answered by clergy included:

- How confident are you in guiding parishioners regarding EOL care options as part of the EOL care process?
- How confident are you in guiding parishioners in the development of a spiritual directive as part of the EOL care process?

Procedure

The study intervention period spanned over 4 weeks. The first 2 weeks included the identification of Black churches in Southeastern Virginia (Accomack County, Dinwiddie County, Hanover County, New Kent County, Charles City County, Gloucester, Powhatan County, James City, York, Isle of Wight County, Matthews County, Norfolk County, and Tappahannock); the creation of the spreadsheet to tracking all volunteer participants meeting inclusion/exclusion criteria; and dissemination of an informational email to all volunteers providing required information related to the DNP project. The remaining 2 weeks were allowed for the complete intervention to include the pre-survey, webinar, and post-survey. Volunteer participants had access to the webinar at their convenience during the 3 weeks but was only allowed one attempt to maintain data fidelity. All components of the intervention were required to be completed from beginning to end during the single attempt.

Project Implementation

Eligible Subjects Obtained. Churches with clergy meeting inclusion/exclusion criteria were identified from the Directory of Black churches website (*Black-Owned Churches Directory - Find Black-Owned Churches*, n.d.). The identified potential participants were offered an opportunity to be part of the study as a volunteer. To ensure a high-quality project, we employed a power analysis using a Z-test and T-test sample size calculator. The results indicated a minimum of 34 participants were necessary to successfully complete the entire intervention process (*Statistics Online - Checks Assumptions, Interprets Results*, n.d.).

Subject Intervention. To be included in the data collection and receive a certificate of

completion, volunteer clergy members participated in all three phases of the project via a virtual format:

1. Completed and submitted a pre-survey prior to viewing the webinar;
2. Viewed the entire educational webinar; and,
3. Completed and submitted a post-survey following the webinar.

Data Collection. Scores from the pre- and post-surveys administered in Qualtrics were collected by the student researcher at the end of the 2-week implementation period. The detailed scores showing each question for individual participants collected in Qualtrics was then exported to a spreadsheet in Microsoft Excel (Appendix G) to allow for separation of the data from the pre- and post-surveys. The data was then entered into the data analysis tool, Statistical Package for the Social Sciences (SPSS), with the assistance of an expert in SPSS to guarantee the accuracy of the data and results.

Data Fidelity. Prospective participants received an email with a response deadline for confirmation of volunteer participation. To preserve coherence, all participants adhered to the same set of instructions and deadlines. Every participant was given 2 weeks within which to complete one attempt at the pre-/post-surveys and webinar training.

Data Protection. Each participant received an encrypted pre- and post-survey using Qualtrics. Confidentiality of respondents was ensured in surveys, which was created through Qualtrics, an easy-to-use data collecting and analytics tool. Qualtrics allowed data to be imported or exported based on the needs of the user. Scores were not shared with other participants.

Data Management

Data Analysis Software Used

The initial calculations expected from Qualtrics were not able to be used because the software Qualtrics combined the pre- and post-survey scores for all participants into a single score. Consequently, to assess the efficacy of the surveys in measuring the improvement of knowledge and confidence levels, the detailed scores showing each question for individual participants collected in Qualtrics was exported to Microsoft Excel (Appendix G). The scores for the pre- and post-surveys were then calculated separately and preliminary statistical calculations were run using formulas in the Excel spreadsheet. The

statistical calculations were then subsequently verified for accuracy using SPSS, with the assistance of an expert in SPSS to guarantee the accuracy of the data and results.

Data Organization and Selection

Upon collection of the data from Qualtrics, 41 participants appeared in the list of participants. However, one of the participants had stopped taking the post-test after the knowledge questions, resulting in zeros being issued as a grade for the Likert questions not completed. Then, the same participant went back into Qualtrics a few days later and signed in to complete the intervention process again. Given the first attempt does not meet the criteria outlined to be included as data for the subject intervention, the initial attempt was removed from the data set as an outlier. Additionally, when the same participant went into Qualtrics a second time and attempted the intervention again, the participant already had access to the questions being asked in the surveys. This concern was supported by the participant's score being 87% on three attempts with all answers being the same. The participant's second attempt was also removed from the data set as an outlier to prevent a measurement error when calculating data. Removal of these outliers also prevented a Type II error due to the statistical analysis showing a $p = 0.057$ when running the paired t-test on the knowledge portion of the surveys, which would have caused the null hypothesis to not be rejected.

Data Analysis

Statistical Tests

The student researcher conducted paired t-tests to determine if the null hypothesis was correct or needed to be rejected (Kim et al., 2022; Melnyk & Fineout-Overholt, 2019). Assessing whether the mean of the combined pre- and post-survey scores differ is possible using the paired t-test (Kim et al., 2022; Melnyk & Fineout-Overholt, 2019). After completion, statistical assumptions were discussed in greater depth to determine whether it was met for each test (Kim et al., 2022; Melnyk & Fineout-Overholt, 2019).

Although the initial plan was to perform a chi-square calculation on the confidence portion of the surveys given the Likert scale questions, the primary focus of the analysis was to determine whether the

mean difference between the confidence level of the participants increased after the webinar intervention (Kim et al., 2022). The correct statistical analysis to obtain this information is a paired t-test, which is what was used for the confidence portion of the analysis (Kim et al., 2022).

Outcome of Statistical Assumptions

To establish statistical significance, a p-value of < 0.05 was used for this study (Kim et al., 2022). The paired t-test was used to compare the participant scores on the pre- and post-surveys for both knowledge and confidence. The statistical analysis using the paired t-test revealed the observed changes in relation to knowledge did reach statistical significance ($P < .001$; Table 1). The utilization of Likert scale questions was employed to evaluate the participants' level of confidence when it comes to discussing EOL services with parishioners. The statistical analysis conducted in this project yielded a result also found to be statistically significant related to confidence ($P < .001$; Table 2). The findings indicated the intervention had a positive impact on the participants' knowledge and confidence levels when discussing EOL services with parishioners.

Chapter 4: Results

Overview of the Results

The aim of this project was to determine whether the implementation of an evidence-based educational approach would result in enhanced knowledge and confidence among Black clergy members in providing support to Black parishioners seeking guidance regarding EOL decisions. To assess the impact of the evidence-based educational approach on knowledge and confidence levels, a pre-survey consisting of eight questions and two Likert scale questions was administered prior to the beginning of the educational webinar. Following the webinar, participants were given a survey with the same questions to gauge whether their understanding and confidence had improved.

Hypotheses

- H(o): An evidence-based educational intervention using a spiritual approach will not provide the knowledge necessary for clergy to confidently educate parishioners on EOL care options founded in the Christian faith in rural communities of Southeastern Virginia.

- H(a): An evidence-based educational intervention using a spiritual approach will provide the knowledge necessary for clergy to confidently educate parishioners on EOL care.

The study findings resulted in the rejection of the null hypothesis (knowledge = $P < .001$; confidence = $P < .001$). The statistical results substantiate the educational webinar played a pivotal role in enhancing the knowledge and confidence levels of participating clergy in the area of EOL care and planning.

Description of the Sample

The sample comprises individuals who identify as Black clergy and reside in a rural region of Southeastern Virginia. The participants for this project were recruited from the 100 Black Churches website, a comprehensive directory of Black churches. The project included individuals who held positions as clergy members within Christian churches located in rural communities. These churches predominantly catered to a congregation consisting of Black parishioners. The specific counties in Southeastern Virginia were identified for the study included Accomack County, Dinwiddie County, Hanover County, New Kent County, Charles City County, Gloucester, Powhatan County, James City, York, Isle of Wight County, Matthews County, Norfolk County, and Tappahannock. This project excluded all churches who identified as belonging to a religion other than Christianity, including non-denominational churches. Churches who do not identify themselves as Black churches were also subject to exclusion. A total of 121 Black clergy members were initially contacted to participate in this study. In total, 41 clergy members meeting the required criteria participated.

Major Project Variables

The primary variables of the project encompassed the educational webinar, pre-survey, and post-survey. These variables played a significant role in determining whether the participants experienced a notable change in both knowledge and confidence.

Independent Variables

The educational webinar served as the independent variable in effecting knowledge and confidence of the participants.

Dependent Variables

Knowledge. Pre- and post-surveys administered to evaluate the effect of the independent variable (educational webinar) served as the dependent variables. In the portion of the pre-survey ($N = 39$) assessing knowledge, the data collected prior to the educational webinar yielded a mean score of 11.36 with a standard deviation of 1.87. The results of the knowledge portion of the post-survey following the educational webinar indicated a mean value of 12.46, with a standard deviation of 2.08%.

Confidence. The pre-survey questions on the Likert scale yielded a mean value of 3.62, with a standard deviation of 1.21 for question one. In the post-survey, question one, the mean value increased to 4.08, with a standard deviation of 1.01. In response to question two, the mean value gathered from the pre-survey was found to be 3.67 with a standard deviation of 1.28% while the post-survey yielded a mean value of 4.21%, with a standard deviation of 0.99%. The results from the pre- and post-survey and Likert scale questions indicated an increase of 10% in confidence levels.

Analyses of Research Question

The research question is, “Will an evidence-based educational intervention using a spiritual approach provide the knowledge necessary for clergy to confidently educate parishioners on EOL care options founded in the Christian faith in rural communities of Southeastern Virginia?” The project employed an evidence-based educational approach to improve knowledge and confidence of clergy members to better assist black parishioners in navigating EOL choices. Based on the statistical analysis conducted in Excel and SPSS, the statistical significance demonstrated an observed increase in the knowledge and confidence of participating clergy following the educational intervention (knowledge = $P < .001$; confidence = $P < .001$).

Methods

The descriptive analysis method was used for the evaluation of the data analysis performed in this study. In Tables 1 and 2, the results are outlined showing the paired t-tests demonstrating a statistically significant change in both knowledge and confidence levels.

Descriptive Statistics

A paired t-test was employed to conduct a statistical comparison of the scores obtained from the pre- and post-surveys. The multiple-choice survey questions used to assess knowledge were assigned a score of one point for each correct answer and zero points for each incorrect answer. The participants had the potential to earn a maximum of 15 points for the knowledge section of the pre-survey. Likert scale questions were scored from 0 to 5 for each of the two questions. Table 3 depicts the frequency distribution of the total points correctly answered by the participants in the pre- and post-surveys for knowledge. Frequency distribution was not evaluated for the Likert scale questions.

The pre-survey on knowledge yielded a mean of 11.36 out of 15 points (76%), with a standard deviation of 1.87 (Table 4). The average score for the knowledge questions in the post-survey was 12.46 out of 15 points (83%), with a standard deviation of 2.07 (Table 4).

When evaluating the confidence levels of clergy in this study, the mean score for the pre-survey was 3.82 but increased to 4.33% post-survey.

Inferential Statistics

The data analysis was performed by using the paired t-test to compare the pre- and post- surveys. The observed changes in both knowledge and confidence were determined to have statistical significance in relation to knowledge ($P < 0.001$; Tables 1 and 2). The results indicate the educational intervention had a direct impact in creating change in knowledge and confidence of the participants in the study. The change created was positive as evidenced by an improvement in the participants' knowledge and confidence in the areas of EOL care planning and the development of a spiritual directive with parishioners.

Hypothesis Testing

The *H(o):* An evidence-based educational intervention using a spiritual approach will not provide the knowledge necessary for clergy to confidently educate parishioners on EOL care options founded in the Christian faith in rural communities of Southeastern Virginia.

The null hypothesis was rejected and supported by data obtained through the SPSS analysis at $P < .05$ when analyzing a change in knowledge, the pre-survey resulted in a mean score of 76%, and the

post-survey showed a mean score of 83% (Table 4). An increase of 7% was recorded. The Likert scale questions were utilized to assess the level of confidence when discussing EOL care planning and spiritual directive with parishioners. A positive change was statistically significant in both in knowledge and confidence allowing for rejection of the null hypothesis ($P < 0.001$).

Additional Statistical Analyses

To evaluate the answers provided by participants from the perspective of improving the education intervention for future dissemination, individual questions were analyzed based on the change in the response from the pre-survey to the post-survey.

Multiple Choice: Question with Highest Learning

When examining the question regarding the initial step a person should take when seeking end-of-life care services (#6), only 24% of the participants answered correctly on the pre-survey. However, on the post-survey, this question yielded the highest level of correct responses among the participants with 85% answering accurately. This result confirmed the education provided within the webinar provided education on this topic allowing for a 61% increase in the overall score during the post-survey. However, with an average score of 85%, the content will need to be adjusted in the webinar to highlight the key concepts and improve future learning.

Multiple Choice: Question with Highest Level of Knowledge Prior to Intervention

Another higher-level score was the question asking the participant to define a spiritual directive (#7). According to the findings of the pre-survey, a significant majority of participants (92%) demonstrated accuracy in their responses to the question. In the post-survey, the overall percentage of participants who demonstrated an understanding of the spiritual directive increased to 94%. These results indicate on a 2% increase in the post-survey score. This was an interesting finding considering a spiritual directive is a newly created document and concept. This question may need to be changed as this question may represent a measurement error.

Multiple Choice: Question with Lowest Level of Knowledge

Although the educational webinar provided details regarding the best time for implementation of

the spiritual directive, only 15% of the participants correctly answered question 9 correctly on the pre-survey. Only 28% of participants answered this question correctly on the post-survey, indicating an improvement of 14%, but still a small percentage overall. These results show the need for improved education in any future educational interventions deployed on when a spiritual directive should be implemented.

Likert Scale Question: Confidence When Discussing EOL Care

The first Likert scale question, “What is your level of confidence in providing guidance to parishioners regarding end-of-life (EOL) care options within the context of the EOL care process?” yielded a statistically significant increase in confidence related to EOL care discussions with parishioners ($P < 0.001$). The mean of the pre-survey was 3.6 out of 5, increasing in the post-survey to 4.0 (Table 4). Additional research will need to be performed in the future to determine specific techniques to integrate confidence building in with education to maximize the impact of the educational intervention.

Likert Scale Question: Confidence in Creating a Spiritual Directive

The second Likert question pertains to the level of confidence one possesses in providing guidance to parishioners regarding the development of a spiritual directive within the context of end-of-life (EOL) care. There was a notable rise in the pre-survey mean from 3.6 to the post-survey mean of 4.1 ($P < 0.001$; Table 4). This question also warrants additional research be performed in the future to determine specific techniques to integrate confidence building in with education to maximize the impact of the educational intervention.

Summary

The objective of this project was to evaluate the effects of an evidence-based educational intervention on the knowledge and confidence levels of Black clergy members. The study examined the efficacy of their guidance in assisting Black parishioners in navigating EOL decision-making processes. In summary, the null hypothesis was rejected because the study demonstrated statistical significance by effectively utilizing data-driven education strategies in response to survey findings. An increase of 7% was found in the knowledge base scores from the pre- to post-survey. The Likert scale questions also yielded an

increase from 3.82 in the pre-survey to a mean of 4.33 for the post-survey. The data and statistical analysis support the intervention had a positive effect on the participants' knowledge and confidence in relation to discussing EOL care planning and spiritual directives.

Chapter 5: Discussion

Relationship of Findings to Prior Research

The purpose of this study was to evaluate whether an evidence-based educational intervention using a spiritually guided approach for clergy in rural communities of Southeastern Virginia. It was the hope of the student researcher this study would improve the ability of clergy to provide guidance to parishioners in the areas outlined within the purpose statement. The evidence revealed clergy reported a lack of education resulting in decreased knowledge in the area of care planning and lower levels of confidence when speaking to parishioners about spiritual needs at the EOL (Harmon et al., 2018; Johnson et al., 2018). This study shows the data analysis supports the current research regarding the benefits of an educational intervention to increase knowledge and confidence and the need for continued education of clergy regarding EOL care planning to support parishioners' spiritual health. A comparison of the spiritual directive to previous research isn't possible because it was recently developed just prior to the implementation of the study (D. Hoffert, personal communication, April 16, 2023). The spiritual directive was found to be a useful tool by the participants, which is supported by the student researcher (D. Hoffert, personal communication, April 16, 2023).

Overall Scores

Knowledge

There were 41 participants surveyed; however, two outliers were identified and removed resulting in N = 39. Enguidanos et al. (2011) conducted a study to assess changes in knowledge using educational material as an intervention in which they employed a pre- and post-test method, similar to the survey in this study. Their present investigation revealed a significant increase in the knowledge on EOL services evidenced by an increase in the overall scores of participants from 83.1% to 95.8% ($P < 0.001$;

Enguidanos et al., 2011). This study aligns with the findings of Enguidanos et al. (2011) in the overall increase in scores related to knowledge was 7% for this study and 12.7% in their study. The overall knowledge scores for this study support prior research.

Confidence

There were 41 participants surveyed; however, two outliers were identified and removed resulting in N = 39. The Dunning-Kruger Effect is clearly displayed in this study (*Scientific American,* n.d.). Prior to the webinar, clergy reported a low level of confidence but not a confidence level of zero, indicating clergy has some previous knowledge related to EOL care. However, it is likely limited to do the low mean score of the pre-survey (M = 3.82). The Dunning-Kruger Effect indicates additional knowledge on a given topic will increase individual confidence on that subject (*Scientific American,* n.d.). The confidence was increased in participants within this study regarding EOL care evidence by the post-survey score (M = 4.33; $P < 0.001$), representing a 10% increase in the reported confidence level of clergy. The improvement in confidence of clergy supports the evidence identified in previous research.

Overview of Similarities and Differences

Knowledge and Confidence Level

Similarities. In addition to the similarities with Enguidanos et al. (2011) noted above, additional research aligned with the findings in this study. For instance, Koss et al. (2018) did a similar study on clergy. To ensure a diverse perspective, the researchers incorporated an oversample of non-White clergy (Koss et al., 2018). Data was collected through a mixed method of quantitative and qualitative interviews (Koss et al., 2018). Their study showed a low confidence level in clergy when discussing EOL services with their parishioners because of the lack of knowledge, understanding, and misconceptions (Koss et al., 2018).

Differences. Johnson et al. (2018) did not provide any empirical evidence to support the assertion the Black clergy derived any benefits from a structural learning program. None of the evidence reviewed only looked at knowledge or confidence but did not intentionally seek out to evaluate knowledge and confidence collectively. The present study examines the collective impact of knowledge

and confidence to assess any potential changes following the delivery of an educational webinar. To gain a comprehensive understanding of the current state of clergy, it was deemed essential to incorporate both variables. This study confirmed Black clergy did benefit from a structured learning program in both knowledge and confidence.

Method

Similarities. Other studies from Johnson et al. (2018) and Johnson et al. (2016) used a similar methodology to include an educational intervention to examine the impact of Black clergy on parishioners' engagement in EOL discussions. Johnson et al. (2018) collaborated with a selection of five Black churches located in the Philadelphia region. The participants in their study consisted of individuals from the Black clergy and other church leaders (Johnson et al., 2018). The approach employed involved the development of a leadership-education initiative, which entailed a comprehensive training program supplemented with educational resources (Johnson et al., 2018). The primary objective of this program was to enhance knowledge acquisition and foster a positive shift in attitudes toward EOL services. The study showcased the viability of involving the Black church in a comprehensive and multifaceted approach aimed at enhancing communication regarding EOL care (Johnson et al., 2018). The findings of their research illustrate the capacity of the Black clergy to serve as a valuable community asset for engaging in discussions pertaining to EOL care with increase knowledge and training.

Differences. The research conducted by Johnson et al. (2018) involved the incorporation of EOL project activities into pre-existing church programs and structures. Harmon et al. (2018) employed interviews as a research methodology, in contrast to the approach utilized in this study. These study methods differed from this study because the pre- and post-survey method was more structured, shorter in duration, and quantitative in nature.

Sample Characteristics

Similarities. Based on multiple research studies, it can be observed this study shares similarities with others in terms of sample characteristics (Harmon et al., 2018; Koss et al., 2018; Johnson et al., 2018). Harmon et al. (2018) and Koss et al. (2018) conducted a study utilizing a sample of Black clergy

members from Southern Black Christian churches. Koss et al.'s (2018) study used a sample of 35 community clergy. The leadership education program implemented by Johnson et al. (2018) demonstrated effectiveness by strategically focusing on a specific group of individuals within each church located within a designated geographical area. The scope of my sample chosen for this study was centered on regions within Southeastern Virginia.

Differences. Other studies used different geographical locations, which impacted sample size, such as Johnson et al. (2018) who limited their study to a sample size of five churches, while Koss et al. (2018) included the entire state of South Carolina (N = 35). Another variation was Johnson et al. (2016) who selected a sample of 100 church leaders from three Black churches. This study covered 41 churches with a net sample size of 39 participants. Other studies incorporated participants from diverse racial backgrounds while this study focused solely on Black clergy (Balboni et al., 2016; Baruth et al., 2014).

Collinearity

The absence of collinearity among the variables is supported by the lack of more than one predictor variable. In this study, the predictor variable would also be the independent variable (the educational webinar). The educational webinar functioned as a crucial indicator that facilitated the transformation of knowledge and confidence levels. After the administration of the post-survey, it served as the primary tool for assessing whether the educational webinar, considered as the independent variable, had a discernible impact on the participants' acquisition of knowledge from the provided information.

General Observations

During the study, a considerable number of Black clergy members expressed their willingness to participate in response to the initial email. However, a significant proportion of these clergy ultimately failed to comply due to the presence of inaccurate information on their respective websites or social media pages, preventing communication necessary for the study. Many churches did not maintain a regular schedule of services, which also resulted in a delay in participation. Six churches out of 120 selected for the project were unable to maintain their status as a religious institution as a result of the COVID-19 pandemic, resulting in the churches being removed as possible participants.

Interpretation of Findings

The data indicates mean scores for knowledge and confidence levels of the participants exhibited a statistically significant positive change ($P < 0.001$). The pre-survey on knowledge yielded a mean of 11.36 out of 15 points (76%) with a standard deviation of 1.87 (Table 4). The average score for the knowledge questions in the post-survey was 12.46 out of 15 points (83%), with a standard deviation of 2.07 (Table 4). When evaluating the confidence levels of clergy in this study, the mean score for the pre-survey was 3.82 but increased to 4.33 post-survey. The data and statistical analysis support the intervention had a positive effect on the participants' knowledge and confidence in relation to discussing EOL care planning and spiritual directives.

Evaluation of the Theoretical Model

The study utilized the transformative learning theory as its theoretical framework. It is an effective theory that explains how the thoughts, emotions, and behaviors of a person can be transformed because of the learning process (Pilli, 2004; Transformative Learning Theory, 2022). The findings substantiate the applicability of the theoretical framework as the clergy underwent training via a webinar that imparted knowledge on end-of-life (EOL) care and service. The provision of information resulted in an increase in survey scores, thereby enhancing the participants' knowledge base. The incorporation of additional variables such as education level, age, and gender could have been advantageous in examining the disparities in learning outcomes across individuals. To further investigate learning behaviors, it would have been beneficial to expand the participant pool service area for comparison of learning behavior, especially given the decreased number of churches available to participate post-Covid.

Limitations

Prior research has utilized a comparable pre-/post-survey design, but there was not an instrument available for use in the study. However, the instrument was developed by the student researcher through the formulation of research-based inquiries, with a specific focus on identifying areas where Black clergy demonstrate knowledge and confidence deficiencies (Johnson et al., 2016; Koss et al., 2018; Rosenfeld et al., 2007).

The COVID-19 pandemic resulted in difficulties faced by numerous Black churches. These churches were unable to maintain a sustainable membership. Had prior knowledge of this change been available, I would have extended the scope of the project and expanded the pool of candidates to increase the sample.

Sampling Plan Impact on Project

Sampling Technique. The utilization of a random sampling technique for the selection of Black clergy members from Southeastern Virginia did not have a detrimental impact on the overall validity of the project.

Homogeneous and Diverse. The chosen sample for this project exhibited a significant level of homogeneity. To examine the potential for improved knowledge and confidence among Black clergy, it was essential to select a sample group that exhibited homogeneity in certain characteristics, including ethnic background, leadership in a rural church environment, and affiliation with a clearly identifiable church. The geographical region in question is located in Southeastern Virginia and encompasses various counties, namely Accomack County, Dinwiddie County, Hanover County, New Kent County, Charles City County, Gloucester, Powhatan County, James City, York, Isle of Wight County, Matthews County, Norfolk County, and Tappahannock. A diverse population would not have addressed the research question given the question was directed specifically to Black Christian clergy members in the identified geographical locations.

Social Desirability. The implementation of this project was deemed necessary in hopes of enhancing the knowledge and confidence of Black clergy to ultimately improve patient experiences at the EOL. The aspiration to enhance knowledge was fulfilled through the provision of an educational webinar, which provided information to the participants. The potential influence of social desirability bias on the survey results was lowered by the participants' lack of awareness regarding the presented information. Data was gathered from multiple rural churches located in Southeastern Virginia to remove potential biases that could have influenced the outcomes. The survey was administered with a closed-ended

approach, whereby participants were not given the opportunity to discuss the survey questions with other selected participants, to prevent information sharing.

Implications for Future Research

A considerable proportion of participants conveyed a need for supplementary information pertaining to the spiritual directive. The following steps would entail continuous provision of additional information regarding spiritual guidance to clergy, along with providing additional educational resources to aid them in proficiently facilitating communication with parishioners. Following the implementation of this project, a discovery was made regarding how a significant number of rural churches in the Southeastern region of Virginia were closed as a direct consequence of the COVID-19 pandemic. To enhance the impact of a future study, it is recommended that future replications of this study consider incorporating a diverse sample from various regions within Virginia to create a larger participant pool from both urban cities and rural counties.

The study utilized the transformative learning theory to examine the perception of the Black clergy regarding EOL care. This was achieved by administering surveys and providing an educational webinar. The project aimed to explore the transformative learning theory, which indicates the learning process has the potential to bring about significant changes in an individual's thoughts, emotions, and behaviors (Pilli, 2004; Transformative Learning Theory, 2022). This theory offers valuable insights into the mechanisms through which personal transformation can occur because of educational experiences. By examining the various components of transformative learning, including cognitive restructuring, emotional reevaluation, and behavioral adaptation, it gives a deeper understanding of how individuals undergo profound changes in their psychological and behavioral functioning. The incorporation of this theory into the project has yielded a significant contribution to the comprehension of the impact of learning on the transformation of thoughts and behavior pertaining to EOL care. A future study exploring the practical application of the knowledge obtained by the clergy in this study based on the various components of the theory would be important to understand how participants reached behavioral adaptation.

Implications for Practice, Health Policy, and Education

The clinical significance of the findings suggests the necessity for additional education to be provided to all clergy. According to the findings of this project, it was observed the implementation of an educational webinar had a significant impact on knowledge and confidence levels of Black clergy. The incorporation of spiritual directives and clergy education within clinical guidelines is a relevant consideration as a potential approach to improve satisfaction in EOL care for all patients.

By examining existing literature and conducting research studies, this project seeks to contribute to the growing body of knowledge on the impact of spirituality and clergy involvement on patient outcomes in EOL care. The findings of this study combined with the previous research make a substantial contribution to the current research landscape. Healthcare professionals and policymakers need to prioritize the creation of comprehensive and patient-centered clinical guidelines promoting the education of clergy on EOL care planning activities. The primary emphasis of these guidelines should revolve around the clergy's understanding of patients' needs and the incorporation of a spiritual approach during the EOL care phase. The integration of spiritual directive into healthcare practices has the potential to improve the overall quality of EOL care delivered to patients.

An emphasis in nursing education should revolve around delivering a comprehensive educational experience to all spiritual leaders. This approach aims to empower them with the necessary knowledge and skills to effectively support and guide their parishioners in matters pertaining to EOL care. Furthermore, it is imperative to educate nurses on the completion process of spiritual directives to effectively communicate the value and advantages of this tool to clergy members and patients.

Conclusion

The purpose of this study is to evaluate an evidence-based educational intervention using a spiritually guided approach for clergy in rural communities of Southeastern Virginia. The project aimed to contribute to the existing body of nursing knowledge by examining the issue of decreased knowledge and confidence among Black clergy when discussing EOL care with their parishioners. The analysis of the data collected from this project revealed that there was a noticeable improvement in the mean scores

for both knowledge and confidence levels among the participants. This positive change suggests the study had a significant impact on enhancing the participants' knowledge and confidence. The pre-survey resulted in a mean score of 76%, whereas the post-survey showed a mean score of 83%, representing an increase in knowledge of 7% overall. Additionally, clergy reported a 10% increase in confidence after receiving the education intervention. The project has provided valuable insights into the importance of education for Black clergy in the nursing profession. Within the realm of nursing, a notable prospect emerges for nurses to advance this project by undertaking a comprehensive exploration of the role played by Black clergy in healthcare settings. To enhance the scope of future research, it is recommended to expand the geographical coverage to encompass a wider array of locations, thereby facilitating a more comprehensive representation of Black clergy. This study showed how providing education to clergy regarding EOL care planning and development of the spiritual directive can result in increased knowledge and confidence optimally benefiting the parishioners within their assigned churches.

References

A spiritual approach—The Janki Foundation. (2017, October 24). https://www.jankifoundation.org/a-spiritual-approach/

American Academy of Hospice and Palliative Medicine. (n.d.). Retrieved September 29, 2022, from http://aahpm.org/

American Association of Colleges of Nursing. (n.d.). Retrieved April 24, 2022, from http://aacnnursing.org/

American Cancer Society. (n.d.). What is hospice care? Retrieved April 23, 2022, from https://www.cancer.org/treatment/end-of-life-care/hospice-care/what-is-hospice-care.html

Balboni, M. J., Sullivan, A., Smith, P. T., Zaidi, D., Mitchell, C., Tulsky, J. A., Sulmasy, D. P., VanderWeele, T. J., & Balboni, T. A. (2018). The views of clergy regarding ethical controversies in care at the end of life. *Journal of Pain and Symptom Management*, *55*(1), 65–74.e9. https://doi.org/10.1016/j.jpainsymman.2017.05.009

Baruth, M., Wilcox, S., & Saunders, R. P. (2013). The role of pastor support in a faith-based health promotion intervention. *Family & Community Health*, *36*(3), 204–214. https://doi.org/10.1097/FCH.0b013e31828e6733

Bazargan, M., Cobb, S., Assari, S., & Kibe, L. W. (2021). Awareness of palliative care, hospice care, and advance directives in a racially and ethnically diverse sample of California adults. *American Journal of Hospice and Palliative Medicine®*, *38*(6), 601–609. https://doi.org/10.1177/1049909121991522

BigMarker. (2017, June 20). 12 Webinar statistics you need to know. *Medium*. https://medium.com/@BigMarker/12-webinar-statistics-you-need-to-know-b3e28b275abe

Birnbaum, H. G., & Kidder, D. (1984). What does hospice cost? *American Journal of Public Health*, *74*(7), 689–697. https://doi.org/10.2105/AJPH.74.7.689

Black-Owned Churches Directory—Find Black-Owned Churches. (n.d.). 100BlackChurches.Com. Retrieved October 9, 2022, from https://www.100blackchurches.com

Boucher, N. A., & Johnson, K. S. (2021). Cultivating cultural competence: How are hospice staff being educated to engage racially and ethnically diverse patients? *American Journal of Hospice and Palliative Medicine®*, *38*(2), 169–174. https://doi.org/10.1177/1049909120946729

Brock, S. E. (2010). Measuring the importance of precursor steps to transformative learning. *Adult Education Quarterly*, *60*(2), 122–142. https://doi.org/10.1177/0741713609333084

Burrs, F. A. (1995). The African American experience: Breaking the barriers to hospices. *The Hospice Journal*, *10*(2), 15–18. https://doi.org/10.1080/0742-969X.1995.11882788

Cipriano-Steffens, T., Cursio, J. F., Hlubocky, F., Sumner, M., Garnigan-Peters, D., Powell, J., Arndt, N., Phillips, L., Lassiter, R. H., Gilliam, M., Petty, L. E., Pastor, R. S. O., Malec, M., Fitchett, G., & Polite, B. (2021). Improving end-of-life cancer outcomes through development and implementation of a spiritual care advocate program. *The American Journal of Hospice & Palliative Care*, *38*(12), 1441–1450. https://doi.org/10.1177/1049909121995413

Davis, G. C., Baral, R., Strayer, T., & Serrano, E. L. (2018). Using pre- and post-survey instruments in interventions: Determining the random response benchmark and its implications for measuring effectiveness. *Public Health Nutrition*, *21*(6), 1043–1047. https://doi.org/10.1017/S1368980017003639

Dictionary.com. (n.d.). Clergy. Retrieved April 29, 2022, from https://www.dictionary.com/browse/clergy

Dillon, P. J., Roscoe, L. A., & Jenkins, J. J. (2012). African Americans and decisions about hospice care: Implications for health message design. *Howard Journal of Communications*, *23*(2), 175–193. https://doi.org/10.1080/10646175.2012.667724

End of Life. (n.d.). National Institute on Aging. Retrieved April 27, 2022, from https://www.nia.nih.gov/health/end-of-life

Enguidanos, S., Kogan, A. C., Lorenz, K., & Taylor, G. (2011a). Use of role model stories to overcome

barriers to hospice among African Americans. *Journal of Palliative Medicine*, *14*(2), Article 2. https://doi.org/10.1089/jpm.2010.0380

Enguidanos, S., Kogan, A. C., Lorenz, K., & Taylor, G. (2011b). Use of role model stories to overcome barriers to hospice among African Americans. *Journal of Palliative Medicine*, *14*(2), 161–168. https://doi.org/10.1089/jpm.2010.0380

Exline, J., Prince-Paul, M., Root, B. L., & Peereboom, K. S. (2013). The spiritual struggle of anger toward God: A study with family members of hospice patients. *Journal of Palliative Medicine*, *16*(4), Article 4. https://doi.org/10.1089/jpm.2012.0246

Fitchett, G., Pierson, A., Hoffmeyer, C., Labuschagne, D., Lee, A., Levine, S., O'Mahony, S., Pugliese, K., & Waite, N. (2020). Development of the PC-7, a quantifiable assessment of spiritual concerns of patients receiving palliative care near the end of life. *Journal of Palliative Medicine*, *23*(2), Article 2. https://doi.org/10.1089/jpm.2019.0188

Feldmeier, P. (2016). What is spirituality? *U.S. Catholic*, *81*(5), 20–24.

Gad, I., Tan, X.-W. C., Williams, S., Itawi, S., Dahbour, L., Rotter, Z., Mitro, G., Rusch, C., Perkins, S., & Ali, I. (2022). The religious and spiritual needs of patients in the hospital setting do not depend on patient level of religious/spiritual observance and should be initiated by healthcare providers. *Journal of Religion & Health*, *61*(2), 1120–1138. https://doi.org/10.1007/s10943-020- 01103-7

Gómez-Vírseda, C. (2019). *Relational autonomy: What does it mean and how is it used in end-of-life care? A systematic review of argument-based ethics literature*. *BMC Medical Ethics, 20*, Article 76.

Hall, E., Handzo, G., & Massey, K. (2016). *Time to move forward creating a new model of spiritual care to enhance the delivery of outcomes and value in healthcare settings* (pp. 1–20) [Position Statement]. https://www.spiritualcareassociation.org/docs/resources/time_to_move_forward_report_2016-06-07.pdf

Harmon, B. E., Strayhorn, S., Webb, B. L., & Hébert, J. R. (2018). Leading God's people: Perceptions of

influence among African American pastors. *Journal of Religion and Health*, *57*(4), 1509–1523.

Jackson, F., Schim, S. M., Seeley, S., Grunow, K., & Baker, J. (2000). Barriers to hospice care for African Americans: Problems and solutions. *Journal of Hospice & Palliative Nursing*, *2*(2), 65–72. https://doi.org/10.1097/00129191-200002020-00005

Jacobs, M. R. (2008). What are we doing here? Chaplains in contemporary health care. *The Hastings Center Report*, *38*(6), 15–18. https://doi.org/10.1353/hcr.0.0079

Johnson, J., Hayden, T., Taylor, L. A., Gilbert, A., Jones, C. H., Mitchell, M. P. H., & Curtis, B. (2018). Engaging the African American church to improve communication about palliative care and hospice: Lessons from a multilevel approach. *Journal of Palliative Care*, *34*(3), 168–174. https://doi.org/10.1177/0825859718810718

Johnson, K., Kuchibhatla, M., & Tulsky, J. A. (2009). Racial differences in self-reported exposure to information about hospice care. *Journal of Palliative Medicine*, *12*(10), Article 10. https://doi.org/10.1089/jpm.2009.0066

Kim, M., Mallory, C., & Valerio, T. (2022). *Statistics for evidence-based practice in nursing* (3rd ed.). Jones & Bartlett Learning.

Koss, C. S. (2018). Does religiosity account for lower rates of advance care planning by older African Americans? *The Journals of Gerontology: Series B: Psychological Sciences and Social Sciences*, *73*(4), Article 4. https://doi.org/10.1093/geronb/gbw155

Koss, S. E., Weissman, R., Chow, V., Smith, P. T., Slack, B., Voytenko, V., Balboni, T. A., & Balboni, M. J. (2018). Training community clergy in serious illness: Balancing faith and medicine. *Journal of Religion and Health*, *57*(4), 1413–1427. https://doi.org/10.1007/s10943-018-0645-8

Lindholm, K. (2018). Handling challenges inherent in the hospice chaplain role. *Journal of Health Care Chaplaincy*, *24*(4), 131–150. https://doi.org/10.1080/08854726.2017.1373055

Lorenz, K. A., Hays, R. D., Shapiro, M. F., Cleary, P. D., Asch, S. M., & Wenger, N. S. (2005). Religiousness and spirituality among HIV-infected Americans. *Journal of Palliative Medicine*, *8*(4), Article 4. https://doi.org/10.1089/jpm.2005.8.774

McDonnell, J., & Idler, E. (2020). Promoting advance care planning in African American faith communities: Literature review and assessment of church-based programs. *Palliative Care & Social Practice*, 1–15. https://doi.org/10.1177/2632352420975780

Melnyk, B., & Fineout-Overholt, E. (2019). *Evidence-based practice in nursing and healthcare* (4th ed.). Wolters Kluwer.

Meneely, C. (2015). Transformative learning and Christian spirituality: Towards a model for pedagogical and theological clarity? *Adult Learner (0790-8040)*, 88–101.

Mercer, J. A. (2006). Transformational adult learning in congregations. *Journal of Adult Theological Education*, *3*(2), 163–178. https://doi.org/10.1558/jate.2006.3.2.163

Moran, K., Burson, R., & Conrad, D. (2019). *The doctor of nursing practice project* (3rd ed.). Jones & Bartlett.

Morgan Consoli, M. L., Unzueta, E. G., Delucio, K., & Llamas, J. (2018). What shade of spirituality? Exploring spirituality, religiosity, meaning making, and thriving among Latina/o undergraduates. *Counseling & Values*, *63*(2), 232–253. https://doi.org/10.1002/cvj.12090

National Hospice and Palliative Care Organization. (n.d.). https://www.nhpco.org/

Ornstein, K. A., Roth, D. L., Huang, J., Levitan, E. B., Rhodes, J. D., Fabius, C. D., Safford, M. M., & Sheehan, O. C. (2020). Evaluation of racial disparities in hospice use and end-of-life treatment intensity in the regards cohort. *JAMA Network Open*, *3*(8), e2014639. https://doi.org/10.1001/jamanetworkopen.2020.14639

Parker, C., Handzo, G., Hughes, B., Wintz, S., Hamish, S., Johns, J., & Riley, H. (2021). *Hospice & palliative care chaplaincy: What everyone should know*. https://www.spiritualcareassociation.org/docs/resources/hccn_sca_hospice_palliative_care_chaplaincy_2021.pdf

Parker, C. J. (2021). Self-compassion and healthcare chaplaincy: A need for integration into clinical pastoral education. *Journal of Health Care Chaplaincy*, *27*(3), Article 3. https://doi.org/10.1080/08854726.2020.1723187

Pentaris, P., & Christodoulou, P. (2021). Knowledge and attitudes of hospice and palliative care professionals toward diversity and religious literacy in Cyprus: A cross-sectional study. *Journal of Palliative Medicine*, *24*(2), Article 2. https://doi.org/10.1089/jpm.2020.0011

Pilli, E. (2004). Longing for a better world: Towards a critical approach in adult Christian education. *Journal of European Baptist Studies*, *5*(1), 18–39.

Ramirez, C. B., Coyne-Beasley, T., Godley, P. A., Adimora, A. A., Goldmon, M. V., Thompson, G. A., Ellis, D., Stevenson, J. L., Williams, J. M., & Howard, D. L. (2019). Black pastors' views on preaching about sex: Barriers, facilitators, and opportunities for HIV prevention messaging. *Ethnicity & Health*, *24*(5), 560–574. https://doi.org/10.1080/13557858.2017.1346180

Rhodes, R. L., Elwood, B., Lee, S. C., Tiro, J. A., Halm, E. A., & Skinner, C. S. (2017). The desires of their hearts: The multidisciplinary perspectives of African Americans on end-of-life care in the African American community. *American Journal of Hospice and Palliative Medicine®*, *34*(6), 510–517. https://doi.org/10.1177/1049909116631776

Rhodes, R. L., Xuan, L., & Halm, E. A. (2012). African American bereaved family members' perceptions of hospice quality: Do hospices with high proportions of African Americans do better? *Journal of Palliative Medicine*, *15*(10), Article 10. https://doi.org/10.1089/jpm.2012.0151

Robinson, M. T. (2016). Helping African Americans of faith embrace end-of-life discussions. *Journal of Palliative Medicine*, *19*(2), 1–2. https://doi.org/10.1089/jpm.2015.0321

Roopa, S., & Rani, M. (2012). Questionnaire designing for a survey. *Journal of Indian Orthodontic Society*, *46*(4_suppl1), 273–277. https://doi.org/10.5005/jp-journals-10021-1104

Rowland, M., & Isaac-Savage, E. (2014). As I see it: A study of African American pastors' views on health and health education in the black church. *Journal of Religion and Health*, *53*(4), 1091–1101.

Sanders, J. J., Chow, V., Enzinger, A. C., Lam, T.-C., Smith, P. T., Quiñones, R., Baccari, A., Philbrick, S., White-Hammond, G., Peteet, J., Balboni, T. A., & Balboni, M. J. (2017). Seeking and accepting: U.S. clergy theological and moral perspectives informing decision making at the end

of life. *Journal of Palliative Medicine*, *20*, 1059–1067. https://doi.org/10.1089/jpm.2016.0545

Scientific American (n.d). Retrieved July 20, 2023, from http://www.scientificamerican.com

Shanko, P. (2020, January 30). What are the benefits of pre and post-tests? *Digitec Interactive*. https://www.digitecinteractive.com/benefits-of-pre-and-post-tests/

Sloan, D. H., Peters, T., Johnson, K. S., Bowie, J. V., Ting, Y., & Aslakson, R. (2016). Church-based health promotion focused on advance care planning and end-of-life care at Black Baptist churches: A cross-sectional survey. *Journal of Palliative Medicine*, *19*(2), Article 2. https://doi.org/10.1089/jpm.2015.0319

Soroka, J. T., Collins, L. A., Creech, G., Kutcher, G. R., Menne, K. R., & Petzel, B. L. (2019). Spiritual care at the end of life: Does educational intervention focused on a broad definition of spirituality increase utilization of chaplain spiritual support in hospice? *Journal of Palliative Medicine*, *22*(8), Article 8. https://doi.org/10.1089/jpm.2018.0579

Statistics online—Checks assumptions, interprets results. (n.d.). Retrieved October 10, 2022, from https://www.statskingdom.com/

Townsend, A., March, A. L., & Kimball, J. (2017). Can faith and hospice coexist: Is the African American church the key to increased hospice utilization for African Americans? *Journal of Transcultural Nursing*, *28*(1), 32–39. https://doi.org/10.1177/1043659615600764

Transformative Learning Theory. (2022). Toolshero. https://www.toolshero.com/personal-development/transformative-learning-theory/

Transformative Learning Theory by Jack Mezirow. (n.d.). Valamis. https://www.valamis.com/hub/transformative-learning

Van Scoy, L. J., Watson-Martin, E., Bohr, T. A., Levi, B. H., & Green, M. J. (2018). End-of-life conversation game increases confidence for having end-of-life conversations for chaplains-in-training. *American Journal of Hospice and Palliative Medicine®*, *35*(4), 592–600. https://doi.org/10.1177/1049909117723619

Virginia Church Directory. (n.d.). https://www.usachurches.org/search/va/

White, K. R., Cochran, C. E., & Patel, U. B. (2002). Hospital provision of end-of-life services: Who, what, and where? *Medical Care*, *40*(1), 17–25.

Williams, R. M., Glanz, K., Kegler, M. C., & Davis, E. (2012). A study of rural church health promotion environments: Leaders' and members' perspectives. *Journal of Religion and Health*, *51*(1), 148–161.

Winston, C. A., Leshner, P., Kramer, J., & Allen, G. (2005). Overcoming barriers to access and utilization of hospice and palliative care services in African-American communities. *OMEGA - Journal of Death and Dying*, *50*(2), 151–163. https://doi.org/10.2190/QQKG-EPFA-A2FN-GHVL

Tables

Table 1

Paired Samples Correlations for Knowledge – Pre-/Post-Survey

		N	Correlation	Significance One-Sided p	Two-Sided p
Pair 1	Knowledge_Post survey & Knowledge_Pre-survey	39	.607	<.001	<.001

Note: This table demonstrates the importance of the study in relation to the null hypothesis. The data presented includes the number of participants, the correlation, and the statistical significance related to the clergy's knowledge based on the eight multiple-choice questions.

Table 2

Paired Samples Correlations for Confidence – Pre-/Post-Survey

		Paired Differences					t	df	Significance	
					95% Confidence Interval of the Difference					
		Mean	Std. Deviation	Std. Error Mean	Lower	Upper			One-Sided p	Two-Sided p
Pair 1	Knowledge_Posttest - Knowledge_Pretest	1.10256	1.75911	.28168	.53233	1.67280	3.914	38	<.001	<.001
Pair 2	POST SURVEY How confident are you in guiding parishioners regarding end-of-life (EOL) care options as part of the EOL care process? - "1" = Not confident at all; "5" is Very confident - PRE SURVEY How confident are you in guiding parishioners regarding end-of-life (EOL) care options as part of the EOL care process? - "1" = Not confident at all; "5" is Very confident	.46154	.78961	.12644	.20558	.71750	3.650	38	<.001	<.001
Pair 3	POST SURVEY How confident are you in guiding parishioners in the development of a spiritual directive as part of the end-of-life (EOL) care process? - "1" = Not confident at all; "5" is Very confident - PRE SURVEY How confident are you in guiding parishioners in the development of a spiritual directive as part of the end-of-life (EOL) care process? - "1" = Not confident at all; "5" is Very confident	.53846	.88396	.14155	.25192	.82501	3.804	38	<.001	<.001
Pair 4	ConfidenceScoreTotal_Postsurvey - ConfidenceScoreTotal_Presurvey	.50000	.76089	.12184	.25335	.74665	4.104	38	<.001	<.001

Note: This table demonstrates the importance of the study in relation to the null hypothesis. The data presented includes the number of participants, the correlation, and the statistical significance related to the clergy's confidence based on the two Likert scale questions.

Table 3

Frequency Distribution – Knowledge Pre-/Post-Test Comparison

Pre-Survey Distribution

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	7.00	2	5.1	5.1	5.1
	8.00	2	5.1	5.1	10.3
	9.00	2	5.1	5.1	15.4
	10.00	4	10.3	10.3	25.6
	11.00	9	23.1	23.1	48.7
	12.00	8	20.5	20.5	69.2
	13.00	8	20.5	20.5	89.7
	14.00	4	10.3	10.3	100.0
	Total	39	100.0	100.0	

Post-Survey Distribution

Valid	6.00	1	2.6	2.6	2.6
	7.00	1	2.6	2.6	5.1
	8.00	1	2.6	2.6	7.7
	9.00	2	5.1	5.1	12.8
	11.00	2	5.1	5.1	17.9
	12.00	6	15.4	15.4	33.3
	13.00	13	33.3	33.3	66.7
	14.00	11	28.2	28.2	94.9
	15.00	2	5.1	5.1	100.0
	Total	39	100.0	100.0	

Note: These tables demonstrate a comparison of the frequency of scores obtained by participants on the pre- and post-surveys. The data presented shows insights into the frequency distribution of scores among the participants, as well as the cumulative scores in relation to those of other participants.

Table 4

Paired Samples Statistics for Knowledge and Confidence

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Knowledge_Posttest	12.4615	39	2.07550	.33235
	Knowledge_Pretest	11.3590	39	1.87065	.29954
Pair 2	POST SURVEY How confident are you in guiding parishioners regarding end-of-life (EOL) care options as part of the EOL care process? - "1" = Not confident at all; "5" is Very confident	4.0769	39	1.01007	.16174
	PRE SURVEY How confident are you in guiding parishioners regarding end-of-life (EOL) care options as part of the EOL care process? - "1" = Not confident at all; "5" is Very confident	3.6154	39	1.20559	.19305
Pair 3	POST SURVEY How confident are you in guiding parishioners in the development of a spiritual directive as part of the end-of-life (EOL) care process? - "1" = Not confident at all; "5" is Very confident	4.2051	39	.97817	.15663
	PRE SURVEY How confident are you in guiding parishioners in the development of a spiritual directive as part of the end-of-life (EOL) care process? - "1" = Not confident at all; "5" is Very confident	3.6667	39	1.28418	.20563

Note: This table demonstrates an overview of the average knowledge and confidence scores for the sample, along with the positioning of the data in relation to the mean.

Appendix A

Matrix

		EVIDENCE MATRIX (Modify spreadsheet as needed)							
Article	**1. Keywords** **2. Database Searched** **3. Number articles found(total)**	**Author, Year, Title** **Source**	**1. Purpose** **2. Research question (if used)** **3. Independent and Dependent variable**	**1. Name of Theoretical/ Conceptual Framework** **2. List major assumptions**	**1. Method/** **(QL or QN)** **2. Design** **3. Sample**	**1. Name of the Survey/** **Questionnaire** **2. Number of questions** **3. Level of Measurement/ scale**	**1. Type of Statistics (descriptive+ inferential** **2. Validity/ reliability** **(if none- NA)** **3. Level of Evidence**	**1.Results** **(add numbers i.e. p-value, mean, t-test)** **2. Conclusions** **(bullet the key findings)**	**1. Limitations** **2. Recommendations for further study** **3. Value of the Information**
1.	1. Hospice, Spirituality, African American, Quantitative design 2.). MedLine	1. Soroka J., Collins, L., Creech, G., Kutcher, G., Menne, K., Petzel, B., (2019). Spiritual care at the end of life: Does educational intervention focused on a broad definition of spirituality increase utilization of chaplain spiritual support in hospice? *Journal of Palliative Medicine 22*(8), 939-944. https://doi.org/10	1. 1.) To better understand what factors, influence spiritual support acceptance in hospice care. 2.) N/A 3.) Independent variable – Spirituality. Dependent Variable- chaplain services.	1. a). Religion is used in the African American communities to make decisions regarding hospice/ palliative care. 2.). Religion and spirituality are important when people are dealing with serious and life-threatening illnesses, according to research. Both were used in the study.	1.) Method: Quantitative. 2.) Quasi-experimental quantitative study. 3.) 200 hospice patients.	1. 1.). N/A 2.) Participants were divided equally into intervention and control arm. 3.). Participants were divided into two equal groups. Information on chaplain support and a referral offer were provided to control participants only. Participants in the intervention received information about hospice chaplain services and the evidence-based benefits of spiritual	escriptive: The participants received information about hospice and chaplain service. Inferential: To answer the research question all patients' data were divided into two subsets. The purpose of the division was to ascertain whether the pattern of data distribution in one subset of patients was similar to that in the second subset, implying that the initial finding was likely to be reliable in the absence of significant changes in healthcare delivery or	1. Results: The Univariate Logistic Regression Models Predicting Chaplain Acceptance. The median (IQR) age was 84 (75–90) years, and 58% were female patients. The most common primary diagnoses were cancer (28.5%), dementia (20.5%), and "other" (e.g., amyotrophic lateral sclerosis, Parkinson's disease, sepsis, and malnutrition) (30%). The majority of patients resided in hospice facilities (68.5%) and had an existing connection to a faith community	1. This study involved a group of participants from a rather small geographic area where diversity was not represented. All participants were white and lived in rural or small urban areas, and the majority of them were of the Judeo-Christian faith. This predominance might preclude the generalization of findings beyond this sample. 2. No recommendation were noted. If I were

		.1089/jpm.2018.0579				support. The measure of chaplain acceptance included treatment group, patient age, disease, church affiliation, support, sex, bereavement risk, and residence.	PC during the assessment period 2. N/A 3.Level II	(71.5%). Among participants, 59 (59%) and 1 (1%) had a medium and a high bereavement risk, respectively. Patient characteristics were similar between the intervention and control arms, except for place of residence. Intervention participants were more likely to be living in the home (41% vs. 22%). This study finds that. *spiritual care in hospice can help a person or their family gain the benefits of spiritual support, which in turn results in greater acceptance.	to make a recommendation, I would separate the sample based on race. 3. The value of the information was necessary to understand how spirituality plays a role in one's health care.
2.	1. Faith, African American Community and hospice. 2. Hospice and Palliative Nursing Association website 0	Pang, G., Qu, L., Wong, Y., Tan, Y., Poulouse, J., Soek, S., & Neo, H. (2015). A quantitative framework classifying the palliative care workforce into specialist and generalist components. *Journal of*	An investigation into clinical data obtained from a palliative care (PC) benchmarking project was undertaken in order to develop a quantitative framework guiding the classification of PC services into specialist and generalist components. /A V chronic illness. DV is palliative care referrals.	1. There wasn't any theoretical framework used. 2. The assumption is early PC referral has been shown to improve quality of life in advanced cancer. However, training issues create problems with the PC's availability for earlier PC referrals. At the moment, no quantitative	1. Quantative 2. Over a two-year period, a descriptive retrospective study of data from 2726 hospitalized inpatients under the care of a tertiary consultative PC service was conducted. The daily categorical symptom, overall psychological, and social distress scores at the start and end of 3392 palliative care episodes, as well as the number of visits made to patients by the	Questions were not asked. Data from 2726 hospitalized inpatients receiving care from the tertiary PC consult service at the National Cancer Centre Singapore (NCCS) encompassing 3392 PC episodes with a total of 15,500 visits made by the PC team to all inpatients between August 2011 and July 2013. 3. For analysis,	1. Descriptive: A descriptive retrospective study of data from 2726 hospitalized inpatients under the care of a tertiary consultative PC service over a 2-year period was conducted. 2. N/A 3. Level I: showed two subsets of 1340 patients (1682 PC episodes with a total of 6967 visits by the PC team) and 386 patients	1. Results: study results provide useful initial insights as to how clinical data may be used to guide PC staff planning or allocation for a consultative PC service. 2. Large-scale clinical data supports the use of a Pareto-based quantitative framework for a workforce that consists primarily of generalist PC staff, with a small	1. Limitations: limitations in trained PC workforce raise issues with the sustainability of delivering PC with early PC referral. 2. Future research could include examining similar data from other PC services to determine if similar patterns can be found in other types of PC services as well as in other settings.

		Palliative Medicine, 18, 1063-1069. https://doi.org/10.1089/jpm.2015.0017		guide for classifying PCs in generalist and specialist components exists.	PC team, were extracted for analysis. 3. 2726 hospitalized inpatients under the care of a tertiary consultative PC service were studied.	reported numerical rating scores for symptoms were converted to their categorical equivalents, with 0 denoting no symptoms, 1–3 denoting mild symptoms, 4–6 denoting moderate symptoms, and 7–10 denoting severe symptoms. These numerical cut-offs for mild, moderate, and severe pain17 and non-pain symptoms have been previously reported.	(1710 PC episodes with a total of 8533 visits by the PC team) were referred to as subset one and subset two, respectively, and included 1340 patients (1682 PC episodes with a total of 6967 visits by the PC team). Patients and PC episodes in the two subsets were statistically similar in terms of demographics as well as the PC services they received.	number of PC specialists on hand to assist them.. Key Findings: * Our preliminary study provides a quantitative basis for forecasting the PC workforce, which is primarily composed of generalist PC staff and a small number of PC specialists. *The fewer PC specialists required may also represent future manpower savings for PC services, thereby increasing their cost effectiveness, but this should be investigated further in future studies.	3. Based on this study, PC is important early palliative care (PC) referral improves quality of life in advanced cancer. The PC workforce's limitations could be an issue with PC-on-first being sustainable. A quantitative guide for classifying PC into generalist and specialist components is currently lacking in the literature. Despite the fact that this study did not address race, it would have been an excellent indicator of the population that is lacking consultation. It does demonstrate the importance of receiving PC treatment early in a person's disease process.
3.	1. Faith, African American Community, women, church and hospice 2. Radford University - Supersearch	Selman, L., Speck, P., Gysels, , M., Godfrey, A., , Natalya D., Downing. J., Gwyther, L., Mashao, T., Mmoledi, K., Moll, T., Mpanga, L., Sebuyira, M., Ikin, B., Higginson, I. &	1. To understand the spiritual aspect of Africans receiving palliative care for incurable, progressive disease experience high levels of spiritual distress,	1. Spiritual care, defined as care related to existential concerns (e.g., meaning and purpose), as well as religious guidance and ritual, is thus an essential component of the holistic, person-centered	1. Quantitative 2. To achieve the study objectives, a mixed-method study design was used: (cognitive interviews with patients exploring their interpretations of 'feeling at peace' and 'feeling life is worthwhile'; patient survey using the POS and the Spirit.	1. N/A 2. With each subject, researchers completed the Spirit 8 and the POS. The Missoula Vitas Quality of Life Index (MVQOLI), a tool developed in the United States and validated in Uganda, was used to create the Spirit	1. Descriptiv- study design included (1) cognitive interviews with 72 patients. 2. The data was analyzed to investigate the content validity of the items, and (2) quantitative data collection (n = 285 patients) using the POS and the Spirit 8 to	1. Peace was interpreted through the themes of 'self and world perception, relationship to others, spiritual beliefs,' and 'health and healthcare. Life was interpreted in terms of perception of self and world, relationship to others, and 'identity.' The quantitative data also revealed conceptual	1. The study's mixed-methods study design and large sample size are assets, but there are limitations related to translation and sampling. The researchers were unable to use best practice methods of tool adaptation due to resource constraints, including synthesis of multiple translations,

		Harding, R. (2013). 'Peace' and 'life worthwhile' as measures of spiritual well-being in African palliative care: a mixed-methods study. *Health and Quality of Life Outcomes*, *11*(94), 2-12. https://doi.org/ 10.1186/1477-7525-11-94	which has a negative impact on their quality of life. 2.N/A 3. Independent variable is the spirituality, and the variable is the n population.	palliative care approach 2. The assumption that neglecting spiritual needs is associated with lower quality of life and satisfaction with care, as well as increased mortality.	Cognitive interviewing is a well-established technique for determining content validity, including patients with advanced disease. 3. A qualified, locally based palliative care researcher approached eligible patients at each palliative care site. A purposive sample was recruited over a 10-week period for cognitive interviewing. When data from each site was analyzed separately, it was projected that recruiting 15–20 patients at each site would reach data saturation, resulting in a target sample of 60–80 patients overall. To obtain a maximum variance sample, the purposive sampling frame addressed diagnosis, place of care (community/inpatient/ outpatient), gender, geography, and ethnic group. Patients were recruited in a systematic order for quantitative data gathering.	8, an eight-item scale. All of the items are rated on a scale of 1 to 5, with 5 indicating a better outcome. Seven of the eight questions demanded that the participants choose between positive and negative statements. Summing the results for all elements yields a spiritual wellbeing score (potential score 8–40). The use of the Spirit 8 as a unidimensional measure of spiritual well-being (= 0.73) in this population is supported by factor and Rasch analyses. 3. All items are scored on a 1 - 5 scale, with 5 indicating a better outcome. Seven of the eight questions require you to choose between positive and negative statements.	assess construct validity. 3. Level I	convergence and divergence: there was a moderate correlation between peace and Spirit 8 spiritual well-being (r = 0.46), but little correlation between life worthwhile and Spirit 8 spiritual well-being (r = 0.18) (both p 0.001). The correlations with Spirit 8 items ranged from weak to moderate. 2. Spirituality was described as seen as important part of one's live *Peace was interpreted through the themes of 'self and world perception,' 'relationship to others,' 'spiritual beliefs,' and 'health and healthcare.' *Life was interpreted in terms of 'perception of self and world,' 'relationship to others,' and 'identity.'	back translation, expert review, and pretesting prior to psychometric testing. 2.I would suggest splitting the group into subsets (men and women) to see if there is a difference between the two. Women are more spiritual than men. 3. Spirit Eight items relating to the meaning and worth of life. Spirit 8 pertain to death preparation rather than meaning.
4.	1. Health care and African American and	Jones, R., Taylor, A., Bourguignon, C., Steeves, R.,	1 Cultural belief influences the stage of prostate	1The conceptual framework was to evaluate how	1. Quantitative and Qualitative.	1. N/A	1. Descriptive - Participants were 119 African American and	1. After controlling for sociodemographic characteristics, African	1. Results of the present study have a number of important

	spirituality quantitative design 2. Radford University - Supersearch 3. 5	Theodorescu, D. &; Kilbridge, K. (2006). Cultural beliefs and attitudes of African american prostate cancer survivors. *Oncology Nursing Forum*, *33*(2), 414–415. https://doi.org/ 10.1177/1073274 80701400311	cancer at which African Americans are more likely to be diagnosed. These beliefs may aid in the selection of acceptable treatments. 2. N/A 3. Independent variable – cultural beliefs/Spirituality . Dependent Variable- African American men	these beliefs and attitudes may or may not have influenced their **health** decis ion-making process. 2. The assumption is African American men use cultural beliefs in making health care decisions. Cultural beliefs were evaluated in this study.	2. The purpose of this study is to investigate the psychosocial cultural beliefs and attitudes of African American prostate cancer survivors regarding their cancer diagnosis and treatment decision-making. It was also investigated how these beliefs and attitudes may or may not have influenced their health decision-making process. 3. This study used a mixed methods design, with the qualitative data being analyzed using a hermeneutic/phenome nological approach to explore the participants' "lived experiences." The "lived experiences" were associated with the participants' perspectives on prostate cancer. Individual interviews were conducted with 14 African American men (N=14) in rural Virginia who had been diagnosed with and treated for prostate cancer. Semi-structured interviews delved into health status, demographics, prostate knowledge, literacy skills, interactions between	2. 15 yes or no questions were asked to participants. 3. N/A	European American men who were newly diagnosed with early-stage and locally advanced prostate cancer 2. N/A 3. Level 5, Evidence from systematic reviews of descriptive and qualitative and qualitative studies	American men reported significantly greater levels of religiosity (Beta = 24.44, P<.001) compared with European American men. African American men (Beta = 6.30, P<.01) also reported significantly greater levels of future temporal orientation. In addition, men with more aggressive disease (eg, higher Gleason scores) (Beta = 5.11, P<.01) and those who were pending treatment (Beta = –6.42, P<.01) reported significantly greater levels of future temporal orientation. 2. •ethnicity is associated with some cultural values, clinical experiences with prostate cancer may also be important. •this research showed the importance of the effects of both ethnicity and clinical factors on cancer prevention and control	implications. First, the findings show that while ethnicity is important to some cultural values such as religiosity, clinical experiences with disease may also be important. 2. I would recommend expanding the age group for more detailed information 3. Many participants' perspectives on health, treatment decision-making, and the healthcare system were shaped by their cultural and spiritual beliefs. The findings of this study shed light on how African Americans chosed what to believe or whom to trust in order to improve their health in light of their religious and spiritual values..

					healthcare providers and family members, prostate myths, and religious beliefs. Data collection was halted at the point of saturation. The data was analyzed using both qualitative and quantitative descriptive methods. The primary treatment for half of the participants (N=7) was a prostatectomy. The study findings revealed three major themes: "spiritual needs are important to health," "trust in healthcare providers is required," and "how men decide what to believe." During cancer treatment, all 14 participants used prayer as a coping mechanism. Each participant stated that spirituality is an important part of their lives and that God works through healthcare providers to provide appropriate healthcare treatments.				

Appendix B

Participant Tracking Form

Name	Identifier	Church	Address	Church Identification	County or Orgin	Phone	Email	High-Speed Internet	Informed Consent Signed	Pre-Test Score	Post-Test Score	Likert Test Score

Appendix C

Email Sent to Potential Participants

From: Hill, Sonja
To: Hoffert, Darleen
Subject: Initial Email
Date: Friday, April 7, 2023 4:39:00 PM

Dear Dr., Hoffert,

My name is Sonja Hill. I am a student in the Doctor of Nursing Practice (DNP) – Nurse Leadership Program at Radford University. I am writing to invite you to participate in my research study titled, Improving Knowledge of Christian Clergy in Rural Communities Through an Evidence-Based Educational Approach to Increase Support of Black Parishioners Seeking Guidance for End-of-Life Decisions. The Radford University Internal Review Board has approved this research study.

The purpose of the study is to increase the knowledge and confidence of clergy through education on end-of-life care services and related planning. While performing my research, I identified you as a clergy member meeting the criteria for participation in the study. The educational program consists of a short, 10-question, pre- and post-survey with a webinar requiring no more than 50 minutes of your time. Upon completion of all program elements, a certificate and a free tool will be provided at the end of the educational session.

Your participation is voluntary. If you would like to participate in this free educational opportunity, please contact me at swhill@radford.edu. Once I received your request to participate, I will respond to your email with a link to the educational program. The link can be accessed from 12:01 am on April 24, 2023 through 11:59 pm on to May 8, 2023.

Please feel free to reach out to me if you have any questions. Thank you for your time and consideration for participation in my research study.

Sincerely,

Appendix D

Telephone Script

School of Nursing

Phone Transcript

Student Researcher: Good day, may I speak with clergy (name)?

If the person is not available: Ask the person what is the best time/day to reach clergy (name)? If the person is available: Confirm you are speaking to the correct person.

Student Researcher: Hello (Clergy Name), my name is Sonja Hill, and I am a student in the Doctor of Nursing Practice (DNP) – Nurse Leadership Program at Radford University. I am conducting a research study titled *Improving Knowledge of Christian Clergy in Rural Communities Through an Evidence-Base Educational Approach to Increase Support of Black Parishioners Seeking Guidance for End-of-Life Decisions*.

Is this a good time to speak? If yes, proceed explaining the reason you are calling.

If the person states it is not a good time? Ask to schedule another time to talk.

Student Researcher: I'm following up to see if you received an email I sent you on April 21st requesting your participation in my research study.

If the clergy says "Yes" I received the email. Ask the clergy (name), if they have any questions regarding the email and state the purpose of why they received the email.

Student Researcher: Clergy (name), do you have any questions regarding the email? The purpose of this study is to increase the knowledge and confidence of clergy through education on end-of-life care services and related planning. I am contacting you because you meet the criteria to participate in this study. The criteria included being a Christian clergy presiding over a church in the rural area of Southeastern, Virginia who identifies as having a Black congregation.

The educational program will consist of a short, 10-question, pre- and post-survey with a webinar requiring no more than 50 minutes of your time. Your participation is voluntary. If you would like to participate in this free educational opportunity, the link included in the email will be open until 11:59pm on May 8, 2023.

If the clergy says "No" I did not receive the email – Confirm email address.

Student Researcher: My apologies, can you please confirm the email address? Thank you, clergy (name), you stated your email address is? Before I resend the link, I would like to discuss the purpose of this study. This study was developed to increase the knowledge and confidence of clergy through education on end-of-life care services and related planning. Clergy (name) you were selected because you meet the criteria to participate in this study. The criteria included

being a Christian clergy presiding over a church in the rural area of Southeastern, Virginia who identifies as having a Black congregation.

The educational program will consist of a short, 10-question, pre- and post-survey with a webinar requiring no more than 50 minutes of your time. Your participation is voluntary. If you would like to participate in this free educational opportunity, the link included in the email will be open until 11:59pm on May 8, 2023.

Student Researcher: Do you have any questions for me at this time?

Answer any questions the clergy may have.

Student Researcher: If you have further questions after this call, please feel free to contact me at swhill@radford.edu. Thank you for your time and consideration to participate in my research study.

Appendix E

Approval Letter from IRB

RADFORD UNIVERSITY

Research Compliance Office

Institutional Animal Care and Use Committee / Institutional Review Board

April 20, 2023

TO:	Darleen Hoffert, DNP
RE:	Initial Expedited Approval
STUDY TITLE:	Improving Knowledge of Christian Clergy in Rural Communities Through an Evidence-Based Educational Approach to Increase Support of Black Parishioners Seeking Guidance for End-of-Life Decisions
IRB REFERENCE #:	2023-057
SUBMISSION TYPE:	IRB Initial Submission
ACTION:	Approved
APPROVAL PERIOD:	April 20, 2023 – April 19, 2026

The above-referenced study has been approved by Radford University's Institutional Review Board (IRB). Your study has been approved under **Expedited Category 7: Research is on individual or group characteristics of behavior (including, but not limited to research on perception, cognition, motivation, identity, communication, cultural beliefs or practices, and social behavior) or the research employs survey, interviews, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies).**

A copy of your approved IRB protocol and approved corresponding documents is available for your records in IRBManager under your dashboard of active protocols.

Note: The number approved is the number of study participants is defined as the number who enroll in the project and NOT the number of subjects with usable data for analysis. If this should change, you must submit an amendment to increase subject numbers.

Your IRB approval period ends on April 19, 2026. If the study remains ongoing after the project end date, you must submit a three-year check-in application no later than ten (10) days prior to the expiration of this approval. If the project is no longer being pursued, a closure report must be submitted.

Should you need to make changes in your protocol, you must submit a request for amendment for review and approval before implementing the changes. Amendments must be submitted via the IRBManager system.

As the principal investigator for this project, you are ultimately responsible for ensuring that your study is conducted in an ethical manner. You are also responsible for filing all reports related to this project.

If you have any questions, please contact the Research Compliance Office at 540.831.5290 or irb-iacuc@radford.edu. Please include your study title and reference number in all correspondence with this office.

Radford University IRB
Approval Date: April 20, 2023

RADFORD UNIVERSITY

Research Compliance Office

Institutional Animal Care and Use Committee / Institutional Review Board

Good luck with this project!

Radford University Institutional Review Board (IRB)
Research Compliance Office
540.831.5290
Irb-iacuc@radford.edu
https://www.radford.edu/content/research-compliance/home.html

Radford University IRB
Approval Date: April 20, 2023

Appendix F

Pre-/Post-Survey

School of Nursing

Pre-/Post Survey Questions

Objective 1

Identify two (2) key elements of defining end-of-life care.

Question #1 - What key elements are addressed by the EOL care process and services?

a) Physical comfort
b) Mental and emotional support
c) Spiritual support
d) All of the above

Question #2 - What is the life expectancy of someone requiring EOL care?

a) Months
b) Years
c) Hour or days
d) A, B and C
e) A and B

Objective 2

Identify at least two (2) available service options provided at the EOL. (1) Hospice and (2) Palliative Care.

Question #3 - EOL care provides holistic care to patients. Select the services considered vital for EOL care? (select all that apply).

a) Medication management
b) Curative Treatment
c) Spirituality
d) Comfort

Question #4 - EOL services can be done in what environment? (select all that apply)

a) Inpatient setting
b) Outpatient setting
c) Primary care Office
d) A place chosen by the patient
e) None of the above

Objective 3

Identify at least two (2) ways to access EOL services. 1.) Contact your Primary Care Physician 2.) Contact a healthcare agency.

Question #5 - How can a person access EOL services?

a) Scheduling an appointment with their primary care provider
b) Request a referral
c) Request a meeting with a home health agency
d) All of the above

Question #6 - If a person is seeking EOL care services what should they do first?

a) Contact a hospice/palliative care agencies and request a meeting.
b) Make an appointment with your Primary Care Physician
c) Delayed treatment to complete an advanced directive or living will
d) Go to the hospital to be admitted.

Radford University
Research Compliance Office

version January 2022

Objective 4

A spiritual directive is a written document that outlines a person's wishes for EOL spiritual care in the event that they become unable to express those wishes vocally. Clergy can better direct parishioners in the application of the spiritual directive once they have a foundational understanding of EOL care.

Question #7 - What is a spiritual directive?
a) A document that states the patient's spiritual wishes when approaching EOL
b) A document that states the family's spiritual request for a loved one during EOL care
c) A document that a clergy completes following a patient's death
d) None of the above.

Question #8 - When should the spiritual directive be implemented?
a) Anytime
b) When the patient is unable to voice their wishes
c) After a patient transitions at the time death
d) Upon admission to hospice care

Objective 5

Increase confidence levels of clergy related to EOL care services and development of spiritual directives.

Question #9 - How confident are you in guiding parishioners regarding EOL care options as part of the EOL care process?
Level 1 through 5; 1 = low confidence and 5 = high confidence

Question #10 - How confident are you in guiding parishioners in the development of a spiritual directive as part of the EOL care process? Level 1 through 5; 1 = low confidence and 5 = high confidence

Appendix G

Project Scoring Worksheet

Pre-Survey Data

IDENTIFIERS/GENERAL INFORMATION			PRE-SURVEY RESPONSES											
StartDate	EndDate	Personal Identifier	Question 1	Question 2	Question 3	Question 3-1 (2)	Question 3-2 (4)	Question 3-3 (5)	Question 3-4 (6)	Question 4	Question 4-1 (1)	Question 4-2 (4)	Question 4-3 (5)	Question 4-4 (6)
4/24/23 9:17	4/24/23 9:55	1600	16	6	2,5,6	1	0	1	1	1,4,6	1	1	0	1
4/24/23 10:26	4/24/23 10:41	0800	16	6	2,4,5,6	1	1	1	1	1,4,6	1	1	0	1
4/24/23 14:49	4/24/23 15:24	1800	16	6	5	0	0	1	0	1	1	0	0	0
4/25/23 12:59	4/25/23 13:32	0500	16	6	6	0	0	0	1	1,4,5,6	1	1	1	1
4/26/23 12:09	4/26/23 12:40	2000	16	5	2,5,6	1	0	1	1	4	0	1	0	0
4/27/23 22:00	4/27/23 22:45	0400	16	6	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1
4/28/23 6:12	4/28/23 6:53	1300	16	6	2,4,5,6	1	1	1	1	1,4,5,6	1	1	1	1
4/28/23 6:46	4/28/23 7:20	0300	16	6	5,6	0	0	1	1	1,4,6	1	1	0	1
4/28/23 8:46	4/28/23 9:23	0100	16	6	2,4,5,6	1	1	1	1	1,4,6	1	1	0	1
4/28/23 8:53	4/28/23 9:28	0200	16	1	5,6	0	0	1	1	1,4,6	1	1	0	1
4/28/23 8:49	4/28/23 9:51	1000	16	1	2,5,6	1	0	1	1	1,4,6	1	1	0	1
4/30/23 11:19	4/30/23 12:11	0000	16	6	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1
4/30/23 19:36	4/30/23 20:06	1900	16	6	2,5,6	1	0	1	1	1,4,6	1	1	0	1
4/30/23 20:06	4/30/23 20:45	2300	16	6	2,5,6	1	0	1	1	1,4,6	1	1	0	1
5/1/23 7:28	5/1/23 8:03	0600	16	6	2,5,6	1	0	1	1	1,4,6	1	1	0	1
5/1/23 19:16	5/1/23 19:48	3100	16	5	5,6	0	0	1	1	1,4	1	1	0	0
5/1/23 19:45	5/1/23 20:23	1700	16	1	2,4,5,6	1	1	1	1	1,4,6	1	1	0	1
4/26/23 7:39	4/26/23 7:49	1100	16	5	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1
5/2/23 7:59	5/2/23 8:34	3500	16	5	2,5,6	1	0	1	1	1,4,6	1	1	0	1
5/2/23 12:55	5/2/23 13:30	2100	16	6	5,6	0	0	1	1	1,4,5,6	1	1	1	1
5/2/23 16:33	5/2/23 16:37	1901	16	6	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1
5/2/23 17:27	5/2/23 18:00	0900	16	6	2,5,6	1	0	1	1	1,6	1	0	0	1
5/2/23 8:31	5/3/23 7:32	3000	16	1	5,6	0	0	1	1	6	0	0	0	1
5/3/23 13:31	5/3/23 14:23	3700	16	6	2,4,5,6	1	1	1	1	1,4,5,6	1	1	1	1
5/3/23 20:21	5/3/23 21:03	2200	16	6	2,4,5,6	1	1	1	1	1,4,5	1	1	1	0
5/3/23 21:11	5/3/23 22:20	3300	16	6	2,5,6	1	0	1	1	1,4,6	1	1	0	1
5/4/23 2:10	5/4/23 2:25	1200	16	6	2,5,6	1	0	1	1	1,4,6	1		0	1
5/4/23 6:30	5/4/23 7:06	0700	16	6	5,6	0	0	1	1	6	0	0	0	6
5/1/24 19:16	5/1/23 19:48	3100	16	5	5,6	0	0	1	1	1,4	1	1		1
5/3/23 21:11	5/3/23 22:20	3300	16	6	2,5,6	1	0	1	1	1,4,6	1	1	0	1
5/2/23 7:59	5/2/23 8:34	3500	16	5	2,5,6	1	0	1	1	1,4,6	1	1	0	1
5/8/23 18:43	5/8/23 19:17	3600	16	1	2,5,6	1	0	1	1	1,4,6	1	1	0	1
5/3/23 13:31	5/3/23 14:23	3700	16	6	2,4,5,6	1	1	1	1	1,4,5,6	1	1	1	1
5/8/23 11:35	5/8/23 12:10	3900	16	6	2,4,5,6	1	1	1		1,4,5,6	1	1	1	1
5/4/23 19:58	5/4/23 20:36	4200	16	6	4,5,6		1	1	1	1,4,6	1	1	0	1
5/8/23 8:19	5/8/23 8:58	4300	16	5	2,5,6	1	0	1	1	1,4,6	1	1	0	1
5/5/23 5:59	5/5/23 17:27	4400	16	1	2,5,6	1	0	1	1	4,6	0	1	0	1
5/6/23 5:49	5/6/23 6:08	4500	16	5	2,5,6	1	0	1	1	1,4,6	1	1	0	1
5/8/23 16:19	5/8/23 16:28	4600	15	5	6	0	0	0	1	6	0	0	0	1
5/8/23 7:17	5/8/23 7:51	4700	16	6	2,4,5,6	1	1	1	1	1,4,5,6	1	1	1	1
	Outliers:													
5/1/23 8:03	5/1/23 8:06	1500	16	6	2,4,5,6	1	1	1	1	1,4,5,6	1	1	1	1
5/2/23 15:48	5/2/23 15:53	1500	16	6	2,4,5,6	1	1	1	1	1,4,5,6	1	1	1	1

PRE-SURVEY RESULTS: [illegible]

Post Survey Data

POST-SURVEY RESPONSES																				
Personal Identifier	Question 1	Question 2	Question 3	Question 3-1 (2)	Question 3-2 (4)	Question 3-3 (5)	Question 3-4 (6)	Question 4	Question 4-1 (1)	Question 4-2 (4)	Question 4-3 (5)	Question 4-4 (6)	Question 4-5 (7)	Question 5	Question 6	Question 7	Question 8	Question 9_1	Question 10_1
1600	16	6	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1	0	7	4	2	1	5	5
0800	16	6	2,4,5,6	1	1	1	1	1,4,5,6	1	1	1	1	0	7	1	2	1	5	5
1800	16	6	5	0	0	1	0	6	0	0	0	1	0	7	1	4	1	4	5
0500	16	6	2,4,5,6	1	1	1	1	1,4,5,6	1	1	1	1	0	7	4	2	1	5	5
2000	16	5	2,5,6	1	0	1	1	1,4,6	1	1	0	1	0	7	4	2	4	5	5
0400	16	6	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1	0	7	4	2	1	3	3
1300	16	6	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1	0	2	4	2	4	4	4
0300	16	6	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1	0	7	4	2	1	4	5
0100	16	6	2,4,5,6	1	1	1	1	1,4,5,6	1	1	1	1	0	7	4	2	4	5	4
0200	16	6	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1	0	7	4	2	4	4	4
1000	16	6	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1	0	7	4	2	5	4	4
0000	16	6	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1	0	7	1	2	1	2	2
1900	16	6	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1	0	2	4	2	4	3	3
2300	16	6	2,5,6	1	0	1	1	1,4,6	1	1	0	1	0	7	4	2	1	5	5
0600	16	6	2,5,6	1	0	1	1	1,4,6	1	1	0	1	0	7	4	2	1	5	5
3100	16	6	2,4,5,6	1	1	1	1	1,4,5,6	1	1	1	1	0	7	4	2	4	5	5
1700	16	6	4,5,6	0	1	1	1	1,4,5,6	1	1	1	1	0	7	4	2	1	5	5
1100	16	5	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1	0	2	4	2	1	3	3
3500	16	6	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1	0	2	4	2	4	5	5
2100	16	6	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1	0	2	4	2	4	3	4
1901	16	5	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1	0	2	4	2	4	4	3
0900	16	6	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1	0	7	4	2	6	4	4
3000	16	6	5,6	0	0	1	1	5	0	0	1	0	0	2	4	2	5	5	5
3700	16	6	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1	0	7	4	2	4	4	4
2200	16	1	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1	0	2	4	2	4	4	5
3300	16	6	2,4,5,6	1	1	1	1	1,4,5,6	1	1	1	1	0	7	4	2	6	4	4
1200	16	6	2,5,6	1	0	1	1	1,4,6	1	1	0	1	0	7	4	2	1	5	5
0700	16	5	2,5,6	1	0	1	1	1,4,6	1	1	0	1	0	2	4	2	1	4	5
3100	16	6	2,4,5,6	1	1	1	1	1,4,5,6	1	1	1	1	0	7	4	2	1	5	5
3300	16	6	2,4,5,6	1	1	1	1	1,4,5,6	1	1	1	1	0	7	4	2	6	4	4
3500	16	6	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1	0	2	4	2	4	5	5
3600	16	1	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1	0	7	4	2	1	5	5
3700	16	6	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1	0	7	4	2	4	4	4
3900	16	6	2,4,5,6	1	1	1	1	1,4,6	1	1	0	1	0	7	4	2	4	5	5
4200	16	5	2,5,6	1	0	1	1	1,4,5,6	1	1	1	1	0	7	4	2	1	4	4
4300	16	5	2,5,6	1	0	1	1	1,4,6	1	1	0	1	0	7	4	2	4	5	5
4400	16	6	5,6	0	0	1	1	0	0	0	0	1	0	2	4	2	1	3	4
4500	16	5	2,5,6	1	0	1	1	1,4,6	1	1	0	1	0	7	4	2	1	4	4
4600	16	5	6	0	0	0	1	0	0	0	0	1	0	5	1	2	6	1	1
4700	16	6	2,4,5,6	1	1	1	1	1,4,5,6	1	1	1	1	0	7	4	2	1	4	4
																		167	171
1500																			
1500	16	6	2,4,5,6	1	1	1	1	1,4,5,6	1	1	1	1	0	7	4	2	4	0	0

POST-SURVEY RESULTS	Question 1 (16)				Question 2 (6)				Question 3 (5,6)							Question 4 (1,4,5,6)						Question 5 (7)				Question 6 (4)				Question 7 (2)				Question 8 (4)					
Personal Identifier	Q1 Pre	Q1 Pre ABS	Q1 Pre Neg	Q1 Final Score	Q2 Pre	Q2 Pre ABS	Q2 Pre Neg	Q2 Final Score	ABS	Neg	Q3 Pre 2	Q3 Pre 4	Q3 Pre 5	Q3 Pre 6	Q3 Final Score	Q4 Pre 1	Q4 Pre 4	Q4 Pre 5	Q4 Pre 6	Q4 Pre 7	Q4 Final Score	Q5 Pre 6	Q5 Pre 6 ABS	Q5 Pre 6 Neg	Q5 Final Score	Q6 Pre 6	Q6 Pre 6 ABS	Q6 Pre 6 Neg	Q6 Final Score	Q7 Pre 6	Q7 Pre 6 ABS	Q7 Pre 6 Neg	Q7 Final Score	Q8 Pre 6	Q8 Pre 6 ABS	Q8 Pre 6 Neg	Q8 Final Score	Individual Final Score	Total Points Possible
1600	4	4	-4	4	4	4	-4	4	1	-1	-1	1	1	1	2	1	1	1	1	1	5	4	4	-4	4	4	4	-4	4	4	4	-4	4	0	4	-4	-4	23	33
0800	4	4	-4	4	4	4	-4	4	1	-1	-1	-1	1	1	0	1	1	1	1	1	5	4	4	-4	4	0	4	-4	-4	4	4	-4	4	0	4	-4	-4	13	33
1800	4	4	-4	4	4	4	-4	4	1	-1	1	1	1	-1	2	-1	-1	-1	1	1	-1	4	4	-4	4	0	4	-4	-4	0	4	-4	-4	0	4	-4	-4	1	33
0500	4	4	-4	4	4	4	-4	4	1	-1	-1	-1	1	1	0	1	1	1	1	1	5	4	4	-4	4	4	4	-4	4	4	4	-4	4	0	4	-4	-4	21	33
2000	4	4	-4	4	0	4	-4	-4	1	-1	-1	1	1	1	2	1	1	-1	1	1	3	4	4	-4	4	4	4	-4	4	4	4	-4	4	4	4	-4	4	21	33
0400	4	4	-4	4	4	4	-4	4	1	-1	-1	1	1	1	2	1	1	1	1	1	5	4	4	-4	4	4	4	-4	4	4	4	-4	4	0	4	-4	-4	23	33
1300	4	4	-4	4	4	4	-4	4	1	-1	-1	1	1	1	2	1	1	1	1	1	5	0	4	-4	-4	4	4	-4	4	4	4	-4	4	4	4	-4	4	23	33
0300	4	4	-4	4	4	4	-4	4	1	-1	-1	1	1	1	2	1	1	1	1	1	5	4	4	-4	4	4	4	-4	4	4	4	-4	4	0	4	-4	-4	23	33
0100	4	4	-4	4	4	4	-4	4	1	-1	-1	-1	1	1	0	1	1	1	1	1	5	4	4	-4	4	4	4	-4	4	4	4	-4	4	4	4	-4	4	29	33
0200	4	4	-4	4	4	4	-4	4	1	-1	-1	1	1	1	2	1	1	1	1	1	5	4	4	-4	4	4	4	-4	4	4	4	-4	4	4	4	-4	4	31	33
1000	4	4	-4	4	4	4	-4	4	1	-1	-1	1	1	1	2	1	1	1	1	1	5	4	4	-4	4	4	4	-4	4	4	4	-4	4	0	4	-4	-4	23	33
0000	4	4	-4	4	4	4	-4	4	1	-1	-1	1	1	1	2	1	1	1	1	1	5	4	4	-4	4	0	4	-4	-4	4	4	-4	4	0	4	-4	-4	15	33
1900	4	4	-4	4	4	4	-4	4	1	-1	-1	1	1	1	2	1	1	1	1	1	5	0	4	-4	-4	4	4	-4	4	4	4	-4	4	4	4	-4	4	23	33
2300	4	4	-4	4	4	4	-4	4	1	-1	-1	1	1	1	2	1	1	-1	1	1	3	4	4	-4	4	4	4	-4	4	4	4	-4	4	0	4	-4	-4	21	33
0600	4	4	-4	4	4	4	-4	4	1	-1	-1	1	1	1	2	1	1	-1	1	1	3	0	4	-4	-4	4	4	-4	4	4	4	-4	4	0	4	-4	-4	13	33
3100	4	4	-4	4	4	4	-4	4	1	-1	-1	-1	1	1	0	1	1	1	1	1	5	4	4	-4	4	4	4	-4	4	4	4	-4	4	4	4	-4	4	29	33
1700	4	4	-4	4	4	4	-4	4	1	-1	1	-1	1	1	2	1	1	1	1	1	5	4	4	-4	4	4	4	-4	4	4	4	-4	4	0	4	-4	-4	23	33
1100	4	4	-4	4	0	4	-4	-4	1	-1	-1	1	1	1	2	1	1	1	1	1	5	0	4	-4	-4	4	4	-4	4	4	4	-4	4	0	4	-4	-4	7	33
3500	4	4	-4	4	4	4	-4	4	1	-1	-1	1	1	1	2	1	1	1	1	1	5	0	4	-4	-4	4	4	-4	4	4	4	-4	4	4	4	-4	4	23	33
2100	4	4	-4	4	4	4	-4	4	1	-1	-1	1	1	1	2	1	1	1	1	1	5	0	4	-4	-4	4	4	-4	4	4	4	-4	4	4	4	-4	4	23	33
1901	4	4	-4	4	0	4	-4	-4	1	-1	-1	1	1	1	2	1	1	1	1	1	5	0	4	-4	-4	4	4	-4	4	4	4	-4	4	4	4	-4	4	15	33
0900	4	4	-4	4	4	4	-4	4	1	-1	-1	1	1	1	2	1	1	1	1	1	5	4	4	-4	4	4	4	-4	4	4	4	-4	4	0	4	-4	-4	23	33
3000	4	4	-4	4	4	4	-4	4	1	-1	1	1	1	1	4	-1	-1	1	-1	1	-1	0	4	-4	-4	4	4	-4	4	4	4	-4	4	0	4	-4	-4	11	33
3700	4	4	-4	4	4	4	-4	4	1	-1	-1	1	1	1	2	1	1	1	1	1	5	4	4	-4	4	4	4	-4	4	4	4	-4	4	4	4	-4	4	31	33
2200	4	4	-4	4	0	4	-4	-4	1	-1	-1	1	1	1	2	1	1	1	1	1	5	0	4	-4	-4	4	4	-4	4	4	4	-4	4	4	4	-4	4	15	33
3300	4	4	-4	4	4	4	-4	4	1	-1	-1	-1	1	1	0	1	1	1	1	1	5	4	4	-4	4	4	4	-4	4	4	4	-4	4	0	4	-4	-4	21	33
1200	4	4	-4	4	4	4	-4	4	1	-1	-1	1	1	1	2	1	1	-1	1	1	3	4	4	-4	4	4	4	-4	4	4	4	-4	4	0	4	-4	-4	21	33
0700	4	4	-4	4	0	4	-4	-4	1	-1	-1	1	1	1	2	1	1	-1	1	1	3	0	4	-4	-4	4	4	-4	4	4	4	-4	4	0	4	-4	-4	5	33
3100	4				4																	4				4				4				4					
3300	4				4																	4				4				4				0					
3500	4				4																	0				4				4				4					
3600	4				0																																		
3700	4				4																																		
3900	4				4																																		
4200	4				0																																		
4300	4				0																																		
4400	4				4																																Mean	19.64	7.46
4500	4				0																																		
4600	4				0																																		
4700	4				4																																		
1500	0	4	-4	-4	0	4	-4	-4	1	-1	1	1	-1	-1	0	-1	-1	-1	-1	1	-3	0	4	-4	-4	0	4	-4	-4	0	4	-4	-4	0	4	-4	-4	-27	33
1500	4	4	-4	4	4	4	-4	4	1	-1	-1	-1	1	1	0	1	1	1	1	1	5	4	4	-4	4	0	4	-4	-4	4	4	-4	4	4	4	-4	4	21	33

Appendix H

Spiritual Advance Directive

I, ____ (date of birth: _______________), make this spiritual advance directive in case I am not able to make spiritual decisions for myself. This spiritual advance directive says what I do want and what I do not want related to my spiritual care. I want my agent and health care providers to communicate with me and consider my views even when I am unable to make my own related to my spiritual care.

A. Important Information Others Should Know About Me Related to My Spirituality

Religious Affiliation: ____

Spiritual Reference/Text: ____

Church Attended: ____

Church Leader Name and Contact Information:

Name: ___________________________________

Phone: ___________________________________

Email: ___________________________________

B. Spiritual Advocate information

I appoint ____ to make spiritual care decisions for me when I cannot make those decisions myself.

First Spiritual Advocate Contact Information

Phone No. (home): ______________________ (cell): _________________________

Phone No. (work): ______________________ Email: __________________________

Home Address: ____

If the first person I picked is not available, able, or willing to act as my spiritual advocate, my chosen back-up spiritual advocate is ______________________________.

Back-up Spiritual Advocate's contact information

Phone No. (home): ______________________ (cell): _________________________

Phone No. (work): ______________________ Email: ___________________________

Home Address: ____

- My spiritual advocate will have full power to make spiritual care decisions for me based on this advance directive.
- My spiritual advocate will have this power only during a time when I am not able to make informed decisions about my spiritual care.
- My spiritual advocate will not have power to make decisions regarding my health care unless I have specifically named the same individual as my Health Care Agent.
- I want my spiritual advocate to follow what I have written in this spiritual advance directive.
- My spiritual advocate may also be guided by information that I have given my spiritual advocate in other ways, such as in conversation.
- If my spiritual advocate cannot tell what choice I would have made regarding my spiritual care, then my spiritual advocate should choose what he or she believes to be in my best interests.

C. Personal Wishes

When the time comes that I am no longer able to speak for myself, the following are my wishes related to my spiritual journey:

1. Music
   a. Play Music: ☐ Yes ☐ No
   b. If yes, I would like the following music to be played:

2. Prayer
   a. Prayer: ☐ Yes ☐ No

3. Favorite passages from preferred spiritual reference:
   a. Read to me: ☐ Yes ☐ No
   b. If yes, I would like the following passages to be read to me:

4. Additional spiritual practices I would like performed:

5. Additional information I feel is important for clergy to know not already addressed in this spiritual directive:

D. Right to Revoke

I understand that I may cancel all or part of my spiritual advance directive at any time that I am able to understand the consequences of doing so.

E. Affirmation

I am signing below to show that I understand this document and that I made it voluntarily.

_____________ ____

Date Signature

The above person signed this advance directive in my presence.

_________________________________ _________________________________

Witness #1 Signature Witness #1 Printed Name

_________________________________ _________________________________

Witness #2 Signature Witness #2 Printed Name

Note: It is your responsibility to provide a copy of your spiritual advance directive to your health care providers. You also should provide copies to your Agent, close relatives and/or friends. In addition to sharing hard copies, you are encouraged to store all parts of your advance directive in Virginia's free Advance Directive Registry located at the Virginia Department of Health website: https://www.connectvirginia.org/adr/. If you have stored your advance directive documents in the Registry, initial here: ______

Appendix I

Memorandum

To: Sonja Hill
From: Darleen Hoffert, DNP, RN, AGNP-C, LNC
Date: March 1, 2023

This memorandum serves as confirmation of my permission for you to use the attached spiritual directive I created. You may use this as free supplemental materials for your Doctor of Nursing project titled, "Improving Christian Clergy Knowledge in Rural Communities Through Evidence-Based Education to Support Black Parishioners Making End-of-Life Decisions".

I hope your project goes well. Please reach out if you have any questions regarding the tool.

Sincerely,

Darleen Hoffert, DNP, RN, AGNP-C, LNC
Assistant Professor
Radford University School of Nursing
Waldron Hall, office #334
231-590-3123 (c)
dhoffert@radford.edu