Compensation of the Faith Community Nurse

Position Statement

Faith community nursing is a professional nursing specialty with its own scope of practice (American Nurses Association and Health Ministries Association, 2025). The Faith Community Nurse (FCN) receives specialty education and delivers nursing care interventions within or with a faith community to individuals, groups, and populations. There are measurable outcomes and demonstrated value for the healthcare consumer, program, faith community, healthcare organization, and nurse. The FCN documents interventions and outcomes and regularly reports to stakeholders. The FCN has the right to fair compensation and to negotiate the terms, wages, and work conditions of their employment with employers. The FCN explores external funding sources for compensation based on specific needs of populations. Additionally, FCNs should be aware of reimbursement pathways efforts for community-based nurses through professional nursing organizations. The FCN as a compensated or uncompensated professional is a value-added asset that provides measurable quality nursing care based on the experience and specialty characteristics of the nurse and allocation of types of interventions, hours, and population.

Introduction

In answering the question about compensation for the FCN, there is much to consider. Compensation for the FCN frequently looks different from traditional nursing roles. FCNs provide care while they work in or with a faith community. Essential attributes are faith integrating, health promoting, disease managing, coordinating, empowering, and accessing health care (Ziebarth, 2014). The FCN as a compensated or uncompensated professional is a valued team member in the health care continuum. However historically, the use of the terms **ministry/ministering, volunteer/volunteering, charitable care, serves/serving** in describing faith community nursing, may influence the way the FCN and others perceive the role. These terms highlight a culture and commitment to altruism that transcends a traditional professional nurse role.

Operationally, there are different models based on the needs of the healthcare organization, faith community, and the FCN. Most FCNs work in uncompensated positions within a faith community with limited financial cost to a faith community (Ziebarth, 2016a). The FCN nearing retirement age may be more prepared to work limited hours in an uncompensated position and view it as a positive determinant for program viability (Bokinskie & Kloster, 2008). However, as seen in several current surveys, a lack of financial support is a major barrier to FCN program success.

- Pre COVID-19 epidemic, FCN survey participants (N=153) indicated that 58.8% were not paid and 41.2% were paid. Compensated hours per week averaged 21.4, while uncompensated hours per week averaged 6.8 (Dyess & Callaghan, 2017).
- Post COVID-19 epidemic, FCN participants in two surveys (N=97 & N=111) indicated that less than a quarter (22%) are compensated. Uncompensated FCNs work less than 10 hours per week (75.31%). A lack of time and financial support were reported to be barriers (97%). FCNs deliver nursing care interventions to individuals across the lifespan but the senior population benefits the most (100%). FCNs take vitals (79%), teach/counsel individuals and groups about health (90%), perform physical examination and assessments such as BP (60%), provide medication management (48%), coordinate care and referrals (80%), and deliver “Transitional Care” (62%) (Westberg Institute, 2024).

Exploring compensation in faith community nursing provides additional clarity and may lead to increased financial support for FCNs. Compensation for FCNs overall may increase access to wholistic nursing care for individuals across the lifespan, primarily the senior population.

This position statement will:

1. Explore what the guiding documents in "nursing" and "faith community nursing" say about compensation.
2. Explore what literature has to say about FCN compensation.
3. Explore what FCNs say about the topic of FCN compensation.
4. Discuss FCN salary and reimbursement models.
5. Offer recommendations through an FCN Position Statement.

What guiding documents in "nursing" and "faith community nursing" say about compensation

- The Nurses Bill of Rights (https://www.nursingworld.org/practice-policy/work-environment/health-safety/bill-of-rights/) is a statement of professional rights setting forth seven premises concerning workplace expectations and environments. The Bill of Rights can help guide development of organizational policy or focus discussions between nurses and employers regarding employment.
  Regarding compensation:
  1) Competitive compensation consistent with nurses' clinical knowledge, experience, and professional responsibilities and that recognizes the value and rigor of nursing practice.
  2) Collective and individual rights for nurses to negotiate terms, wages, and work conditions of their employment in all practice settings.
- The Faith Community Nursing: Scope and Standards (American Nurses Association and Health Ministries Association., 2025) discusses compensation, reimbursement, and cost-effective care. The authors suggest that capturing cost saving/cost avoidance interventions and outcomes may demonstrate value. They further state that compensation for the faith community nurse (FCN) varies. Compensation for the FCN has reportedly come from:
  - Grants, a consortium, denomination, institution, or congregation
  - Federal grants, state Medicaid funds, and non-profits funding
  - Reimbursement for continuing education conference, travel costs, professional licensure, association fees, publication subscriptions, other resources, and professional liability coverage.

  Many FCNs are "unpaid professionals." Some state nursing regulatory bodies are creating special licensure categories for registered nurses in good standing who choose to leave paid employment but want to continue their nursing practice. The FCN is encouraged to educate themselves about the business of healthcare and funding streams.

What Faith Community Nursing Research/Literature has to say about FCN Compensation

There is an identified gap when exploring compensation in faith community nursing research/literature. Instead, we find related topics on 1) what makes for sustainable programs, 2) termination, 3) economic and altruistic value of faith community nursing interventions, and 4) key elements contributing to successful Faith Community Nursing initiatives, as well as common challenges faced. The following short summaries shed light on the impact of these topics on faith community nursing compensation.

1. **Sustainable and Successful Faith Community Nursing Programs**
   Descriptors such as "long term, sustainable, and successful" pertain to both paid and unpaid models (Solari-Twadell & Ziebarth, 2020). Regardless of model:
   (a) have a clear and concise communication plan;
   (b) encourage the inclusion of "health of [individuals]" be part of the mission and vision of the faith community;

(c) create a job description in collaboration with leadership and have annual evaluations;
(d) create an organizational structure;
(e) create policies and procedures;
(f) use evidenced–based resources and tools;
(g) document, collect data, and communicate regularly regarding the altruistic and economic value of the program;
(h) work hard to build a respectful and collegial relationship with leadership, stakeholders, and other health care providers;
(i) nurture your volunteers;
(j) and pray.

Recommendation: 1) Address compensation early and consistently in program development and communication plan; 2) The job description is created in collaboration with leadership with agreed upon hours and role expectations; 3) Discuss how annual evaluations consider merit increases; 4) Who the FCN reports to is part of the organizational structure; 5) Policies and procedures address annual evaluation, compensation/merit increases, mileage, family leave, supervision, and termination; 6) Data collection and regular reporting regarding the altruistic and economic value of the program are based on the needs of stakeholders; 7) Build relationships with leadership, stakeholders, and other health care providers.

2. **Faith Community Nursing Termination**

An FCN termination survey (Ziebarth, 2018; Ziebarth, & Knighten, 2021), revealed that out of 264 FCNs who responded to the survey, 23.69% (59) of them lost a position as a faith community nurse and 12.73% (28) lost a position as a faith community nurse coordinator. One may surmise that a faith community nurse in a non-paid position would be insulated from termination, but that was not the case. It can be reasoned that both paid and unpaid models can be sustainable and successful, or not. When paid FCNs are terminated, they return most often to unpaid positions as a FCN, FCN educator, FCN researcher, or member of a faith community health committee.

3. **Economic and Altruistic Value of Faith Community Nursing Programs**

The interrelated concepts of value and measurement of faith community nursing interventions, from both altruistic and economic perspectives, have been thoroughly explored (Ahn, et al, 2025; Brown, et al, 2009; Rydholm, 1997, 2006; Yeaworth & Sailors, 2014; Ziebarth, 2024; 2016; 2015).

- FCN documents cost savings/cost avoidance

  A cost savings/cost avoidance (CS/A) tool, developed by Henry Ford, classifies medical diagnoses most frequently documented by the FCNs into Diagnostic Related Group (DRG) product lines. This tool lists the cost to the patient based on cost per day and average length of stay per DRG. CS/A demonstrate the power that FCNs contribute to the health and well-being of individuals, families, communities, and institutions. CS/A documentation helps FCNs and the networks with which they partner to tell the stories of both quality-of-life improvements and dollars. Interventions by FCNs and their health ministries allowed families to avoid the costs of unnecessary emergency department and physician office visits. They also help decrease unwarranted hospitalizations, assisted living and nursing home placements by providing early interventions, ongoing chronic disease management assistance, and in-home support. In 2008, the Henry Ford network reported savings of $280,050 (Brown et al, 2009).

- FCN documents cost savings/cost avoidance
  In addition to what was being collected as part of the cost savings/cost avoidance (CS/A) tool developed by Henry Ford, Alegent Creighton Health Faith Community Health Network (ACHFCHN) captures other non-health and healthcare cost savings. It was estimated that faith community nursing services saved $1,910,630 in cost savings from 2005 to 2012. In addition to cost savings, ACHFCHN counts a conservative $25 per hour of community service delivered by FCNs. At 105,189 volunteer hours documented from 2006-2012, FCNs contributed $2,629,725 of in-kind service to the community. These CS/A figures can be reported to institutions, churches, and community benefit boards to assist in securing funding for programs and obtaining paid positions where needed (Yeaworth & Sailors, 2014).
- FCN program value: A five-finger model for hospitals
  Termination may occur in hospital-funded programs because they operate in a missional environment, are non-revenue producing, and are "most at-risk for elimination when margin is threatened" (Ziebarth, 2015b, p.89). Revenue-producing activities are the core business of hospitals. Margin means having excess money to do missional activities such as faith community nursing. The author suggests a five-finger response when asked, why should a hospital support a faith community nurse program? (a) The connection to the hospital's mission and vision statement, (b) continuity of care in the community, (c) new community partnerships and grant opportunities, (d) achieving organizational and national health goals, and (e) the federal mandate of community benefit. Each of these reasons is discussed in depth: *Why a Faith Community Nurse Program: A five-finger response* (Ziebarth, 2015).
- Value of FCN prevention interventions
  In one exploration of literature (Ziebarth, 2016), various methods were described to assess program effectiveness and to influence stakeholder's value perceptions of the FCN's interventions. Altruistic and economic measurements methods were identified and described, such as storytelling, documentation - activity reports, net benefits, cost benefit, fixed and variable cost percentage equations. A review of both altruistic and economic measurements methods of documentation can show the value of nursing interventions, such as prevention and screening activities.
- FCN transitional care interventions decrease readmissions and shorten length of stay saving hospital unnecessary cost
  In this quantitative study (Ahn et al., 2025), effectiveness of transitional care interventions provided by faith community nurses was measured. Specifically, hospital readmission and length of stay at 30, 90, and 180 days after discharge compared to a non-faith community nursing group. The method used was a two-group (faith community nurses vs. non-faith community nurses) with a pre-and multiple post-tests design. Matching two groups showed similar demographic characteristics in sex, payer, and race/ethnicity. After matching, FCN patients were less likely to readmit to hospital relative to non-FCN counterparts in 30, 90, and 180 days by 8.1%, 7.8%, and 8.3%, respectively. FCN patients also tended to have shorter length of stay (LOS) relative to non-FCN patients in 30, 90, and 180 days by 0.37, 0.55, and 0.85 days, respectively. Using FCNs to provide transitional care interventions can save hospitals unnecessary readmission and extended LOS associate cost.
- FCNs administering coordinated care for the neediest with external funding
  This case study describes the grant journey that the Faith Community Health Network (FCHN) took to support recruitment and training of FCNs, and engagement of IHN-CCO community members (Ziebarth, Fell-Carlson & Shanks, 2024). The FCHN applied for and received a *Supporting Health for All through*

Reinvestment (SHARE) grant (Oregon Health Authority, 2023). The goal was to equip and sustain a network of coordinated care for IHN-CCO members using trained FCNs in local faith communities, thus bringing FCNs back into the continuum of care. This required several strategic steps: 1) recruit and train additional FCNs, 2) equip FCNs with computers, software, and training to encourage documentation and data sharing, and 3) engage IHN-CCO members within their respective faith communities in health information exchanges, healthcare coordination, and advocacy for qualified services. These services included accessing Oregon Lifeline phone service, connection to resources using the UniteUs platform (ConnectOregon), assistance to help community members obtain stable housing, transitional care (especially upon discharge from hospital or emergency room), consistent and appropriate Medical Home connection, and health literacy support.

4. **Common Challenges Faced**

Surveying attendees of a (Parish Nurse) PN training program yielded a large study (3 surveys) conducted over 3 years. The questions examined factors which either supported or did not support a successful PN ministry. A lack of financial support ranked high as a barrier to establishing and sustaining a successful PN ministry (Bokinskie & Kloster, 2008).

Barriers experienced by Parish Nurses	N=431	N=435	N=463
Time/scheduling constraints	71.5%	84.8%	75.2%
Lack of financial support	48.6%	63.2%	65.8%

- To explore FCN documentation practices and documentation barriers, a survey (N=153) of FCNs (Dyess & Callaghan, 2017) indicated that:
  - 58.8% were not paid and the uncompensated weekly hour's mean was 6.8
  - 92.8% most often serve middle aged and older adults
  - Roles assumed included integrator of health (64.1%); health educator (76.5%); health counselor (65.4%); referral agent (68.6%); facilitator of volunteers (46.4%); developer of support groups (32.7%); health advocate (64.1%); health screenings (60.1%); home visits (62.1%); transitional care (24.8%)
  - Only 10.2% indicated they never document, 31.5% indicated sometimes, 26% indicated frequently, and 32.3% indicated they always document.

Nursing Research

The *Nursing Human Capital Value Model* (Yakusheva et al., 2024) examines the full scope of nursing's economic contribution. The foundational ingredient of the model is the delivery of high-quality nursing care provided to patients, families, communities, and populations delivered by a nurse with specific education, experience, expertise. Authors offer that nursing should not continue to be viewed as an undifferentiated, uniform input; rather, nursing is a value-added capital asset and measurable.

Recommendation: Even though the model was developed for those employed by healthcare organizations, the FCN can refer to this study to aid in discussions about the value of faith community nursing. The FCN should be seen as a value-added asset that provides measurable care based on the characteristics of the nurse (experience and specialty) and allocation (population, types of interventions, and hours). Outcomes of the healthcare consumer, program, organization,

and nurse are demonstrated. Revenues come from patients giving to faith community 2) the use of faith community or healthcare organizational resources, 3) internal and external organizations (grants), and 4) potential government reimbursements. Uncompensated hours may also be viewed as revenue.

FCN Research - Compensation Survey

Due to a gap in FCN research regarding compensation, a national survey (N=97) was conducted by the Westberg Institute Research Committee (2024). It explored FCN roles, compensation, and perceptions regarding the need for compensated positions. There is a predominantly uncompensated workforce with significant challenges related to compensation and recognition of the FCN role. There is a strong belief that compensated positions could enhance the effectiveness and sustainability of programs. Suggestions for improving compensation models and alleviating funding barriers were emphasized, indicating greater awareness and support from both faith communities and healthcare organizations.

Results:

1. Current Roles and compensation:
    - (N=94) 76.60% are uncompensated FCNs and 20.21% are compensated FCNs
2. Compensation for uncompensated FCNs:
    - (N=80) 65% reported receiving no compensation, 33.75% received recognition as compensation, and 1.25% received a yearly non-monetary gift.
3. Work hours for uncompensated FCNs:
    - (N=81) 75.31% work 1-10 hours per week.
4. Hourly rates for compensated FCNs:
    - (N=24) (open-ended): most indicating a range of $31-50 per hour.
5. Salary for compensated FCNs:
    - (N=53) 5.09% earn between $25,001 to $50,000
6. Work hours for compensated FCNs:
    - (N=26) (open-ended): Hours varied, with 4 working 1-10 and 4 working more than 40.
7. Benefits received by compensated FCNs:
    - (N=48): 47.92% reported receiving no benefits, 25% receive health insurance, and 20.83% receive continuing education costs.
8. Sources of compensation:
    - (N=49) 44.90% reported no defined source of payment and 18.37% are salaried by faith communities or healthcare organizations.
9. Perceptions on compensating FCNs:
    - (N=96) A weighted average of 4.19 on a scale of 1 to 5 indicated agreement that paying FCNs would help attract and retain qualified nurses.
10. Recommended fair compensation levels:
    - (N=88) 35.23% suggested an hourly rate of $31-40.
11. Barriers to funding:
    - Open-ended responses highlighted several barriers, including a lack of understanding of the FCN role, perceived undervaluation of services, and financial constraints within faith communities.
12. Services for compensation:
    - (N=96) 83.33% believe FCNs should be compensated for conducting health education and 62.50% believe providing direct patient care should be compensated.

Reimbursement Model for FCNs

The American Nurses Foundation's Reimagining Nursing Initiative's *"Direct Reimbursement Model"* pilots are generating data to inform researchers about reimbursement pathways for registered nurses (RNs) providing nursing services in the community. This includes FCNs. Obtaining a National Provider Identifier (NPI) is one of those pathways.

The American Nurses Association (ANA) has published a position statement specific to the NPI for RNs. It states that "RNs must be recognized for their expertise and the clinical services they provide and, therefore, ANA recommends … All RNs and APRNs should obtain an NPI to elevate and recognize them as clinicians providing vital services to patients…" The ANA website has a landing page with information about the NPI and how a nurse can obtain one. FCNs are encouraged to stay informed on this important topic. American Nurses Association National Provider Identifier. https://www.nursingworld.org/npi

- American Nurses Association National Provider Identifier (NPI) as the Unique Nurse Identifier. ANA Position Statement. Approved: June 2022. https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/national-provider-identifier-npi-as-the-unique-nurse-identifier/
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