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Faith Leaders' Perceptions and Experiences of Advancing Collaborative Health Care Partnerships Focused on Community Health

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This is to certify that the doctoral dissertation by

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and that any and all revisions required by
the review committee have been made.

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Walden University
2024

Abstract

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MPhil, Walden University, 2021

MSS, United States Sports Academy, 2001

BA, University of Maryland Eastern Shore, 1999

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Management

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Abstract

Faith leaders [FLs] have launched interventions and partnerships to improve health care in rural communities in the United States, yet these areas still experience unfavorable health outcomes in comparison to other areas. The purpose of this study was to explore how a sample of nine FLs perceive and experience their roles as agents for social change in collaborative healthcare partnerships that focus on community health in the rural Delmarva region of the United States. The conceptual framework that informed the work was based on the social-ecological model [SEM] and transformational leadership theory. A qualitative, interpretative description research design was employed, and a constant comparative analysis of data was performed. Findings revealed that participating FLs were social agents for addressing personal and community health issues; they did so by collaborating with other institutional partners, identifying and using organizational environments to appropriate resources to aid positive healthcare outcomes, and guiding and moving others to action. Specific transformational FL actions, along with collaborative partnerships, contributed to positive health outcomes within specific subsystems of the SEM. The findings suggest that transformational FLs, as community-as-system leaders, can positively affect community ills and help reduce shortages of health resources and improve health outcomes in rural areas, thus contributing to positive social change.

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Dedication

I dedicate my dissertation to my family and friends. I would like to specifically dedicate my dissertation to my grandparents, Daniel and Lois Ridout. Without them, completing my dissertation would have never happened. I also dedicate my dissertation to my loving parents, Paul and Danna Trotter, and uncle, Dr. Daniel Ridout III who were in my corner since the beginning of my multiple doctoral journeys. I also devote this dissertation to my wife, Okiima Trotter, and daughters for having the patience with me to finish. They have been my biggest cheerleaders and supporters. For all my friends who experienced my doctoral journey, through inception to finish, I would also like to dedicate my dissertation work to them. Finally, I also dedicate this dissertation to my dissertation committee and chair for their continued support, guidance, and instruction.

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Thank you to my committee member, Dr. William Schulz. And committee chair, Dr. Jean Gordon for providing guidance and feedback throughout this project. Thanks also to my wife, Okiima, and my parents, Paul and Danna Trotter, for being patient while I completed my dissertation.

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Chapter 1: Introduction to the Study

Throughout the United States, populations in many rural areas report poorer health status, require greater medical resources than are available, and show worse health outcomes when compared to populations in urban and suburban areas (Harrington et al., 2020). Solutions to these complex challenges require collaborative and active engagement within affected communities, including the participation of leaders of faith-based organizations (FBOs; Heward-Mills et al., 2018). Opportunities to engage resources among rural communities could be pliable to alleviate various health care issues.

Faith leaders [FLs] serve others through their professional practice [religion, discipline, education, and stewardship] and their involvement in FBOs, and are prominent leaders in communities, in addition to being sources of expertise to meet specific needs of a populations (Heward-Mills et al., 2018; Levin, 2016). FL organizations have a unique position to address various community issues [e.g., social determinants of health, environmental injustices, and health disparities] through active involvement with other stakeholders, community health care organizations, and key leaders (Rivera-Hernandez, 2015). This context provides FLs with a platform and capacity to innovate solutions to address various health outcomes.

Key stakeholders, community health care organizations, and leaders have partnered with FBOs to address national initiatives in the United States (Campbell et al., 2007). Although some church-based health promotion studies have assumed that FLs have a role in influencing the health of people and communities they serve, little research

exists on the extent of leaders' influence and the mechanisms involved (Williams et al., 2012). In reviewing the literature, I found even less research on how FLs perceive and experience their roles in advancing collaborative health care partnerships that focus on community health. In conducting this qualitative interpretation description research study, I sought to address gaps in the literature by exploring the role of FLs, from their own perspective, in helping their local communities improve overall health conditions and outcomes. Chapter one will include detail concerning the background of the study, problem statement, purpose of the study, research question, conceptual framework, nature, definitions, assumptions, scope and delimitations, limitations, and significance of the study.

Background of the Study

Complex social problems play a significant role in generating unfavorable health outcomes. According to research, rural areas tend to be the most impacted due to the inherent effects of health status, education level, inadequate housing, low income, unhealthy environments, and high unemployment (Bui et al., 2019; Hood et al., 2016). Risk factors such as geographical isolation, lower socioeconomic status, higher rates of health risk behaviors, and limited access to health care and job opportunities make it more likely that rural Americans will receive unfavorable health outcomes (Rural Health Information Hub, n.d.) Rural Americans also encounter various barriers to health care and services (Dassah et al., 2018). The influence of social problems demonstrated in rural areas could lead to worse health outcomes in those areas. There is a need for change agents in rural areas, interventions to address unfavorable health outcomes, attention to

the drivers of health outcomes and intervention in rural areas, insight on leadership studies that focus on health outcomes, awareness on some of the causes and effects of health outcomes, and insight on the value of community collaboration to combat the issues and concerns that impact health outcomes.

Rural areas require change agents to optimize the strength and assets of community leaders and organizations so that residents have their needs met (Meit et al., 2018). Resource scarcity in rural areas may motivate community leaders to partner with other organizations [e.g., employers, community organizations, and FBOs] and organizational systems [e.g., health care system and local school districts] to prevent disease and to improve the health of rural Americans (Harrington et al., 2020). Collaborative health care partnerships may contribute to social capital, expansion of social health care networks, development of funding streams, inception of sustainable health-related programs, and identification of appropriate community leaders to enhance community health (Rural Health Information Hub, 2022). Organizational and community resources in rural areas may provide an opportunity for rural leaders to address rural health.

Numerous multidisciplinary and case study researchers have explored possible interventions that address unfavorable health outcomes [e.g., Behane, 2020; Igalla, 2020; Mshana et al., 2018]. Leadership studies have highlighted evidence of community leadership partnering with others to improve health outcomes, and effect multilevel prevention behavior change (Mayberry et al., 2020; Mshana et al., 2018). Within the last 20 years, stakeholders have expressed interest with FLs and FBOs as a resource to

contribute to related health outcome efforts (Harmon et al., 2020; Jansen, 2019; Powers et al., 2019; Withers, 2020). Recent engagement of FLs in efforts to improve health outcomes in rural communities could enhance community health.

In addition to research regarding public health and leadership that has focused on health outcomes, recent studies have demonstrated solutions to address the effects of social conditions and its influence on health outcomes (Artiga & Hinton, 2018; Daniel et al., 2018, Ellen et al., 2001; Moran et al., 2019; Purnell et al., 2016; Shi et al., 2009; Shoesmith et al., 2019). Researchers have provided insight on various causes [e.g., social determinants of health] and effects [e.g., health disparities and health inequities] that have led to various health outcomes. However, based on my research, few have explored the role of faith-based leadership style and collaboration of health care partnerships to alleviate unfavorable health outcomes. Focusing on the leadership style of FLs and their partnerships could reveal innovative collaborations and drive key solutions to common health issues in rural areas.

Leadership studies have highlighted evidence of community leadership partnering with others to improve health outcomes, as well as using community constituents to effect multilevel prevention behavior change (Mayberry et al., 2020 Mshana et al., 2018). Collaboration has become a popular course of action to meet changing expectations and new urgencies (Figueroa et al., 2019). Foco's (2011) study revealed FLs as useful resources that faith communities bring to partnerships. FLs are capable role models in their communities to remove barriers and roadblocks in communities that impair the livelihoods of others (Heward-Mills et al., 2018). The discipline of their work may allow

FLs to be effective for combating social norms and behaviors. FLs can also serve as key figures or change agents who take part in organizational and collaborative efforts to improve the well-being of individuals, families, and communities.

Problem Statement

Despite the many interventions and establishment of FL health care partnerships, a social problem still exists for the continual occurrence of unfavorable health outcomes in rural areas of the United States. Rural Americans continue to have a higher occurrence of chronic disease when compared to their urban counterparts (Garcia et al., 2019). Social determinants of health, health disparities, and health inequities are influential social conditions that affect rural Americans' ability to achieve adequate levels of well-being and livelihoods (Dawes, 2020; Entress & Anderson, 2020; Martin-Howard & Farmbry, 2020). On the topic of health outcomes in rural areas, the problem statement will reveal the current problem and the specific research gaps in the field of leadership and management that pertain to efforts to enhance community health in rural areas.

The specific leadership and management problem was the lack of understanding of how FLs perceive and experience their roles for social change in advancing collaborative health care partnerships that focus on community health in rural areas. Within the field of leadership and management, some researchers have attempted to understand social and non-social conditions that account for the achievement of positive health outcomes from collaborative activity (Nyström et al., 2018; Karlsson et al., 2023). Yet rural Americans continue to see the quality of their health outcomes decline (Weber et al., 2017). Schoenberg and Swanson (2017) argued that faith-based related programs in

rural areas have a potential to improve health outcomes. FLs in rural areas could serve as a major contribution to spur social change in rural areas.

One of the specific gaps in the field of leadership and management is the lack of understanding of how FLs perceive and experience their roles for social change in advancing collaborative health care partnerships that focus on community health outcomes health outcomes in rural areas. To address this gap, I used a qualitative interpretive description research design to explore how FLs perceive and experience their roles as agents for social change in collaborative health care partnerships that focus on community health in a rural setting. My goal was to further understand how to better bridge the adverse impacts of the influence of social conditions on health outcomes in rural communities.

Purpose of the Study

The purpose of this qualitative interpretive description research study was to explore how FLs perceive and experience their roles as agents for social change in collaborative health care partnerships that focus on community health in a rural setting. The purpose illustrates the opportunity to acquire a unique understanding about leadership style and collaborative partnerships from FLs' perspectives. The new knowledge and practice arising from this study could be applicable to various industries and disciplines for responding to diverse issues in a rural community. FLs may serve as a valuable resource to respond to community health issues as social agents. They can potentially do so by identifying a leadership style and collaborative partnership activity to

achieve personal and organizational objectives through their lines of business, operational affairs, and community involvement/engagement of rural areas.

Research Question

How do FLs experience their role as agents for social change within collaborative partnerships that seek to improve local healthcare outcomes in rural settings?

Conceptual Framework for the Study

Previous literature highlighted FBOs for being actively engaged in the areas of community welfare, such as health, community education, conflict resolution and disaster management (Chowdhury, 2019). FBOs supply support and aid to vulnerable individuals, families, organizations, and communities. FLs exhibit a dynamic ability to use organizations to engage and to navigate through various systems for interacting with key stakeholders and community actors (Chowdhury, 2019). Most FLs have the leadership and engagement ability to supply the necessary intervention to meet the needs of a rural community and will be required to address health outcomes that are exacerbated by social determinants of health, health disparities, and health inequities for constituents in their communities (Schoenberg & Swanson, 2017). The discussion of the study's conceptual framework will supply a brief awareness on the context of leadership and environment and how a specific community resource could influence health outcomes in rural areas.

Health outcomes are the product of multiple systems of influence derived from not only the individual, but also from the internal and external environments of the individual (Long et al., 2020). The effects of specific social conditions [e.g., social determinants of health, health disparities, and health inequities] contribute to unfavorable

health outcomes in rural areas. Social conditions and health outcomes also result from structures and systems that limits an individuals' choices, access, and knowledge (Golden & Wendel, 2020). The field of public health is beginning to recognize the social and structural determinants of health and equity to better understand health outcomes (Golden & Wendel, 2020). Combating the influences of social conditions on health outcomes should require a new innovative approach from key stakeholders. Even though public health has demonstrated innovation and intervention at the individual and interpersonal stages (e.g., the interpersonal and intrapersonal factors of the social ecological model [SEM]; Bronfenbrenner, 1989, 1999, 2005, 2006), research is still needed in the areas of FL leadership that focuses on the engagement with individual and the interpersonal stages of the social ecological model for forming and sustaining collaborative health partnerships.

Social Ecological Model

According to the work of Bronfenbrenner (1989, 1999, 2005, 2006), the interplay of the SEM factors and social conditions can influence attitudes and beliefs, interactions with other people, rules and regulations that impact healthy behavior, group norms that impact healthy behavior, and policies and laws that regulate or support healthy actions for disease prevention. SEM provided a foundation to explore the study's problem. SEM offers insight into how [or what levels of] individual or group factors contribute to desirable outcomes (Bronfenbrenner, 1977, 1986, 1989, 1994, 1999, 2005, 2006). The SEM supplies a framework to understand leadership and collaborative partnership within a continuum of mico-, meso-, and macro-levels, through a range of individual, social, and

community influences (Bronfenbrenner, 1989, 1999, 2005, 2006; Long et al., 2020). SEM supplies a context to expand conceptions of well-being, redress a history of inequitable assessment of knowledge and culture, or advance systemic and sociopolitical changes (Bronfenbrenner, 1989, 1999, 2005, 2006; Golden & Wendel, 2020). Not only does SEM serve as an effective foundation to understand leadership and collaborative partnership, but it also offers an effective model to understand how social conditions impact livelihoods.

Earlier leadership research on population health focused on the individual level of SEM for developing interventions but did not incorporate innovation and interventions according to the outer layers of the SEM (e.g., intrapersonal, organizational, community, and public policy; Bronfenbrenner, 1989, 1999, 2005, 2006; Golden & Wendel, 2020). Because there are occasional difficulties with collaboration and innovation, intervention will continue to require reassessment for improvement, due to the ongoing nature of change that leadership encounters throughout all levels of SEM (Bronfenbrenner, 1989, 1999, 2005, 2006; Echaubard et al., 2020). The outer layers of SEM could provide insight on the functional facilitation of leadership and collaborative activity that could be conducive to the alleviation of unfortunate health outcomes.

Transformational Leadership Theory

FLs have the capacity to supply effective leadership due to their serving as allies and change agents to represent and shepherd their communities to make positive health-related changes, alongside their own faith-related premises (Idler et al., 2019). Collective leadership among FLs and other partners arise where the common roles and

responsibilities come together to address a situation or problem (De Brún et al., 2019). Public health and leadership researchers have found that poor leadership is a potential casual factor for adverse health outcomes (De Brún et al., 2019). Leadership is also influential for shaping health behaviors, strategies, health service improvement, and community health. Due to the current health indicators in rural areas, there is a continual need for stakeholders, policy makers, and community leaders to develop innovative solutions for interventions to improve the well-being of rural populations. Despite earlier and current interventions, strategies, and leadership, communities in rural areas still need the proper leadership to alleviate unfavorable health outcomes. Rural populations may also succumb to external pressures and events [e.g., pandemics, natural disasters, and climate change] that may add to the effects of social conditions to become even worse, as well as hindering the effects of responsive leadership (Logan & Castañeda, 2023).

Transformational leadership theory (TL; Burns, 1978, 2003) in this study provides intuition on how the leadership characteristics of FLs are involved in collaborative partnership activity with others, through the four dimensions of: (a) idealized influence, (b) inspirational motivation, (c) intellectual stimulation, and (d) individualized consideration of TL. Through encouragement, empowerment, and support, FLs could meet the needs of others, and their communities (Jandeska, 2019). Leadership of FLs contribute to stakeholder efforts to improve health outcomes in rural areas, due to their ability to reach vulnerable populations according to their resourcefulness and boundary spanning capabilities for navigating through various systems [interpersonal, intrapersonal, organizational, community, and public policy]. The four dimensions of TL

(Burns, 1978, 2003) may interplay with personal [individual and interpersonal] and non-personal [organizational, community, and public policy] factors of the social ecological model (Bronfenbrenner, 1977, 1986, 1989, 1994, 1999, 2005, 2006) for efforts to enhance the health of rural populations. TL (Burns, 1978, 2003) connects with the concepts of the study (leadership style and collaborative partnerships) by understanding the theory dimensions that may inform how FLs sustain collaborative health partnerships.

Nature of the Study

The nature of this study is exploratory, and, as such, the specific research design will be qualitative and will use an interpretative description research design to explore FLs' perceptions and experiences in their roles in advancing collaborative healthcare partnerships that focus on community health. To address the research questions in this qualitative study, the specific research design includes a qualitative interpretative description research study to explore the transformative FLs' role on collaborative partnership activity in the Delmarva region to improve local health outcomes. An interpretative description design serves as a logic model to generate meaningful scholarly products with application in various disciplines and industry (Thorne, 2008; 2016a; 2016b). The goal of this design is to focus the inquiry where research is necessary [community health outcomes], utilize the research to make decisions about a sample [FLs in the Delmarva region], and develop knowledge within a leadership and collaborative partnership context that would be advantageous to alleviate unfavorable health outcomes in rural areas of the United States.

Due to the many aspects of practice disciplines, there are many observable patterns of subjective experience that require better understanding [such as interpretive analysis] to sort out specific aspects that often require the following: (a) aspects that require further study; (b) how that might be conducted; and (c) what one might possibly do to work with those patterns (Thorne, 2016a, 2016b). A qualitative interpretative description research study purposively supplies a logic model for generating meaningful scholarly products for relevant utility in various disciplines and the health fields (Thorne, 2016a; Thorne, 2016b). An interpretative description design tends to develop reason from a disciplinary orientation to justify the application of specific techniques and procedures outside a conventional context (Thorne, 2016a; Thorne, 2016b). Therefore, the interpretative description design is applicable for a qualitative method, due to its ability to provide the coherence and integrity of the theoretical approach [TL theory] with the design variations required by my research study for supporting the 'context, situation, and intent' [Context – FLs; Situation(s) – unfavorable rural health outcomes, leadership style/collaborative partnerships, and exploration of SEM; and Intent - addressing rural health], of the research disciplinary setting [rural area – understand the FL contributions to alleviate unfavorable rural health outcomes in the Delmarva region].

Definitions

Collaborative partnership: A relationship that is characterized by at least two or more parties agreeing or acting to use their resources to carry out a mutual goal (Boyer et al., 2019).

Community health: The health status and related actions and conditions of a defined group or population that live in a localized area (Goodman et al., 2014).

Community organization: An organization that provides service to neighborhoods and communities (Srivastava & Guin, 2021).

Faith leader [FL]: A leader who has a divine mandate and responsibility to preach, educate, and teach the word of God, to help others (Heward-Mills et al., 2018). Pastors, ministers, and deacons are examples of FLs.

Faith-based organization [FBO]: A term that encompasses a group of individuals who are united based on religious or spiritual beliefs and who strive to meet various needs of their members and community (Bielefeld & Cleveland, 2013). Churches were the FBOs of interest in this study.

Health disparities: A phenomenon that occurs when the extent of a health outcome varies between populations (United States Department of Health and Human Services, n.d.).

Health inequities: The extent of differences in health between population groups (World Health Organization, 2021). Health inequities are more severe in rural areas than in urban and suburban areas in the United States (Logan & Castañed, 2020)

Leadership style: The behavioral action of a leader that they use to lead a group of people or an organization (Northouse, 2015).

Rural area: Consists of either outlying counties economically tied to the core counties, or nonmetro-labor-market areas centered on urban clusters of 10,000 to 49,999 persons, as well as noncore counties remaining counties (United States Department of

Agriculture, Economic Research Service, 2019). Northampton and Accomack counties of Virginia; and Carolina, Dorchester, Kent, Somerset, and Talbot counties of Maryland are rural areas of the Delmarva region. Baltimore, Maryland; Annapolis, Maryland; Washington, District of Columbia; and Wilmington, Delaware are the largest nearby urban areas.

Rural health: The health of rural populations in a rural area (Harrington et al., 2020).

Rural population: Various populations that live in rural areas (Campbell et al., 2020). The Delmarva region is an area that includes several rural areas, and it has health indicators that require attention. I drew study participants from this area for these reasonsd reveal.

Safety net health care provider: A complex web of public and private professionals and institutions that provide most of the care to the uninsured, underinsured, low-income, or Medicare and Medicaid recipients (Agency of Healthcare Research and Quality, n.d.)

Social conditions: Social, economic, and political factors, including the built environment, that shape, and are shaped by, the circumstances in which people live and work (Braveman, 2010). Social determinants of health, health inequity, and health disparities were the particular social conditions of interest in this study.

Social determinants of health: The conditions in the environment in which a person is born, lives, works, plays, worships, and ages that affect a wide range of health,

functioning, and other quality of life outcomes and risk (United States Department of Health and Human Services, n.d.).

Transformational leadership: A leadership style that is characterized by a leader who strengthens cooperation and team learning with others to transform or change a person, place, or thing (Purwanto et al., 2020).

Assumptions

Assumptions are considerations of a study proposed to be true (Marshall & Rossman, 2016). Assumptions supply a reflection on the foundation of research (Coates 2020) and aids the me to build a distinct framework to guide practice and lessen biases (Frels et al., 2015). An assumption for this study is that the participants of the study will supply honest responses. Another assumption is that lived experience of the participants will be acceptable and correct. More important, the assumption that the participants will be honest in meeting the pre-scribed selection criteria for the study, and eligibility criteria [transformational leadership style] for interviews.

Scope and Delimitations

The Delmarva region is a suitable area of consideration for this study, due to the region being rural, as well as having high mortality and morbidity rates, compared to its urban and suburban counterparts. Meyer (2018) had previously said that the Delmarva region illustrates a range of chronic health problems including among the residents in Accomack County, Virginia, 32% has high blood pressure, 35% has high cholesterol, and 73% are overweight (Pittman et al., 2020). The states [Delaware, Maryland, and Virginia] among the Delmarva region that meet the rural area definition will be used to retrieve the

purposive sample. Purposive sampling will allow me to get a representative sample of FLs in a rural area. Personal identifiable information will not be included or used in the study. Participants will receive a twenty-dollar gift card as thanks for their participation. Having participants self-report responses on surveys may not yield legitimate answers. Self-reporting could be subjected to various biases, such as social desirability bias (Pekrun, 2020). Social desirability bias could occur due to inherited perceived notions and awareness of leadership styles and partnerships among participants.

Limitations

Limitations of a research study affects the results of the study and hinders my ability to prove the effects of the unknown (Booth et al., 2008). Study limitations are weaknesses that may influence outcomes and conclusions of the research (Ross & Bibler Zaidi, 2019). As a main limitation of the research study, the results will not be generalizable to other populations. Rural areas in the Delmarva region may not show similar population characteristics in other rural areas. Other populations and locations [urban, suburban, regional, national, and/or international] will serve as delimitations of the study since they may restrict the replicability of study results and findings. Results and findings from the study may not be consistent with urban populations among an urban region.

Effects from the COVID [Coronavirus Disease 2019] 2019 pandemic, time management, conflict of availability among the me and participant, and influence of participant bias will serve as challenges while conducting the study. The coordination of days and times for semi-structured in-depth interviews may be cumbersome. Scheduling

interviews for participants may be difficult, due to inabilities to adapt to availability among me and participants. The barriers of conducting the study will be the attainment of sufficient financial resources to support the study [e.g., research equipment and participation incentives]. Data analyzing software, computer, and related supplies may not be accessible when needed to perform the research study. Gift cards and/or monetary incentives for participants may be difficult to provide to maximize study participation.

Significance

The significance of the study will supply the significance to practice, theory, and social change. The study will highlight the probable community benefits, knowledge advancement opportunity in the areas of leadership and management, and a capacity for social change. These highlights derived from the significance of the study could potentially address community health issues and concerns in rural areas. The significance of the study is described in terms of (a) how this study will/may fill a gap in the literature, (b) professional application, and (c) positive social change [e.g., improvement of human or social conditions by promoting the worth, dignity, and development of individuals, communities, organizations, institutions, cultures, or societies].

Significance to Practice

The leadership and management of public health and public administration could benefit due to the study's potential to meet organizational, management, and leadership interest of stakeholders in a rural community for developing solutions to alleviate community health issues. FLs can serve as resourceful leaders in communities and have the potential to become stewards of their communities resulting from the added

knowledge gained during collaborative partnership experience. Public health officials, health administrators, and community leaders could benefit from this study to spearhead applicable policies and guidelines to enhance rural health. Generation of best practices could develop from this study, due the study's possible implication to satisfy community health interest among key stakeholders, as well as enable community leaders to better help, manage, and organize important resources to alleviate barriers that impede the well-being of rural communities.

Significance to Theory

The potential contributions of the study are to advance leadership and management knowledge in the role of a leadership style and collaborative partnership through the abilities of transformative FLs and their involvement to achieve effective community healthcare relationships. Transformational leadership could be refined and revised due to the findings and results of the study. This study could provide the following significance: (a) add additional meaning to collaborative partnership derived from the findings and results of the study, (b) offer additional insight to suggest or recommend additional concepts, factors and/or elements to better understand and refine theory development of collaborative partnerships; and (c) could engage the SEM (Bronfenbrenner, 1977, 1986, 1989, 1994, 1999, 2005, 2006) to evolve the meaning, definition, and theory development of collaborative partnership. This study could also contribute to further theoretical developments of public health and community health.

Significance to Social Change

Earlier research had shown that adaptation to work environments and setting up and managing partnerships with other organizations are the least two factors affecting leadership in the 21st century (Cooke, 2020). Leadership is often the context that frames a partnership from the start (Aunger et al., 2020). Having insight on a leadership style can contribute to creative conceptualization and management implications for FLs to continue to develop and/or sustain needed partnerships to address social health issues in rural areas. Engaging community leaders and organizational resources for health improvement could contribute a better understanding of socioeconomic and cultural determinants of specific populations in rural areas (Hartley, 2015). Artiga & Hinton (2018) supported the notion to address social determinants of health to improve health and reduce longstanding disparities in health and health care. Other influential factors among social determinants of health could also account for barriers that affect the enhancement of community health. It is necessary to set up a connection between the community and professionals in public health to reinforce actions of educational institutions, student associations, government officials, and other professionals, with the aim of supporting public health initiatives that will help a community (Bonilla & Gomez, 2020). FLs who may be impacted by the effects of social determinants of health could apply leadership that could support collaborative partnerships.

The research community has shown that social networks and partnerships enable leadership to support other related needs [e.g., funding, materials, and equipment] that facilitates achievement of goals and objectives of a partnership (Cook, 2020). There is

also growing support for innovative partnerships to work with community groups and other public or private sector partners (Giachello et al., 2020). Levin (2014) mentioned that formal partnerships between FBOs and public health sectors often entail activities in various health fields. FLs in rural areas who show characteristics and/or attributes of transformational leadership could serve value with developing, sustaining, and maintaining community healthcare relationships treatment programs, to meet the health needs of rural populations.

Results from the examination of the effects of health disparities and/or social determinants of health in a rural area from a leadership style and partnership perspective could be useful for social change efforts [environment, health, and justice]. These effects could improve rural health policy [e.g., provision of resources and service delivery of health services] and health service promotion for rural populations. Examining FLs and collaborative partnerships could contribute to the larger economic picture [awareness for better conditions of employment, education, housing, healthcare services and access]. These efforts may also supply managerial opportunities for rural FLs to advance positive social change through an awareness of leadership style to better the livelihoods of populations in rural areas. The significance of social change is in terms of: (a) how this study will/may address a gap in the literature, (b) professional application, and (c) positive social change [e.g., improvement of human or social conditions by promoting the worth, dignity, and development of individuals, communities, organizations, institutions, cultures, or societies].

Summary and Transition

FLs will need to address a range of issues and concerns that impact specific populations in rural areas. The leadership practices of FLs could influence collaborative partnerships among key stakeholders. Even though there has been many interventions and established partnerships to address these range of issues and concerns in rural areas, a social problem still exists from the continual occurrence of unfavorable health outcomes showed in rural areas.

This qualitative interpretative description research study will provide an opportunity to tend to the lack of understanding of how FLs perceive and experience their roles in advancing collaborative healthcare partnerships that focus on community health in rural areas. TL (Burns, 1978, 2003) and social ecological model (Bronfenbrenner, 1977, 1986, 1989, 1994, 1999, 2005, 2006) will provide the appropriate conceptual framework to explore the problem and purpose of the study. Using an interpretative description research design will describe FLs, and their ability to impact collaborative partnerships in a specific region that encompass rural areas.

As a main limitation of the study, the results may not be generalizable to other populations due to possibilities that the study's population characteristics would not be consistent in other rural areas. This study could offer significance to practice for stakeholder leadership to develop solutions to alleviate community health issues in rural areas. This study also could offer significance to theory from its potential to provide new knowledge and insight for further research and development of TL (Burns, 1978, 2003), as well as an opportunity to revise and crystallize the meaning of collaborative

partnership from a different conceptual point of view. This study has an implication for social change to show possible intervention and innovation for solution development concerning various organizational leadership efforts to alleviate social conditions in rural areas that hinder well-being and livelihoods.

Chapter 2: Literature Review

Introduction

Elevated levels of disease continue to affect rural Americans at disproportionate levels (Garcia et al., 2019). Research has showed that faith-based related programs in rural areas have a potential to improve health outcomes (Schoenberg & Swanson, 2017). But there is a lack of understanding of how leaders, particularly FLs in rural communities, perceive and experience their task to improve collaborative healthcare partnerships and rural health outcomes. The purpose of this qualitative interpretative description study is to explore this gap in knowledge related to FLs in a particular rural setting—the Delmarva region. This research can supply insights about leadership style and collaborative partnerships that focus on rural healthcare outcomes from a FL perspective. FLs serve as a valuable rural community resource through their skills to identify with leadership style and collaborative partnership activity to achieve personal and organizational objectives, which can affect community health outcomes (Idler et al., 2019). Chapter 2 will include the implications of the social problem and purpose of the study by providing detail about the literature search strategy components, theoretical ideas and constructs of the conceptual framework, and key features included in the literature review.

Literature Search Strategy

The search for relevant research occurred online using Google Scholar and Walden University Online Library. Specific search engines and databases include Scholar Works, Dissertations & Theses @ Walden University, ProQuest Dissertations & Theses

Global, ProQuest Central Journals, Emerald Insight, SAGE Journals, Thoreau Multi-Database Search and Public Administration Abstracts. Relevant peer-reviewed journals were from 2017 to current date of this writing. To gain better understanding of the topic and conceptual framework, I included older literature from peer-reviewed journals, books, and other databases such as MedlinePlus and the United States Department of Health and Human Services, National Center for Health Statistics, Center for Disease Control, Morbidity and Mortality, and National Institute of Health. The key terms used for the literature review searches to develop research questions and obtain the appropriate research methods to evaluate this area of concern included *community health*, *rural health, faith leader*, *health disparities, health inequities, health outcomes, ecological models, social ecological model*, *leadership, transformational leadership, collaborative partnership, faith-based organization*, *rural population*, *social change*, and *church*.

The perspectives of FLs and their engagement with improving health outcomes were important to this study (Bruce et al., 2013; Kruger et al., 2010; Taylor et al., 2021; Toni-Uebari & Insusa, 2009). But I found little to no in-depth studies on the impact of leadership from the point of view of FLs, their leadership style, and the nature of their collaborative healthcare partnerships. Research opportunities are unlimited around faith-based partnerships, and stakeholders are interested in health leadership and management efforts in rural areas that alleviate unfavorable health outcomes (Alves et al., 2021; Nelson, 2020; Taylor et al., 2019). This study will contribute to various stakeholder and research community efforts to improve community health in rural areas of the United

States by focusing on the impact of leadership style and the lived experiences of FLs who show collaborative partnership activity among the Delmarva region.

Conceptual Framework

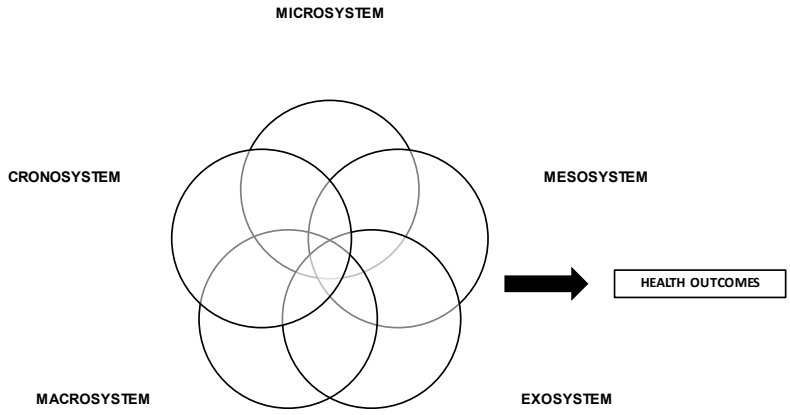
This section will review the core theoretical constructs incorporated into a conceptual framework to support the study on how FLs perceive and experience their roles in collaborative healthcare partnerships focusing on community health in a rural setting. The conceptual model that grounds this qualitative interpretive description study is a blend of Bronfenbrenner's social ecological model (Bronfenbrenner, 1977, 1986, 1989, 1994, 1999, 2005, 2006) and Burns's (1978, 2003) seminal writing on TL. The concepts from the social ecological model supply a dynamic, systems-orientated perspective on rural health outcomes, and TL supplies a theoretical frame from which to understand how FLs affect influence and potential change within the system. Some of the macro-level concepts that relate to the social ecological model that will inform this research study include the microsystem, mesosystem, exosystem, macrosystem, and cronosystem. The concepts from TL include idealized influence, inspirational motivation, intellectual stimulation, and individual consideration.

Numerous studies have confirmed that health outcomes not only result from individual behaviors and genetics, but from policies, structures, and systems (Al-Azri, 2012; Braveman et al., 2011; Golden, 2019; Knight, 2014; Plough, 2010), which are elements among the various subsystems of social ecological model [see Figure 1]. One of the challenges for any leader is to be able to understand the systems that affect outcomes at both an organizational and community level and to help transform those systems

(Baltaci & Balci, 2017; Lichtenstein et al., 2006; Viitala, 2014). A FL can sustain or enhance collaborative healthcare partnerships in rural areas by showing the necessary leadership that advances capacity and adaptability through the social ecological model subsystems (Corbin et al., 2018). Additionally, Burns and other researchers have also suggested that a transformational approach to leadership is most effective when a larger-scale and systemic change is necessary (Burns, 2003; Middlebrooks, 2013; Senge, 2006).

Figure 1

Social Ecological Model Subsystems



Note. Adapted from, "The Ecology of Human Development*"* by U. Bronfenbrenner, 2006, *Harvard University Press*. Copyright 2006 by President and Fellows of Harvard College.

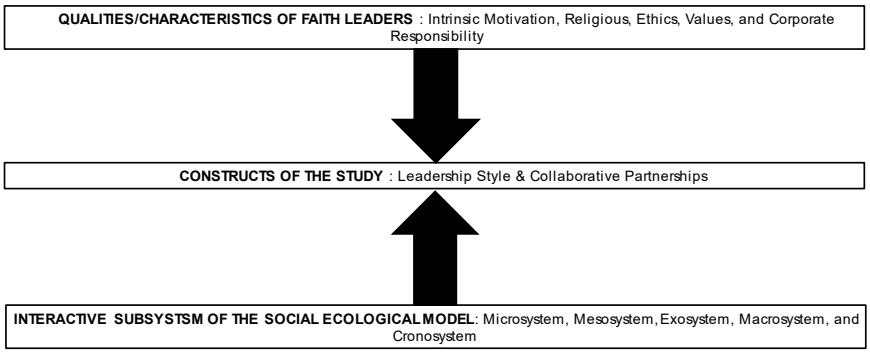
TL can affect outcomes of organizations and the behavior and actions of followers through motivation and influence (Burns, 1978, 2003). Collaborative partnerships are mechanisms that not only advance organizational performance but also extend capacity to promotion of health equity and alleviation of health disparities (World Health Organization, WHO, 2013).

Social Ecological Model

In this research, I will use the social ecological model framework to explore how FLs experience collaborative partnership activity. The social ecological model supplies a context to explore the qualities of FLs through the interactive subsystems that may contribute to collaborative partnerships (see Figure 2).

Figure 2

Qualities of Faith Leaders and Their Application to the Social Ecological Model



Note. Adapted from, "The Ecology of Human Development*"* by U. Bronfenbrenner, 2006, *Harvard University Press*, Copyright 2006 by President and Fellows of Harvard College; and "Spiritual Leadership: A Guide to a Leadership Style that Embraces Multiple Perspectives" by Smith et al., 2018, *Journal of Instructional Research*. Copyright 2018 by Center for Innovation in Research and Teaching at Grand Canyon University.

In effort to satisfy followers' well-being and organizational outcomes, leadership researchers observed the following characteristics/qualities of FLs: (a) intrinsic motivation [emphasizing individual needs of others], (b) religious [care and compassion for others], (c) ethics [facilitating responsibilities to achieve mutual outcomes], (d) values [supportive organizational environments that ascertain meaningful work], and (e) corporate social responsibility (Fry, 2003; Fryet al., 2005; Oh & Wang, 2020).

With concern centered on rural health, the social ecological model helps understand the implication of leadership style and collaborative healthcare partnerships of FLs that address health inequities and health disparities. Bronfenbrenner (2005) postulated that the total ecological system that influences human growth and development has five subsystems. Each subsystem is dependent on the person's context for growth and development through the dynamic interactions among subsystems (Bronfenbrenner, 1999; Golden & Earp, 2012). For instance, the subsystems of social ecological model impact health outcomes through intrapersonal/individual, interpersonal,

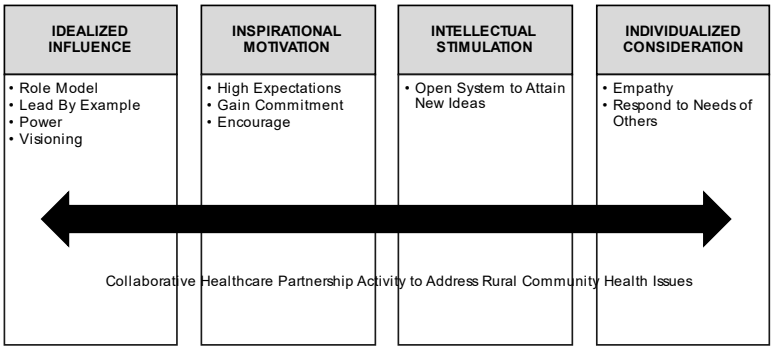
institutional, and organizational, community, and public policy factors (Berk, 2000; Bronfenbrenner, 1989; 1994; Galinsky, 1999; Swick, 2004; Swick & Williams, 2006). Personal interactions with physical, social, and cultural environments serve as the root of most health problems (Rimer et al., 2005). Health disparities and inequities are key social conditions attributed to the myriad of socioeconomic, behavior, environmental, and policy influences described in the subsystems of social ecological model (Ferrer, 2018). Each factor of social ecological model also has the capacity to impact the nature of collaborative partnerships of FLs.

Transformational Leadership Theory

TL theory (Burns, 1978, 2003) will provide insight on how the leadership features of FLs are involved in collaborative partnership activity with others through TL's four dimensions: (a) idealized influence, (b) inspirational motivation, (c) intellectual stimulation, and (d) individualized consideration—while supporting the needs of FLs that enable and motivate others [community healthcare organizations] to extend beyond expectation (Bass, 1999; see Figure 3). The four dimensions of TL have the potential to foster and improve partnerships to achieve desired outcomes (Rela et al., 2020).

Figure 3

Four Dimensions of Transformational Leadership



Note. Adapted by content from, "Leadership*"* by J. Burns, 1978, *Harper & Row*, Copyright 1978 by James MacGregor Burns; and "Spiritual Leadership: A Guide to a Leadership Style that Embraces Multiple Perspectives" by Smith et al., 2018, *Journal of Instructional Research*. Copyright 2018 by Center for Innovation in Research and Teaching at Grand Canyon University.

Burns (1978, 2003) concluded that transforming leadership was a process in which leaders and followers support each other to advance to a higher level of morale and motivation. TL satisfies basic and higher needs through inspiring and motivating followers to supply innovative solutions (Claudine, 2015). TL also shows the concerns for achievement, self-actualization, and the well-being of others, the organization, and

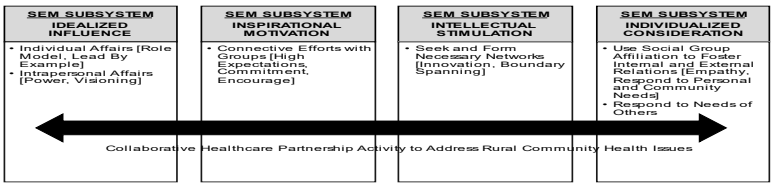
society (Bass & Riggio, 2006). Leaders who are transformational stimulate followers to go beyond the interests of themselves for the good of the team, organization, and/or society to achieve the organization's mission and vision (Draft, 2018).

Faith Leaders and Transformational Leadership

The four dimensions of TL inspire, nurture, and develop others through an open communicative and diverse culture (Bass, 1985). TL is valuable for developing and sustaining collaborative partnerships through the impacts of social ecological model subsystems to address community issues in various settings and locations [see Figure 4].

Figure 4

Transformational Leadership and the Social Ecological Model



*Note***.** Adapted from, "The Ecology of Human Development*"* by U. Bronfenbrenner, 2006, *Harvard University Press*, Copyright 1978 by James MacGregor Burns; "Leadership" by J. Burns, 1978, *Harper & Row*, Copyright 1978 by James MacGregor Burns; and "Spiritual Leadership: A Guide to a Leadership Style that Embraces Multiple Perspectives" by Smith et al., 2018, *Journal of Instructional Research*.

Not only could TL benefit followers but also organizational partners to address community issues in various settings and locations.

Summary of Conceptual Framework

The conceptual framework introduced how concepts from Bronfenbrenner's (1989, 1999, 2005, 2006) social ecological model and Burns's (1978, 2003) TL framework can be integrated to understand how FLs may be able to effect social change and positive heath care outcomes for rural communities. In the rest of this literature review, I will explore these concepts in more detail and demonstrate how they will inform how I will collect and analyze data from FL participants to gain a better understanding of their experiences, perceptions, and practices as agents for social change.

Literature Review

The literature review entails relevant background about health disparities, health inequity, rural areas and rural health, community health, Delmarva region, FBO, transformational leadership, and social ecological model. Content of the literature review supports the understanding of the background of the problem, purpose, and insight on the research method of the study.

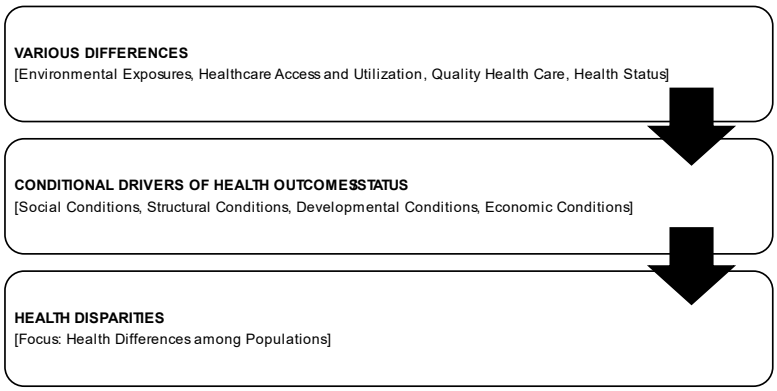
Health Disparities

Health disparities refer to populations that have differences in environmental exposures, healthcare access and use, quality, health status, and/or health outcomes (Carter-Pokras & Claudia, 2002; National Academies of Sciences, Engineering, and Medicine, 2017). A health disparity is a specific type of health difference intricately

linked with social, economic, and/or environmental disadvantage (Healthy People 2020, 2016, see Figure 5).

Figure 5

Impact of Health Disparities



*Note***.** Adapted from, "Healthy People 2020", 2016 https://www.healthypeople.gov, Copyright 2021 by the Assistant Secretary for Public Affairs [ASPA], U.S. Department of Health and Human Services; and by "The Ecology of Human Development*"* by U. Bronfenbrenner, 2006, *Harvard University Press*, Copyright 1978 by James MacGregor Burns; "Leadership" *by* J. Burns, 1978, *Harper & Row*, Copyright 1978 by James MacGregor Burns; and from "Communities in action: Pathways to health equity Communities in action: Pathways to health equity" in 2017, https://www.ncbi.nlm.nih.gov/books/NBK425845/, Copyright 2017 by the National Academy of Sciences.

Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, mental health, disability, sexual orientation or gender identity, geographic location, or other characteristics historically linked to discrimination or exclusion (United States Department of Health and Human Services, n.d.). To end health disparities, health professionals and key stakeholders often trace health disparities by rates of illness, death, chronic conditions, behaviors, and other types of health outcomes in relation to demographic factors (United States Department of Health and Human Services, n.d.). However, there are situations that lead to health disparities even when there is an absence of disease. Complex relationships exist between health and biology, genetics, and individual behavior, and between health and health services, socioeconomic status, physical environment, discrimination, racism, literacy levels, and legislative policies (United States Department of Health and Human Services, n.d.).

History of Health Disparities

Differences in health status among various groups of people may be related to both medical and nonmedical determinants (Gibbons, 2005). The earliest reported observation of the association between socioenvironmental risks factors and health outcomes occurred in Italy over three centuries ago through a detail of unusually high frequency of breast cancer in Catholic nuns (Institute of Medicine, 2002). There were also differences in mortality between the social classes living in Liverpool, England due to poverty and lifestyle factors common to the poorer working classes (Institute of

Medicine, 2002). In the early to mid-1900s, two British researchers, Titmuss and Logan, evaluated class-based mortality trends and recognized that the disparity in infant mortality rates between upper- and lower-class infants continued to rise from 1910 to 1950 (Macintyre, 1997). Not only was it clear for the poor to experience the health burdens but also among the well-educated and employed (Marmot et al., 1978). By the late 1990s, scientific evidence had shown that issues of disparity, practice variation, substandard care, and socioenvironmental determinants of health may all be related to the quality of health care experienced by patients (Gibbons, 2005).

More research in the United States suggested the importance of the socio-environment in determining health outcomes through small area analysis and geographical information systems analytic techniques (McLeroy et al., 1988). During the 1980's, a report by the United States Department of Health and Human Services highlighted the burden of death and illness experienced by minority Americans compared with the nation's population (National Center for Health Services Research, 1983; National Center for Health Statistics, 1984). Shortly after this report, a Harvard medical practice study highlighted a correlation between substandard care and healthcare centers treating poor and minority patients (Brennan et al., 1990; Brennan et al., 1991; Leape et al., 1991). Independent of personal behavior, a recognition of certain community and society factors appeared including stress, early life experiences, social capital, and income inequality that contributed to health and disease outcomes (Colman, 1988; Marmot, 1978, 1986; Sapolsky & Mott, 1987; Tager et al., 1983; Wilkinson, 1992). National and international attention among health professionals has begun to

acknowledge health disparities as a major deterrent in achieving adequate levels of health status among various populations (Friscella et al., 2000; Griffith et al., 2010).

Drivers of Health Disparities

When considering the complexity of health disparities and their application to various health conditions, a variety of factors may arise from different organizational levels, whether at an individual, family, or neighborhood level (Jefferies et al., 2019). This complexity is often manifested among various contextual features. As an example, health disparities cut across racial and ethnic groups, gender, sexual orientation, age, disability status, socioeconomic status, and geographic location (National Academies of Sciences, Engineering, and Medicine, 2017).

Underlying Causes

Health disparities have persisted through complex mechanisms that include socioeconomic, environmental, and system-level factors (Brown et al., 2019). As an example, undernutrition during the prenatal period and economic disadvantage during childhood can change physiological and behavioral set points and later health outcomes (Gluckman et al., 2008). Health disparities also exist even in healthcare systems that offer patients similar access to care, which suggests that disparities originate outside the formal healthcare setting (Saha et al., 2008). The structural and environmental conditions where people are born, live, learn, work, worship, play, and age are determinants of health and health disparities (Office of Disease Prevention and Health Promotion, 2018).

Structural and Development Causes

Social structures and developmental factors are some of the significant mechanisms that instigate health disparities (Jefferies et al., 2019). Developmental perspectives on health disparities emphasize the biological and behavioral mechanisms by which structurally patterned exposures during substantial periods of a life course result in sustained shifts in health trajectories (Gluckman et al., 2008). Developmental factors in human development manifested throughout generations often facilitate the progression and health disparities (Jones et al., 2019).

Structural perspectives on health disparities finds how biopsychosocial mechanisms translate to fundamental social causes into different population distributions of health, disease, and longevity (Link & Phelan, 1995). The structural perspective focuses on physiological processes repeatedly or chronically activate across the life course in disadvantage groups because of high effort coping with stressors (Jones et al., 2019). Structural perspectives functions as an input to various social impediments that are experienced by various social groups.

Population-level health disparities result from socially structured different life experiences, exposure to stressors, and access to coping resources (Geronimus et al., 2015). People's social identity and socioeconomic position influence their agency and ability to mobilize resources in response to various exposures (Jones et al., 2019, Zahnd et al., 2021). Population-level health disparities could possibly provide an indication of health status according to the level of social class status of a particular social group.

Impact of Health Disparities on Health Outcomes

The cascading impacts of health disparities extend not just beyond the individual, but also, to their children, communities, and society at large (Healthy People 2020; 2016). Unemployed, low-income individuals are less likely to have access to quality health insurance, and if they are unable to afford health care, they become incapable to contribute to the economic and healthy stability of communities (LaVeist et al., 2011). An added cascading effect of health disparities is its ability to impact future generations. As an example, how healthy a mom is before and during pregnancy can have a major impact on her baby. Health disparities present a cost to Americans, due to persistent gaps in health-related outcomes that lead to economic consequences. A National Vital Statistics Report (2003–2006) had estimated that ending health disparities for minorities would have reduced direct medical expenditures by $230 billion and indirect costs associated with illness and premature death by one trillion dollars for the years of 2003 through 2006 (LaVeist et al., 2011). Developmental and structural perspectives serve as a catalyst of health disparities and supplies the necessary insight and knowledge to understand the dynamic complexity of health disparities on various populations. Along with the development perspectives of health disparities, the attention has aggressively evolved to the structural perspective of health disparities due to their influence on health status and health outcomes.

Health Inequity

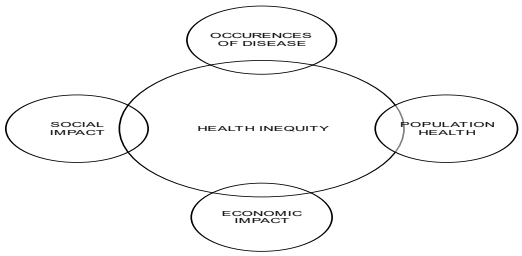
On human differences [race, ethnicity, gender, class, and other related markers], the prevalent American story often depicts a distinct division between the past and

present periods of the United States, with the 1960s and 1970s as a crucial before-and-after moment in that narrative (National Academies of Sciences, Engineering, and Medicine, 2017). Civil rights, women's liberation, gay rights, and disability rights movements and their aftermaths had contributed to a narrative that social, political, and cultural institutions have made progress toward equity, diversity, or inclusion (Dierenfield, 2021; Gee & Ford, 2011).

Contemporary polls and surveys have shown that most Americans believe that interpersonal and societal bias based on identity no longer shapes individual or group social outcomes (National Academies of Sciences, Engineering, and Medicine, 2017; Polling Report, 2021). For example, when considering racial and ethnic categories, various polls, and surveys [such as the Quinnipiac University Poll, CBS News Poll, Public Religion Research Institute Poll, Pews Research Center Poll, Gallup Poll, CNN Poll, NBC News/Wall Street Journal, and/or Ms. Foundation for Women Survey], they often tell a different narrative. A recent survey by Pew Research Center (2016), revealed that 70% of African Americans, compared with 36% of whites, believe that racial discrimination is a major reason that African Americans have a harder time getting ahead than whites. The driving force behind health inequity is the ability to show health differences linked with social, economic, and/or environmental disadvantages (Healthy People 2020, 2016; see Figure 6).

Figure 6

Health Inequity



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It is also important to acknowledge that equity is an ethical concept because it does not mean that resources are equally shared. It recognizes that sometimes different resources are necessary for different groups enjoy equitable health outcomes (Whitehead, 1992). The persistence of disparities like socioeconomic position, gender, race, ethnicity, immigration status, geography, and the like has been well documented and continues to

contribute to related perceptions (National Academies of Sciences, Engineering, and Medicine, 2017).

The differences in health status and/or conditions among specific populations sets the context for those specific populations to acquire [or not receive] either a fair or unfair health difference; and this could be inversely implied as well, meaning that the health inequities among specific populations can set the context in health status and/or conditions among specific populations for health disparities to occur (Mindell, 2019; Rodriquez et al., 2015).

The healthcare system in the United States is a microcosm of American society, where the allocation of power and resources are not even (Evans, 2020). Health inequity is the unjust systematic differences in health status among population and/or social groups defined by socially economically, demographically, or geographical characteristics (Whitehead, 1992; WHO, n.d.) According to Whitehead (1992) the nature of health inequities [aside from individual health] focuses on the distribution of resources to the community. Due to the nature of the health system in the United States and the health inequity, disadvantage populations and localities often encounter hardship with resource allocation. It has also been documented since the mid-1800's of health inequities between people of different races and ethnicities, geographical locations, and social classes (Evans, 2020; Krieger, 2011; National Academy of Sciences, Engineering, and Medicine, 2017).

Public policy leverages and administers goods and services for the public (Cairney, 2019). Lack of investments in non-health sectors facilitate the continual effects

of health disparities and health inequities (Woolf, 2019). Non-health sectors are interrelated [as well as the health sector being interrelated with the non-health sector] to allocate resources to address various public concerns.

Many communities may show the lack of inclusion of stakeholders across sectors to achieve changes in living conditions, disease prevention, workforce productivity, tax revenue, law enforcement, and incarceration that no sector could do alone (Dailey et al., 2016; Ortiz et al., 2020). Leadership in United States must also not only focus on local health issues, but also at a regional, state, and national level to maximize the assessments, solutions, and interventions of public health among various populations (Bradley et al., 2016; van Roode et al., 2020).

Some of the current health and social policies lack alignment among influential sectors. These sectors onset the facilitation of social determinants across the life-course of vulnerable and underserved populations. Policies that do not incorporate community organizations fosters the continual of health inequities, due to the lack of engagement with organizations that are most familiar with imposing social conditions (Marmot & Commission on Social Determinants of Health, 2007; van Roode et al., 2020).

Drivers of Health Inequity

Health care, health behaviors, physical and social environment, socioeconomic status, and public policy are the five core domains that shape health (Kaplan & Milstein, 2019). Complex interlinkages and interrelationships between these five domains make it challenging to measure how much each domain matters because the domains are not solely independent of each other. For example, risky behaviors catalyze chronic diseases;

an individual's environment creates the context of choices, structural racism inherently position individuals to adapt to unfortunate circumstances and situations that impact their health and livelihood (Palmer et al., 2019; Woolf, 2017).

Socioeconomic Status. The socioeconomic status serves as the most relevant among the five domains due to its ability to influence health through the resources from education and income [e.g., food, good jobs, medical care, and healthy neighborhoods] to reach better health (Woolf, 2017). For example, the less well-off a person is [according to their socioeconomic status], the fewer opportunities that person will be able to attain regular health care, as well as occupations that have low physical danger, and environments that demonstrate well-built housing in safe neighborhoods with low pollution (Palmer et al., 2019; Pampel et al., 2010).

Healthcare Systems. Failure of healthcare systems tending to the social needs of their patients contributes to the manifestation of health inequities (Woolf, 2019). This lack of involvement supports the continuance of health inequities by the absence of effectively assessing social needs, help with connecting patients, and lack of support for providing community initiatives to improve social conditions (Braveman et al., 2018; Centers for Medicare and Medicaid, 2022.; Dailey et al., 2016; Woolf et al., 2019). Most of the subsystems of the healthcare system do not affectively find at-risk neighborhoods and living conditions to help clinicians to make better healthcare decisions (Woolf, 2019). Some areas of the healthcare system do not have procedures in play to connect patients with community resources, such as housing, transportation, and job training (Centers for Medicare and Medicaid, 2022).

It is also clear that some components of the healthcare system, along with its subcomponents, do not engage with other sectors to pursue community identified goals (Dailey et al., 2016). Impediments to such efforts present cost and fragmentation that divides health care, social services, and community organizations (Woolf, 2019). Budgets from large healthcare systems that do not effectively address social needs do so by only investing in treating solutions symptoms and not the underlying conditions that cause them (Brownlee et al., 2019; Strange et al., 2014).

Health Behaviors and Economic Factors. Also influencing health behaviors are the circumstances of an individual and opportunities in which people have, along with the choices they make according to their opportunities (Asada, 2019; Bayram & Donchin, 2019). Social background influences health outcomes through the effects and interactions of healthy behaviors (Dubay & Lebrun, 2012). According to Dubay and Lebrun (2012), minority individuals have fewer protective health behaviors compared to most individuals.

Local economic factors also induce stressors influential for creating unfavorable health behaviors (Brondolo et al., 2018; Macintyre et al., 2018). For example, specific sources of stress such as childhood maltreatment, financial strain, and discrimination that affect our target groups, have been regularly associated with a wide variety of negative health behaviors (Brondolo et al., 2018). Unhealthy exposures during early life stages can affect the maximum capacity for health, and exposure to more adversity later in life development would be likely to impede health risks and behaviors of earlier life stages (Vineis et al., 2016). Negative health behaviors interactively accelerated may these

processes. The negative behaviors include substance use, inadequate exercise, and poor nutrition and sleep habits (Vineis et al., 2016).

Social and Economic Policy. Social determinants of health are the primary drivers of health outcomes, and the social and economic factors also shape individuals' health behaviors (Bayram & Donchin, 2019). The lack of focus on social and economic factors by policy makers and/or stakeholders often propel unfavorable health outcomes (Swain, 2016). Mounting evidence point to social and economic policies influencing health. According to Acevedo-Garcia et al. (2008), policies have the tendency to influence distribution of social determinants of health across subgroups through either a reinforcement or mitigation of health inequities.

Social policies have the capacity to influence health by predispositions of income, education, employment, housing, and marriage factors for serving as causes for certain health outcomes (Berkman & Kawachi, 2000; Courtin et al., 2020). For example, housing and neighborhood policy, employment policy, welfare policy, income support policy, unconditional income supplementation are examples of common policies that do not incorporate health as being a part of their design (Acevedo-Garcia et al., 2008). Policymakers do not evaluate their policies on these premises, whether if they either decrease or increase disparities and/or inequities (Acevedo-Gargia et al., 2008; Courtin et al., 2020).

Physical and Social Environment. To understand how social and physical context impact health inequities, it is also important to understand the nature of a physical environment on the effects of people's health (Artiga & Hinton, 2018; Gelormino et al.,

2015). According to Gelormino et al. (2015) only a few researchers reviewed the impact of built environment on health inequities. Air pollution, climate characteristics, soil and water pollution, noise pollution, lack of green areas all influence social conditions and health behaviors (Bastain et al., 2021; Gelormino et al., 2015).

The socioeconomic and environmental context of neighborhoods may be shaped by segregation and limited opportunities to obtain equitable health care independent of individual-level factors (Bastain et al., 2021). According to Gordon et al. (2019), certain healthcare specialties may be affected by health inequalities due to shortage of resources [e.g., healthcare professionals] and geographical unbalanced resource allocations [e.g., availability of health resources in urban, suburban, and rural areas]. Various health outcomes from the built environment to any health equity effect through natural environment, social context, and behaviors, are all somewhat connected to either density [e.g., concentration of buildings and population in an area], availability of public spaces and facilities, and/or integration of different functions within the same neighborhood (Gelorimino et al., 2015).

Impact of Health Inequities

The impact of health inequities prolongs disease and cost effectiveness and presents a burden on the population of the United States (Engelgau et al., 2019). At the individual and family level, poverty is characterized by upstream social determinants that include unfavorable social [e.g., education] and economic [e.g., employment] factors, inadequate public policies, unfavorable demographic trends [e.g., outmigration from locations with low economic or social opportunities], and suboptimal physical and social

environments (Price et al., 2018). As a downstream, poverty leads to poor health outcomes among families, driven by economic factors such as the inability to afford medicines, medical treatment, or follow-up care (Hamel et al., 2016; Politz et al., 2014). These upstream and downstream imperatives result in disadvantaged health characterized by excessive morbidity and premature mortality rates (Engelgau et al., 2019). In turn, diminished health from chronic diseases, at the population level, can ultimately lead to lower economic growth, less economic opportunities and finally loop back to cause additional poor health (Abegunde & Stanciole, 2006; see Figure 6).

Health inequities tend to not only affect vulnerable and underserved populations, but also serve as a threat to other populations, organizations, healthcare systems, and governments. For example, individuals and family households may encounter losses in income due to disability and need to use household wealth to fiancé healthcare services; employers may experience decreased productivity due to worker disability; healthcare systems may incur more health expenditures; governments may lose taxes and incur excess social welfare payments; and the entire population could experience a lower gross domestic product (Engelgau et al., 2019). Populations that are affected by health inequities often lack the resources to participate in the social and economic mainstream of society.

Another impact of health inequity is the limitations of interventions aimed at improving access to health care. There is documentation that health interventions outside the health sector that influence basic social determinants of health offer the greatest impact, the best evidence is only significant in heath sector programs, due to the

difficulty to accurately acknowledge health improvements that are specific to a particular policy (Gepkens et al., 1996, National Health Committee, 1998). In effort to improve access to health care, factors like economic, social, cultural, and geographic barriers to health care must continue to evolve the necessary resources and policy to combat barriers to health care (United States Department of Health and Human Services, n.d.).

Rural Areas and Rural Health

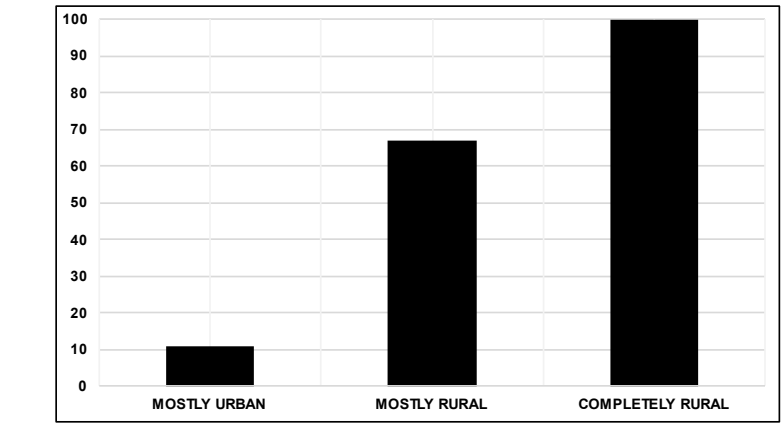
Rural areas exhibit a lesser population when compared to their urban and suburban counterparts and are inherently distant and isolated from other non-rural areas (Harrington et al., 2020). Small population, low population density, lower cost of living, lower wages, extreme poverty, abundant natural resources, outdated road/bridge/tunnel infrastructures, and a high presence of older adults are some of notable characteristics of a rural area (United States Department of Agriculture, Economic Research Service, n.d.).

United States

In the United States, rural areas include most of the landscape, but they are not home to most of the population [see Figure 7].

Figure 7

County Rurality Categories



Note. Adapted from, "Rurality Matters", 2016, by K. Holder et al., of the United States Census Bureau, https://www.census.gov/newsroom/blogs/random-samplings/2016/12/rurality_matters.html. Copyright 2022 by U.S. Census Bureau.

According to Meit at al. (2014) 65% of the 3,142 United States counties are nonmetropolitan. Some of the demands imposed on rural areas of the United States are the outcomes from rural-urban migration (Pender et al., 2019). Better well-paying jobs are normally located in non-rural areas, due to the need to pay more income to support higher standards of living costs (Pender et al., 2019). Employment reduction in agriculture in rural areas force rural residents to seek employment in other non-rural areas (Cho et. al, 2020). Natural disasters and weather disruptions in rural areas creates

unavailable land for the sustainment of farming and related employment (Chapagain & Raizada, 2017; Kapucu & Rivera, 2020). The influence of technology on various industries [particularly the agricultural industry], may decrease the need for agricultural labor in rural areas through the improvement of transportation of tools, supplies, and crops, which further induces rural residents to find better means of employment outside rural areas (Rotz et al., 2019).

Rural residents also seek employment in non-rural areas to pursue a better standard of living (Marré, 2017; Ziliak, 2019). Employment opportunities in urban areas are greater than due to the need of meeting various demands of the population and consumers because most of the United States population lives within city, urban, and suburban areas. Areas among the United States that are the most impacted are the rural populations, and/or non-urban/suburban populations [see Figure 8].

Figure 8

Population Characteristics

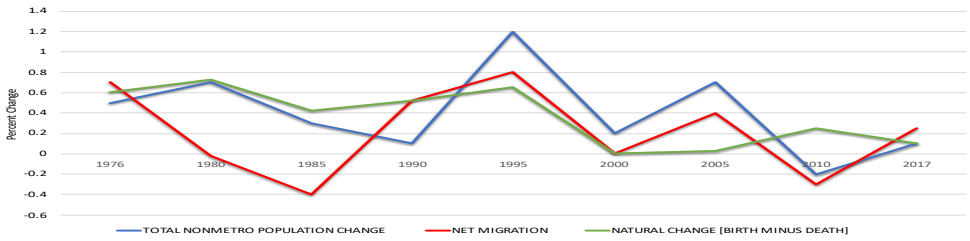
	NUMBER OF COUNTIES	POPULATION 2020	POPULATION PER COUNTY	POPULATION PER NUMBER	CHANGE 2010-2020
Nonmetro	1,976	46,005,635	23,282	-287,771	-0.6
Persistent Poverty	301	5,742,693	19,079	-345,491	-5.7
Not Persistent Poverty	1,675	40,262,942	24,038	57,720	0.1
Metro	1,166	285,443,646	244,806	22,991,514	8.8
Persistent Poverty	52	11,689,533	224,799	639,584	5.8
Not Persistent Poverty	1,114	273,754,113	245,740	22,351,930	8.9
United States	3,142	331,449,281	105,490	22,703,743	7.4

Note**.** Adapted from, *"Rural America at a Glance, November 2021"*, by E. Dobis et al. United States Department of Agriculture, Economic Research Service, https://www.ers.usda.gov/webdocs/publications/102576/eib-230.pdf?v=5831.4. Copyright 2021 by U.S. Department of Agriculture, Economic Research Service.

On the contrary, sometime between 2010 and 2017, people from urban and suburban have been gravitating to rural areas [see Figure 9].

Figure 9

Change in Migration to U.S. Rural Areas, 1976–2017



Note. Adapted from, "Overview", *(n.d.)*., by the United States Department Of Agriculture, Economic Research Service, https://www.ers.usda.gov/topics/rural-economy-population/population-migration/. Copyright 2023 by U.S. Department of Agriculture, Economic Research Service.

Rural areas are attractive to home buyers seeking residences or property near esthetic landscapes, which in turn, generates the rise in home values that are unaffordable to residents (Cromartie, 2018). Land usages in rural areas have also become attractive,

due to the revenue opportunities for mining, forest, and retail industries (Cromartie, 2018). This influx of new residences often gives rise to additional populations and exerts economical stress on businesses to support new consumer demands.

Drivers of Rural Health

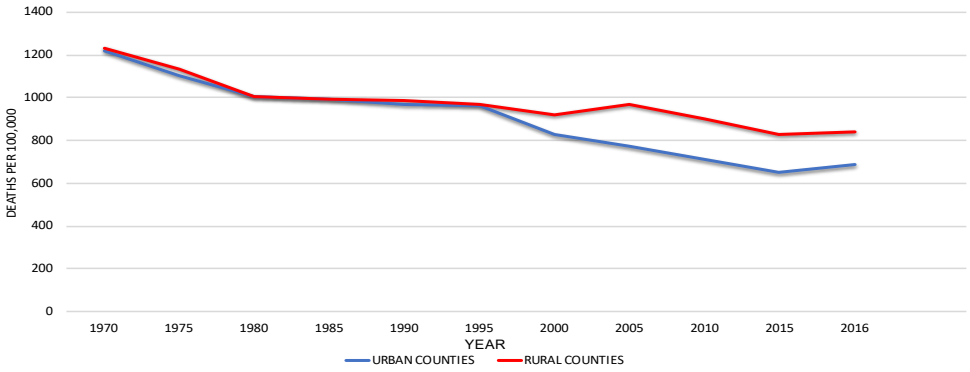
Rural health presents a unique set of health determinants that shape health. Rural Americans are older, poorer, more likely to be overweight or obese, and sicker, when compared to urban and suburban areas (Meit et al., 2014; Ziliak, 2019).

Physical Environment. Access to healthcare, working conditions, personal health, and the physical environment all play a role on health outcomes of rural Americans. For example, environmental pollutants can cause health problems like respiratory diseases, heart disease, and some types of cancer (Brusseau & Whitt-Glover, 2019). The physical environments of rural areas tend to pose a threat to health outcomes demonstrated by insufficient public water treatments, exposure to chemicals, deteriorating road infrastructures.

Health Care. People living in rural areas tend to have less access to adequate health care, as opposed to their urban/suburban counterparts. Healthcare workforce shortages and related difficulties recruiting healthcare professionals, health insurance status, transportation, health literacy, and stigma associated with conditions in rural areas are some of the major barriers that rural residents experience that impact their access to adequate health care (Lahr et al., 2021; MacKinney et al, 2014; see Figure 10).

Figure 10

Trends in Rural and Urban Age-Adjusted (All-Cause) Mortality for the United States, 1976–2016



Note. Figure created by content from, "Growth and Persistence of Place-Based Mortality in the United States: The Rural mortality penalty", (2019), by Cosby et al. of the *American Journal of Public Health*. https://doi.org/10.2105/AJPH.2018.304787. Copyright 2024 by the American Public Health Association.

Working Conditions. Rural businesses and industries often specialize in resource-based activities such as agriculture, forestry, mining, or natural amenity-based recreation (United States Department of Agriculture, n.d.). Some working conditions in rural areas are often more hazardous, due to the common industrial presence in the region requiring work that is more physical and enduring on a person's health, which in most cases predisposes these workers to become prone to injury and unfavorable health

conditions (Henning-Smith, 2019). For example, exposure to disease and animal waste for those working in animal production can lead to rural residents acquiring short- and long-term unfavorable health conditions (Rural Health Information, Social Determinants of Health for Rural People, n.d.). This dilemma could also impact families in passing down diseases through generations, due to the level of influence and direct effects of unhealthy environments has on individual and family health.

Personal Health. It is also clear that personal health of rural Americans is compromised due to unhealthy behavior [e.g., smoking and obesity], provoked by coping mechanisms and lifestyle changes to adjust to imposing living conditions of rural areas. A Center for Disease and Control and Prevention report highlighted that only one in four rural adults' practices at least four of five health-related behaviors that can prevent chronic disease such as not smoking, maintaining a normal body weight, being physically active, less alcohol intake, and getting sufficient sleep (Center for Disease Control and Prevention [CDC], n.d.).

Rural Health Outcomes

Rural health researchers, advocates, policymakers, communities, and programs generally describe rural populations as older, sicker, and poorer than urban populations (Rural Communities: Age, Income, and Health Status, n.d.). Gaps in health outcomes have widened between rural and urban areas over past three decades, and health outcomes are now significantly worse in rural than urban areas (Harrington et al., 2020; see Appendix B). Rural residents have shorter life expectancy than urban residents, due to the variance of influence on life expectancy from chronic disease and physical

inactivity (North Carolina RHRC, 2017; Singh et al., 2014; Rural Health Information Hub, 2018). Rural health also demonstrates the following: (a). drug overdose being among the leading causes of death in 2021, (b) suicide being among the leading causes of death in 2020 (Ivey-Stephenson et al., 2017; Mack et al., 2017). Researchers also indicated that environmental, economic, and social factors may predispose people living in rural areas at a higher risk of death than people who reside in urban and/or suburban areas (Rural Health Information Hub, 2018).

Rural Health Indicators

Neilson et al. (2017) and Garcia et al. (2019) found that rural Americans showed higher rates of the leading causes death than their counterparts in nonrural areas. Even though mortality rates have decreased overall, rural heath disparities continue to grow, when compared to non-rural areas of the United States (Garcia et al., 2019; James, 2014). Heart disease, diabetes, cancer, and unintentional injuries are rural health outcomes that require continual and immediate attention [because they contribute lower life expectancy of rural Americans] when compared to urban areas (Kochanek et al., 2019, Sequist et al., 2011; see Appendix B). Health researchers concluded that differences in cancer death rates were possibly due to disparities more than health care and proper diagnosis and treatment, along with behaviors related to tobacco use and obesity (Garcia et al., 2019; Morbidity and Mortality Weekly Report, 2017). As an example, the need for rural Americans to travel further to acquire health care prompts them to make crucial decisions [e.g., taking off from work] that could eventually impact their health status, which could lead to additional delays in health care that prolongs sick and illness status (Henning-

Smith, 2019; Warsaw, 2017). As another example, heart disease among rural residents has grown over the past decade, depicting rural areas having higher rates for cardiovascular disease and stroke, than urban areas between 1999 and 2009 (Garcia et al., 2017; Kulshreshtha et al., 2014; Quinn et al., 2019). An increase in cardiovascular deaths of women in rural areas has also driven the growth in maternity mortality over the past three decades (Center for Disease Control and Prevention, 2020).

Health Services. Differences in health services in rural areas play a significant role in rural health outcomes. The Center for Disease Control and Prevention Rural Health Series demonstrated that women aged between 18 and 64 who were enrolled in employer-sponsor health insurance revealed lower rates of generic testing for breast cancer gene mutations, which was detrimental for prevention and treatment decisions (Kolor et al., 2017). Rural Americans who do not have education above a high school education also demonstrated more prevalence to acquire more unfavorable health outcomes (Coughlin, 2019; Rutledge et al., 2017).

Environmental Injustices. Effects of unequal environmental conditions in rural areas pose a threat to rural health, due to rural Americans being exposed to vapor-gas, dust, and fumes among both agricultural and non-agricultural jobs (Doney et al., 2017; Marselle, et al., 2019; Thomas et al., 2018). According to the Center for Disease Control and Prevention, at least 15 % of the United States population is not served by approved public water systems, whereby rural areas being the location where rural Americans are most effected (Long et al., 2018; Prasanth et al., 2019). Based on reports of health

outbreaks in Canada and the United States, approximately 50 % of all waterborne diseases occur in small non-community drinking water systems (Pons et al., 2015).

Probst et al. (2016) compiled information on various components of the rural environment that may contributed to rural health outcomes and revealed the need for public health surveillance and solutions that entail multisectoral engagement. Tulimiero et al. (2020) conducted a study about healthcare access in rural Latino communities and concluded that structural and cultural barriers had impeded Latinos in rural communities to receive better health care. Increasing education about environmental injustices and those rural populations effected would be conducive to propagate rapid change for a more equitable healthcare system (Ashraf et al., 2022).

Community Health

A community consists of a group of people who share some or all the following: geographic boundaries; a sense of membership; culture and language; common norms, interests, or values; and common health risks or conditions (Bell & Newby, 2021; Institute of Medicine, 1995; Jewkes & Murcott, 1996; Ricketts, 2001; Ruderman, 2000). Members of communities often experience the shared reality of living or working in the same location or environment and can influence, and be influenced, by the social, economic, and physical risk factors in that environment (Bell & Newby, 2021; Roussos & Fawcett, 2000; Kreuter et al., 2001). Online groups are considered an extent of a community to demonstrate activities in geographic communities (Aglamaz & Rodriguez-Menes, 2021; Institute of Medicine, Committee on Assuring the Health of the Public in the 21st Century, 2002).

According to Himmelman et al., (2001) and Bell & Newby (2021), not only do communities consist of individuals and families, but also organizations and associations that make up a community's civil society [e.g., nonprofit, nongovernmental, voluntary, ethnic, and cultural groups, advocacy organizations, and faith community]. Organizations in a community serve as a medium between people and the community of the people (Bell & Newby, 2021; Himmelman et al, 2001). Most organizational members are from the public [e.g., local government officials and agencies] and private [e.g., private schools, colleges, universities, healthcare providers and payers, and small and large businesses] sectors who demonstrate health-related, and cooperative extension service responsibilities (Bell & Newby, 2021; Himmelman et al., 2001). While health serves as a function of community health, other factors [e.g., income, education, social connectiveness, employment, and access to quality care] are just as important to for shaping community health (Bell & Newby, 2021; Himmelman et al., 2001). Environmental constraints and inadequate physical infrastructures in a community effects lives of groups and populations in community, as well as the entire community itself (Bell & Newby, 2021; Humelman et al., 2000; Ruderman, 2000).

Role of Community Health

The core role of community health is to focus on the maintenance, protection, and improvement of health status of various population groups and communities, through a variety of disciplines among the medical and clinical sciences (Office of Disease Prevention and Health, 2018; Perry & Hodgins, 2021). Community health is the intersection of social, environmental, and economic resources to maintain the emotional

and physical well-being of people of a specific geographical region (A Discussion Document on the Concept and Principles of Health Promotion, 1986). Community health serves as an entity under public health to execute public health initiatives to assist community members to maintain and improve health, prevent the spread of infectious diseases, and prepare for natural disasters and pandemics (Perry & Hodgins, 2021). Community health is essential for stakeholders and policymakers to promote healthy living, and to help prevent chronic diseases in effort to bring the greatest health benefits to the greatest number of people in need (Centers for Disease Control and Prevention, n.d.).

Educational achievement, safety and crime, people's ability to work, life expectancy, and happiness are influential aspects on community health, and conversely community health acting as their influencer (Himmelman et al., 2001; Maraccini et al., 2017). A community that demonstrates unfavorable community health are inept to produce health gaps caused by differences in race, ethnicity, location, social status, income, and other factors that can affect health (Center for Disease Control and Prevention, n.d.).

Factors That Effect Community Health

Personal health behavior, physical location, social, cultural, healthcare organizational resource, and community organizing, are reckoned as key factors that affect the health of a community or population (Choudhary, 2021; Healthy People 2020, 2016). Diet, physical activity, sleep, substance use, and sexual activity are some examples of personal health behaviors (Short & Mollborn, 2015). Geography [or

landscape], environment, community size, and industrial development are examples of physical factors (National Research Council, 2013). Beliefs, traditions, and prejudices, economy, politics, religion, social norms, and socioeconomic status are examples of the social and cultural factors (National Research Council, 2011). Various healthcare facilities are examples of healthcare organizational resources. Federal, state/local health care, volunteer organizations, along with and organizational capacity in communities to address community issues are examples of the community organizing factor.

Personal Health Behavior. Personal health behaviors such as exercise, getting immunization, eating habits, and recycling are some of the health enhancing behaviors that serve as the personal behavior factor (United States Department of Health and Human Services, n.d.). Positive changes in personal behavior can reduce the rates of chronic disease (United States Department of Health and Human Services, n.d.). For example, a system that focuses on improving personal health behaviors related to activity nutrition, sleep, and tobacco-free living could have a profound impact on health and well-being (Teyhen et al., 2018). A variety of health themes demonstrated in a geographical area [along with health inequities, health disparities, polarization, scale, globalization, and urbanization] are also all related to community and public health (Asthana et al., 2002).

Physical Factors. Spatial location [the geographic context of places and the connectedness between places] is a physical factor that plays a major role in shaping environmental risks and health effects (Tunstall et al., 2004; Yuan et al., 2022). Geographical location provides stakeholders, health researchers, and health professionals

with an insight to identify patterns, causes, and diseases to plan and provision health services for various populations in an area (Fayet et al., 2020; Tunstall et al., 2004). Geographical locations entail natural environments that reveal various interactions between lifestyles, environment, occupation, social and health organizational infrastructure [e.g., distance between home and healthcare facilities and professionals] that provide fundamental understanding of health risk exposures (Dalghren & Whitehead, 1991; Fayet et al., 2020). Environmental change, demographic transition and the internationalization of health service organization are global issues that establish a geographical context for devising solutions to address community health and public health, due to the spreading of diseases, migration patterns, and population changes in geographical areas (Poku-Agyemang, 2018; Tunstall et al., 2004). Reducing health inequities involves the description and the clarification of how factors accumulate and interact in an area (Padilla et al., 2016).

Social Factors. Certain socioeconomic groups may bear more of the burden of environmental externalities than other groups are often prone to acquiring health conditions (Braubach, 2013; Deguen & Zmirou-Navier, 2010; on Behavioral & National Academies of Sciences, Engineering, and Medicine, 2021). Studies have indicated that persons with a low socioeconomic status in various geographical areas tend to be more exposed to environmental conditions and hazards (McMaughan et al., 2020; Padilla et al., 2016). Economic development, general living conditions, social well-being, and rates of illness are often identified as health indicators of various populations, as well as the

effectiveness of the healthcare system in a specific geographical area (Padilla et al., 2016).

According to Wright (2016), studies have shown that people with low social support levels demonstrate a higher risk of mortality compared to people who have stronger and more satisfying support networks. Positive forms of social networks have the capacity to reinforce health behavior change, which is why in most cases social support groups are considered valuable for encouraging positive health behaviors (Wright, 2016). The multi-use of social media and technical related platforms establishes social networking as an effective medium to encourage health behavior change (Al-Dmour et al., 2020; García del Castillo et al., 2020). Research on online support communities for people who have health problems indicates that online community members can attract the collective experience of participants who exhibit similar health issues in ways that are not possible in the face-to-face world, because the use of internet has a capacity to reach far across geographical boundaries (Wright, 2015).

Cultural Factors. Culture may also contribute to various health differences among populations in a geographical area. Due to the manifestation of ideas, values, customs, traditions, and beliefs exhibited among various populations in a geographical location, a specific population or group has the potential to shape individual and collective health behaviors in communities (Oteh et al., 2021). While culture emanates from the values and standards which people consider to be important, culture can manipulate healthcare systems and value structures that impact health (Oteh et al., 2021). The culture of a geographical area often leads people to label and assign meanings,

generate expectations for certain behaviors, and behave in particular ways (National Research Council, 2011).

Healthcare Organizational Resources. Among some communities, hospitals serve other functions beyond health (Hacke & Dean, 2017). Even though healthcare organizations frequently respond to root causes of illness, hospital and healthcare systems still lack a consistency to address the social determinants of health, especially among their surrounding communities (Hilt, 2019). Leider et al., (2017) concluded that most hospitals do not conduct community spending in health capacities areas, such as health improvement or physical infrastructure building activities (Leider et al., 2017). In some cases, there are prestigious and well-known hospital campuses adjacent to low-income neighborhoods and/or communities, which suggests that the increases in hospital revenue were not necessarily shared with community investment among adjacent communities for changing health outcomes (Diamond, n.d.).

Community Organizing

Community organizing is an interactive planned process to galvanize community to use social capital and resources to accomplish various community goals (Bracht, 1999; Pastor et al., 2017). Local organizations spur social and health changes in their communities through community members and by promoting community health (Bezborauh, 2013). Communities differ in their provision of public health, and majority of healthcare services for undeserved and vulnerable populations are often provided through private organizations and public service deliverers (Bezborauh, 2013; Pastor et al., 2017). Health scholars also understand the importance of nonprofits in service

delivery and advocacy for health promotion and health care (Haslam, et al., 2018; Marwell, 2004). Nonprofits and their partnering organizations provide healthcare services that are like public and for-profit organizations for underserved and vulnerable populations, and their value is more acknowledged with their interest in treating underserved and vulnerable populations with more dignity, respect, and trust to provide better access and affordable health care (Haslam et al., 2017; Schlesinger et al., 2005; Schlesinger & Gray, 2009).

Public health has recognized the importance of grassroots community organizing for tackling health disparities and health inequities (Minkler, 2012). Efforts to achieve health equity has emerged as a unique social movement frame that can exploit a universal sense of health while furthering other social justice concerns about inequality in at least three ways: (a) public policy innovation, (b) structural cause awareness, and (c) community organizing groups (Pastor et al., 2018). Community organizing engaged with a pursuit to achieve health equity encourages community organizing to frame advances to achieve equitable outcomes around key health measures (Pastor et al., 2018).

There have been previous studies to highlight the ramifications of community health and their contribution to health outcomes. Echaubard et al. (2020) conducted a case study in rural primary schools and households in two districts in Cambodia and revealed community engagement as a medium to create ownership of community health interventions. Berhane (2020) conducted a study about the significance of community collaboration relationships and revealed strategic solutions to barriers to understand organizational pathways to achieve health outcome goals in rural areas. Morales et al.,

(2023) conducted a study about addressing health disparities through community participation and results revealed that co-created public health actions produced opportunities to reduce health inequity and promote social change. Understanding the capacity and role of community health and community organizing provides a perspective to achieve necessary health outcomes in rural areas to promote well-being of individuals and community health.

Delmarva Region

The Delmarva Peninsula [also known as the Eastern Shore] contains a large portion of rural areas among the Maryland and Virginia counties of the eastern shore and state of Delaware. The name Delmarva was derived from the states that make up the region [Delaware, Maryland, and Virginia]. The Chesapeake Bay borders the western portion of the Delmarva Peninsula, and the Atlantic Ocean and Delaware Bay borders the eastern portion of the Delmarva Peninsula (Delmarva Peninsula, n.d.; see Figure 11).

Figure 11

Delmarva Peninsula

Note. Adapted from, *Delmarva Peninsula* by WorldAtlas.com, https://www.pinterest.com/pin/9992430406419009/. Copyright 2024 by WorldAtlas.

The Delmarva region has a rich history and diverse population from many cultures and backgrounds (Nabb Research Center Online Exhibits, n.d.). The peninsula was inhabited by Native Americans for thousands of years and was one of the first places in North America colonized by European and African immigrants (The Delmarva Region, n.d.). The Delmarva region has natural resources that makes it distinctive (The Delmarva Region, n.d.) This region is mostly rural and supports numerous urban and suburban locations through an influence of agricultural, maritime, lumbering, tourism, seafood, and industries of the Delmarva region. The Delmarva region is a couple of hours away from nearby cities, such as Baltimore, Maryland; Washington, D.C.; and Philadelphia, Pennsylvania [as well as their neighboring suburban areas] and other smaller cities [e.g., Salisbury, Maryland; Annapolis, Maryland; Dover, Delaware; Wilmington, Delaware; Virginia Beach, Virginia; and Richmond, Virginia].

Demographics of the Delmarva Region

There are 14 counties that comprise the Delmarva region. Kent, Queen Anne's, Talbot, Caroline, Dorchester, Wicomico, Somerset, and Worcester are the nine counties of Maryland. Kent, Sussex, and New Castle are the three counties of Delaware. Accomack and Northampton are the two counties of Virginia. To access the Delmarva region from locations of the United States, there are three main accessible entry points: (a) Chesapeake Bay Bridge [connecting western and eastern Maryland], (b) Chesapeake

Bay Bridge and Tunnel [connecting southeastern Virginia to eastern shore Virginia], and (c) commute from north to south [e.g., Pennsylvania]. The 14 counties make up the Peninsula of the Delmarva region.

The Delmarva region demonstrates common characteristics of other rural areas, such as natural resources, small population, poverty, and aging population (Food and Agricultural Organization, December 2018). When compared to other states of the Delmarva region and the nation, health disparities, health inequities, and differences in poverty, education, median household income, and population were greatly apparent (United States Census Bureau, n.d.; World Life Expectancy, n.d.) When compared to the poverty rate of the United States [as a whole], at least half of the counties in the Delmarva region demonstrate a higher poverty rate (United States Census Bureau, n.d.) When compared to the United States as a whole, the Delmarva region has lesser persons who attained a bachelor's degree or higher (United States Census Bureau, n.d.) When compared to the United States as a whole, half of the counties in the Delmarva region demonstrate lesser household median income (United States Census Bureau, n.d.) When compared to the United States as a whole, majority of the counties of the Delmarva region displayed a higher percentage of an older adult population (United States Census Bureau, n.d.) When compared to the United States as a whole, majority of the Delmarva region demonstrate a lesser percentage of individuals who are aged at 65 years or older that do not have health insurance (United States Census Bureau, n.d.) When compared to the United States as a whole, majority of the Delmarva region demonstrates a higher percentage of individuals who are under the 65 years with a disability that do not have

health insurance (United States Census Bureau, n.d.; see Figure 10 and Appendices A, C, D, and E).

The counties of the Delmarva region reveal differences in the leading causes of death when compared to the encompassing states of the Delmarva region, as well as the United States as a whole. For example, there were higher incidences of heart disease, cancer, and stroke, when compared to similar incidents of Delaware, Maryland, Virginia, and United States (United States Census Bureau, n.d.; World Life Expectancy, n.d.). As another example, regarding stroke incidences, almost all the counties among the Delmarva region demonstrated higher incidences of stroke, when compared to stroke incidences of the United States (United States Census Bureau, n.d.; World Life Expectancy, n.d.). Kent County, Delaware of the Delmarva region displayed a higher incidence of stroke than the entire state of Delaware; Accomack and Northampton counties of the Delmarva region displayed a higher incidence of stroke when compared to the entire state of Virginia; and Wicomico, Dorchester, Talbot, Kent, Caroline, and Cecil counties of Maryland displayed higher stroke incidences than the entire state of Maryland (United States Census Bureau, n.d.; World Life Expectancy, n.d.).

In regards of cancer incidences, the entire Delmarva region demonstrated higher cancer incidences of stroke, when compared to the cancer incidences of the United States (United States Census Bureau, n.d.; World Life Expectancy, n.d.). All the Maryland counties of the Delmarva region displayed higher cancer incidences when compared to the entire state of Maryland; all the Delaware counties of Delmarva region displayed higher cancer incidences when compared to the entire state of Delaware; and all the

Virginia counties of the Delmarva region displayed higher cancer incidences when compared to the entire state of Virginia (United States Census Bureau, n.d.; World Life Expectancy, n.d.).

Regarding heart disease, the entire Delmarva region demonstrated higher heart disease incidences, when compared to the incidence of heart disease of the United States (United States Census Bureau, n.d.; World Life Expectancy, n.d.). All the Maryland counties of the Delmarva region displayed higher incidences of heart disease than the entire state of Maryland; all the Delaware counties of Delmarva region displayed higher incidences of heart disease when compared to the entire state of Delaware; and all the Virginia counties of the Delmarva region displayed higher incidences of heart disease than the entire state of Virginia (United States Census Bureau, n.d.; World Life Expectancy, n.d., [refer to Appendix F]). Due to the health outcome statistics of the Delmarva area, it is evident that the Delmarva region demonstrates health disparity issues. Leadership research to address health disparity concerns among the rural landscape of the Delmarva area is relevant to enhance community health in the region. Purnell et al., (2016) and Martin et al., (n.d.). discussed gaps in knowledge and translation regarding rural and low-income populations experiencing access quality health care, and highlighted factors that influenced disparities in access to care and quality of healthcare services. Moran et al., (2019) also similarly highlighted in a study by discussing the importance of research capacity building in healthcare to generate and apply new knowledge to improve health outcomes among rural settings.

Faith-Based Organizations

A FBO is an organization whose values are based on faith and/or beliefs and conducts activities through a specific faith group by a mission derived from the social values of a particular faith (Bielefeld & Cleveland, 2013; Tagai et al., 2018). FBOs have also been involved in humanitarian relief (Khafagy, 2020). Not only are FBOs viewed as active grass-root organizations of local communities but are also viewed as active grass-root organizations at an international scale (Christens et al., 2021; Ferris, 2005). The organizational size, structure, and interest of FBOs also vary (Khafagy, 2020). Funding for FBOs is often from member donations, and from federal, state, and international grants (Fritz, n.d.) Volunteers make up some of the professional staff of FBOs, and their missions adhere to efforts that have continuing societal impacts (Khafagy, 2020). FBOs encounter challenging boundaries that entail interactions among a mission [and/or missionary] whether functioning as a humanitarian or religious activity. The common organizational boundaries of FBOs inherits connections with community and religious organizations, as well as connections with federal, state, and local governments (Christens et al., 2021; Watson, 2012).

Context of Faith-Based Organizations

During the eighteenth and nineteenth centuries, mission societies provided medical aid under colonial governments in Asia, Africa, and Latin America, which are still demonstrated in developing countries today (Kagawa et al., 2012). In the 1980's FBOs continued their involvement in humanitarian relief all over the world, especially for economically distressed countries, communities, and regions (Khafagy, 2020).

Policies of various countries that favor less engagement with government, in consort with the provision and funding implication of diasporas [dispersion of people from their original homeland/country], and the influence of identity politics have resulted in the increased dependence on FBOs (Tadros, 2011).

Identity politics influenced FBOs among major denominations of religions [e.g., Islam, Christianity, and Hinduism] to become more pronounced with service provision to solidify their religious identify among their constituency (Tadros, 2011). The engagement of FBOs in post-war periods was momentous to undeveloped societies becoming more developed [or modern] to receive more secular assistance than non-secular assistance (Cooper, 2019). By the 1990's FBOs began to attract attention from notable donors and the development of international policy became more prominent, especially in the United States (Cooper, 2019).

History of Faith-Based Organizations

The most common FBOs are congregations and houses of worship (Cnaan & Curtis, 2013). Congregations and houses of worship are considered as prominent social service providers. However, the organizational capacity of FBOs also entail other organizational entities aside from congregations and houses of worship consisting of other organizations that provide humanitarian, relief, and other related service.

Social welfare had evolved from the application and practice of religion, from a concept of love and care for others (Langer, 2003; Placido, 2015). In ancient times, religion practices and entities had served the needs of others all over the world (Adkins et al., 2010). In medieval Europe, monasteries and convents of the Roman Catholic church-

built orphanages, hospitals, leprosariums, and universities (Adkins et al., 2010). During this period, institutional churches taught children and adults, nursed the sick, fed and sheltered orphaned children and tended to the needs of the poor through their church facilities (Adkins et al. 2010). After the Protestant Reformation [Religious Reform Movement that occurred in Europe during the 1500s A.D.], the catholic church lost power, wealth, and capital, which led to less provision of social goods that occurred before the Protestant Reformation (Adkins et al., 2010). For hundreds of years, religious organizations have offered charity and social services to the poor (Adkins et al., 2010).

Since the inception of modern times, eventually non-religious organizations around the world took the lead in providing social welfare (Trattner, 1999). In the 1980's the World Bank included FBOs in strategic planning and launched the World Faiths Development Dialogue, which brought together the World Bank and leaders from the world's faiths to discuss development issues (World Faiths Development Dialogue, 2009). The United Nations also formulated millennium development goals which included the engagement of faith groups (World Faiths Development Dialogue, 2009). Academic scholarship of this phenomenon was established, and the increased visibility of the role of religion and FBOs continued to be recognized (Cooper, 2019).

In the United States, congregational and religious involvement in social ills began long before the onset of the Constitution (Adkins et al., 2010). In pre-modern periods in the United States [colonial and early American history], social welfare was provided mostly by only religious organizations, or in partnership with secular agents (Bielefeld & Cleveland, 2013). For example, during the 19th century, the Social Gospel movement

emerged to combat societal forces that contributed to poverty and inequality and insisted that Christians had responsibility to work for the transformation of social order (Adkins et al., 2010). Parachurch organizations [also known today as FBOs] also arose during the 19th century to address the needs of the urban poor through humanitarian aid which consisted of emergency food and various social services (Adkins et al., 2010).

Regarding designing social welfare systems in the United States, the modernization framework became under scrutiny in the latter decades of the twentieth century (Orloff, 1993), which drove opportunities for re-assessments of religion contributions for providing human services (Bielefeld & Cleveland, 2013). In the United States, various legislation was created to recognize FBOs as means to meet the needs of poor Americans and communities.

The emergence of FBOs spawned from the trials and tribulations of the United States government to effectively establish programs to address and manage the various needs of people. During the 1930's, the Social Security Act enhanced the role of government in responding to the needs of the unemployed and needy in America (Placido, 2015). In the 1940's public spaces [e.g., education] became more secular and gravitated away from the promotion of religion (Kaeger & Stoesz, 2008). In the 1960's, prayer and bible teachings were removed (Placido, 2015). In the 1970's tax support for parochial schools [schools supported by a church] was decreased (Kaeger & Stoesz, 2008).

Most of the inception and development of FBOs occurred during President Clinton Administration to tune up social welfare policy and program in the United States

(Placido, 2015). The Personal Responsibility and Work Opportunity Reconciliation Act [Welfare Reform of 1996] had shifted primary responsibility for human service delivery to state and local communities and provided a space for religious organizations to be involved (Bartowski & Regis, 2003). The Charitable Choice provision of the Welfare Act considered the faith-community as a valuable resource among stakeholders to address social needs (Kennedy & Bielefeld, 2006). According to Cooper (2019), between 2001 and 2005, 159 FBOs received 1.7 billion United States Dollars in contract, grants, and agreements by the United States Agency for International Development. On January 29, 2001, President Bush created an Executive Oder to establish a White House Office of Faith-Based and Community Initiatives to help the federal government coordinate a national effort to expand opportunities for faith-based and other community organizations and to strengthen capacity to better meet social needs in America's communities (Olarinmoye, 2012). On February 5, 2009, President Barack Obama created amendments to the previous Executive Order of President Bush by establishing an advisory council for Faith-Based and Neighborhood Partnerships to deliver services effectively in partnerships with Federal, State, and local governments, in conjunction with other private organizations to address the needs of low-income and other underserved persons and communities (Olarinmoye, 2012). On May 8, 2018, President Donald Trump created an Executive Order to establish a White House Faith and Opportunity Initiative to assist faith-based and other organizations to strengthen the institutions of civil society and American families and communities by allowing FBOs to compete for federal funding opportunities.

The Role of Faith-Based Organizations

The main role of FBOs is to provide social service delivery to address the many facets that contribute to the well-being people (Cnaan, 1999). FBOs serve a complementary role for the provision of social services through their emphasis on transitional assistance, multi-service orientation, and their reliance on interventions (Graddy, 2008). FBOs, along with other civil society organizations are actively involved with international and national development, and disaster assistance through partnerships and investments that are geared toward saving lives, reducing poverty, strengthening democratic governance (Global Health News, 2018). For some cases, FBOs have been providing services [particularly health and education], for both their own faith communities and the wider community, and in both their own countries and internationally for a very long time (Deakin & Tomalin, 2015). In the health sector, FBOs are known to engage with service delivery, and are very active in remote areas among the world (Global Health News, 2018).

Among rural areas, FBOs serve as a safety net to address shortcoming on state delivery of basic needs. FBOs play a significant role in health care and social service throughout the world which stem from the funding capacity of donors, as opposed to other secular organizations. FBOs are also closer to the poor than other secular organizations, which strategically position FBOs to make better contributions for poverty reduction. FBOs often have organizational links with other organizations in their communities through common interests, which catalyze potential organizational development efforts for communities to respond to various issues and concerns in

communities. FBOs have capacity to bring change in human societies through political, economic, and social areas of interest.

Rural regions in the United States demonstrate a unique relationship with religion and have the capacity to support opportunities to utilize current and future organizational and community connections to increase health behaviors (Martin et al., n.d.) Policymakers, health professionals, and spiritual leaders can improve rural health by partnering with FBOs to decrease health disparity and health inequity gaps in rural areas (Singh & Siahpush, 2014). FBO can provide geographical convenience, volunteers, cultural competency, and a community legacy to healthcare providers' efforts to improve access to healthcare in rural communities; the relationships between healthcare providers and the spiritual communities are, therefore, a natural partnership (National Center for Cultural Competence, n.d.) With religious institutions being a key construct in rural communities, they offer access to rural ethnic/racial groups that are concentrated in specific geographical areas (National Center for Cultural Competence, n.d.)

FBOs also serve as economic engines in rural communities through a variety of outreach and engagement capacities in communities to respond to various social [e.g., substance abuse, violence, poverty, crime, malnutrition, disaster relief, and unemployment] and community [e.g., environmental injustice, unfavorable health outcomes, climate change, homelessness, pollution, and access to technology and health care] dilemmas that benefit the well-being of underserved and vulnerable populations in rural areas (Huff, 2020). Mshana et al. (2018) highlighted literature to support FBO opportunities to engage as a community leader to improve health access through utility of

community health and social programs. Shoesmith et al. (2020) provided insight on organizational features of FBOs to improve collaboration among various health and FBOs to improve access to care and health outcomes in rural areas. A study by Jansen (2020) provided insight on the utility of FBOs to impact boundary spanning, to address the health needs of underserved and/or vulnerable populations in rural areas. A study by Robles et al. (2019) provided an assessment of FBOs to support how FBOs influence healthy behaviors through partnering with local health departments. Harmon et al., 2020 conducted a study that examined the needed, barriers of health programs of FBOs and revealed that effective leadership and collaboration overcame certain barriers related to trust and health behavior norms.

Transformational Leadership

The term ‘transformational leadership’ was initially introduced by James Downton in a 1973 paper about rebel leadership (Downton, 1973). James Burns expanded the concept of ‘transforming leadership’ in his descriptive research on political leaders (Burns, 1978, 2003). Burns concluded that transforming leadership was a process in which leaders and followers support each other to advance to a higher level of morale and motivation (Burns, 1978, 2003). Burns established two concepts [transactional and transforming] to differentiate management and leadership (Burns, 1978). Burns mentioned that the two leadership styles were mutually exclusive, and that transactional leadership was embedded in a give and take relationship, whereas, transforming leadership was embedded in the leader’s personality, leading by example, and communicating a vision and goal (Burns, 2003).

During the 1980's, Bass (1985) extended the work of Burns (1978) by articulating the psychological mechanisms that grounded transforming and transactional leadership and created the term "transformational" instead of "transforming leadership." Bass (1985) and other researchers established nine factors [transformational: idealized influence, inspirational motivation, intellectual stimulation, individualized consideration; transactional: contingent reward; and laissez faire: absence of leadership] that contributed to the full-range leadership model (Diaz-Saenz, 2011). Full-range leadership model entailed the leadership factors of transformational, transactional, and laissez-faire leadership.

Bass (1985) began to focus on transformational leader factors and noticed leaders who became roles models had followers that wanted to identify and imitate those leaders. He noticed those leaders' providing pathways for their followers to meet their vision (see also Diaz-Saenz, 2011). Bass also recognized that leaders had encouraged followers to revisit old problems in new ways and examine old assumptions for feasibility (Diaz-Seanz, 2011). Bass (1985) had also observed leaders focusing on the needs, abilities, and aspirations of followers (Diaz-Saenz, 2011).

Even though Bass conducted research related to full-range leadership and transformational leadership, he proposed that the most effective approach for leaders were to demonstrate both transformational and transactional leadership factors (Bass, 1985; Diaz-Saenz, 2011). In the 1990's, Waldan and his colleagues, expressed the importance of augmenting transformational leadership, besides the effect of transactional leadership, due to its value for enhancing optimal performance (Avolio et al., 1991). In

the early 2000's, numerous studies and papers about transformational leadership evolved for examining the relationship between transformational leadership and follower performance (Antonakis, 2012; Wang et al., 2011).

Contributors of Transformational Leadership

Not only were Bass and Burns instrumental with the development of transformational leadership, other contributors had also conducted research on transformational leadership (Arthur, 1994; Avolio et al., 1999; Barbuto, 1997; Becker & Grant, 1996; Beyer, 1999; Bycio et al., 1995; Carless, 1998; Den Hartog et al., 1997; Goodwin et al., 2001; House, 1977; Lower et al., 1996; McClelland, 1975; Mey & Allen, 1997; Tejeda et al., 2001; Tepper and Percy, 1994; Vadnerberg et al., 1999; Yukl, 1999; and Weber, 1968). Bennis and Nanus (1985) presented a model of transforming leadership that delineated four conventional strategies used by leaders in transforming organizations: (a) having a clear vision of the future state of their organization; (b) social architects capable of mobilizing followers to accept a new group identity; (c)creators of trust within their organizations; and (d) leaders capable of using creative deployment of self. Kouzes and Posner (1987, 2002) conducted qualitative research to come up with five fundamental practices that allowed leaders to accomplish extraordinary things: (a) modeling the way; (b) inspiring a shared vision; (c) challenging the process; (d) enabling others to act; and (e) encouraging the heart.

Posner and Kouzes (1988) had also developed the leadership practice inventory to measure these five fundamental leadership practices. Another model of Bass' transformational leadership was developed that was conceptually similar by highlighting

six transformational leadership factors: (a) articulating a vision, (b) providing an appropriate model, (c) fostering the acceptance of group goals, (d) having high-performance expectations, (e) providing individualized support, and (f) having individualized consideration (Podsakoff et al., 1990). The contributions of Posner and Kouzes, and Bass laid the foundation for subsequent developments to measure and scale leadership. The multi-factor questionnaire and transformational leadership questionnaire were the resulting developments.

Research on Transformational Leadership

The multifactor leadership questionnaire developed by Avolio and Bass (1990), revealed transformational leadership for having a major impact on individual and team performance, satisfaction with the leader, and positive workplace attitudes and behaviors. The multi-factor leadership questionnaire had demonstrated the effects of transformational leadership on follower attitudes, and increase organizational citizen behavior, and followers' well-being (Cho & Dansereau, 2010; Dumdum et al., 2002). In a more recent study, the multi-factor leadership questionnaire had highlighted transformational leadership to be positively related to individual, team, and organizational level performance (Wang et al., 2011).

Dvir et al. (2002) conducted longitudinal randomized field test and revealed that leaders who had transformational leadership training had a more positive impact on direct followers' leader development, than did leaders in the comparison group that received comprehensive leadership training. Some studies have also declared that higher productivity, lower employee turnover rates, higher job satisfaction and self-motivation

occur more from the application of transformational leadership than transactional leadership (Atan & Mahmood, 2019; Hautala, 2016). These backgrounds gave way to the development of additional leadership scales. As an example, Rafferty and Griffin (2004) tested behaviors of leaders who demonstrated transformational leadership that led to the development of a transformational leadership scale that had identified five dimensions: (a) vision, (b) inspirational communication, (c) supportive leadership, (d) intellectual stimulation, and (c) personal recognition by testing behaviors that were demonstrated by leaders who were transformational.

Transformational Leadership Theory

According to Burns (1978, 2003) a leader is perceptible as transformational when leader's support and encouragement advance the level of followers' morals, motivation, beliefs, perceptions, and association according to the objectives of the organization (Bass et al., 1987; Metwally & El-bishbishy, 2014). Transformational leadership onsets when a leader inspires followers to share a vision, by empowering them to achieve the vision with necessary resources to rise their personal potential (Avolio & Gardner, 2005; Bass et al., 1987; Smith et al., 2004). Leaders who demonstrate transformational leadership often serve as idols and support positivity by rising employees' sense of self with structural values (Avolio & Gardner, 2005; Bass & Riggio, 2006; Smith et al., 2004). Transformational leadership extends transactional leadership by highlighting the transaction or exchange that occurs among leaders, colleagues, and followers (Bass, 2006). Transformational leadership also satisfies basic and higher needs through inspiring

and motivating followers to provide innovative solutions (Claudine, 2015; Liu et al., 2019).

Transformational leadership escalates the consciousness of followers by appealing to higher ideals and values, and accentuate new ideas for transforming organizational culture, (Joyce & Judge, 2004; Sarros & Santora, 1995). Leaders who are transformational motivate followers to achieve performance beyond expectations, due to the transformation of followers' attitudes, beliefs, and values (Bass et al., 1987, Yukl, 1989). Transformational leadership also demonstrates the concerns for achievement, self-actualization, and the well-being of others, the organization, and society (Bass, 2006; Liu et al., 2019). Leaders who are transformational, stimulates followers to go beyond the interests of themselves for the good of the team, organization, and/or society to achieve the organization's mission and vision (Hautala, 2016; McNair, 2019; Metwally & El-bishbishy, 2014).

Leaders who demonstrate transformational leadership have interest to maximize their leadership by focusing on their followers and organization. These leaders lead by example and maximize the potential of their followers. Leaders who are transformational exercise specific tactics to attain optimal level of organizational performance. By focusing on the needs of their followers, these leaders exhibit capacities to influence and motivate others to achieve their vision, mission, and goals.

Four Dimensions of Transformational Leadership Theory

In result of prior research from various leadership researchers, Burns had concluded four main elements of transformational leadership: (a) idealized influence, (b)

inspirational motivation; (c) intellectual stimulation; and (d) individual consideration (Avolio & Gardner, 2005; Bass, 1999; Meit et al., 2018; Shrestha, 2020).

Idealized Influence. Idealized influence refers to leaders who act as solid role models for their followers, due to their capabilities and ethical conduct (Avolio & Gardner, 2005). Leaders who demonstrate transformational leadership attain admiration, trust, and respect from their followers (Avolio & Gardner; Bass, 2006). These leaders provide a clear vision and mission for their followers and/or organization which results in high levels of respect and trust from their followers (Avolio & Gardner, 2006; Meit et al., 2018).

Inspirational Motivation. Inspirational motivation entails the leaders' ability to motivate followers to perform beyond expectation (Jain, 2015, Meit et al., 2018). The aim for this dimension is to raise the consciousness of followers about the organization's mission and mission, encourage, and making followers commit to the organization (Kirkbride, 2006). These leaders who are motivated to fulfill goals with this dimension tend to demonstrate a cooperative vision that are rational to followers (Metwally & El-bishbishy, 2014). This dimension also enables leaders to align individual and organizational goals to achieve organizational goals for the benefit to also achieve personal goals (Seloane, 2010).

Intellectual Stimulation. The intellectual stimulation dimension focuses on effort to question expectations, reframing impediments, and forecast new ideas (Bass, 2006, Meit et al., 2018). Leaders who demonstrate this dimension stimulates followers to critically think through issues and problems for themselves for developing their own

abilities (Kirbride, 2006). Followers are encouraged to engage in new approaches without the worrisome of criticism (Bass, 2006). Intellectual stimulation generates empowerment and continuous improvement to followers or people (Reza, 2018).

Individual Consideration. The individualize consideration dimension provides attention to followers' needs for self-actualization and growth by acting as a coach or mentor (Bass, 2006, Meit et al., 2018). Individualized consideration is enacted when new learning opportunities are upheld with a supportive climate (Avolio & Bass, 1995; Bass, 2006). This dimension recognizes differences among people regarding their strengths and weaknesses, and similarities and differences, and used by leaders for considering the needs of their followers through preparedness and encouragement for the development of appropriate behavior (Kirkbride, 2006; Sarros & Santora, 1995).

The four dimensions of TL expressed by Burns (2003) provides a significant influence on the attributes of followers. Work attitudes and the behavior of followers were acknowledged as prominent attributes. Follower job satisfaction, follower job performance, follower creativity, follower organizational citizen behavior, and follower organizational commitment are the main outcomes driven by the four dimensions of TL (Keskes, 2014).

Summary of Transformational Leadership Theory

Bass (1985) and Burns (1978) originated transformational leadership from their research or political leaders, which drove the development of leadership characteristics and the concept of full-range leadership. Other leadership researchers proposed the ideal to separate TL (Waldan et., al, 1990), due to its impact on organizational performance.

Additional research was continual, which led to further developments of TL (Burns, 2003). TL (Burns, 2003) began to research its application and relevance on individual and organizational outcomes. Leadership strategies, practices, factors, and models, along with the onset of specific leadership measurement instruments, had fostered the growth of general leadership research and matured the development of TL research (Burns, 2003). Research findings from various leadership measurement instruments and analysis had yielded a variety of leadership outcomes. Leaders who demonstrate transformational leadership tend to foster the growth of their followers and organization. Among the numerous studies, research findings, and leadership instrument developments, four dimensions of TL were generated (Bass & Bass, 2008; Burns, 2003).

Faith Leader Opportunities

Faith plays an important role to recognize and motivate others (Podaskoff et al., 1990). FBOs [particularly churches] have historically served the poor and the underserved throughout the world (Dawkins, 2011; Raney & Raveloharimisy, 2016). While FLs of FBOs frequently provide necessary leadership to manage resources to underserved populations within their communities, it is important to understand the transformational effect of FLs on how they contribute to the enhancement of community health and individual well-being in rural areas.

A multi-level faith-based public health initiative in rural Alabama demonstrated social change by enhancing health outcomes regarding health behaviors, and development of others through health education (Powers et al., 2019). A study conducted by Mehrad et al. (2020) provides insight on how transformational leadership could be

used as a facilitator to enhance collaborative partnerships to achieve goals and desired health outcomes for vulnerable communities. A study by Mayberry et al. (2020) favors the potential of FLs to serve in a capacity to engage in prevention behavior strategies to impact community health, as well as contribute to the building of necessary resource capacities in underserved communities to influence social and health norms. Echaubard et al. (2020) conducted a case study describing the processes of community engagement and transdisciplinary collaboration and revealed FLs catalyzing processes of community engagement toward ownership of community health interventions through health community organizations. Withers (2020) conducted a study of pastoral leadership and revealed insights on leadership styles that were conducive for collective actions and coordination design to facilitate a community-based outreach for opiate addicted millennials.

Social Ecological Model

Previous contributors fostered the evolution of the SEM. These contributors have aided the conceptualization, principles, and philosophical views of social ecology. Social ecology is the study about the relationship between ecological and social issues (Bookchin, 2007). Kropotkin brought attention to the complex conception of nature concerning mutual aid, political and economic decentralization, human-scaled production, communitarian values and the history of democracy (Clark, 2000). Reclus advanced the concept of social geography for social ecology by the exploration on the history of the interaction between human society and the natural world (Clark, 2000). Geddes philosophy of the biosphere brought attention to the need to create decentralized

communities in harmony with surrounding cultural and ecological regions and proposed the development of new technologies that would cultivate humane, ecologically balanced communities (Clark, 2000). Mumford's considered the battles between freedom and oppression among history provided insight on the strengths and creativeness of a self-sustaining environment and a need for a balanced communal life (Clark, 2000). McLeroy and his colleagues declared that health was not solely determined by biological factors, but also by a collection of subsystems that occur at various levels (McLeroy et al., 1988). The most famous contributor was Bookchin, regarding his insight on understanding environmental issues through a belief that a human can and should control nature, from a standpoint that life and society should be viewed as ecosystem, where all the moving parts are equally important to a healthy stable and sustainable environment (Bookchin, 1965; Clark, 2000). These contributors facilitated the evolution and progression of thought, research, and continual evolution of the SEM.

Origins of the Social Ecological Model

Not only have the contributors of SEM guided the origin of SEM, but there have also been philosophical connotations that supported SEMs' evolution. The concept of systems thinking served as the core foundation of SEM. To fully understand something [or an occurrence], systems thinking brings insight about the need to understand the parts that are relative to the whole (Susser & Susser, 1996). System thinking has been applied for prior developments of ecological theories related models (Bánáthy, 2000). Systems thinking facilitated the notion of social ecology in effort to understand natural ecosystems for establishing theoretical principles to comprehend the dynamic interrelations among

various personal and environmental factors (Schulze, 2005). The interdependence and homeostasis concepts of system theory was captured by social ecology to exemplify differentiate reciprocal and dynamic person-environment transactions (Stokols, 1992, 1996)

Bronfenbrenner applied the concepts of SEM for understanding human development in the 1970s and enacted SEM as a theory in the 1980s (Bronfenbrenner, 1977, 1986, 1989). Bronfenbrenner applied his ecological framework to human development from an inclination that the entire social ecological system that influence growth was applicable to human development (Bronfenbrenner, 2006). Bronfenbrenner engaged in many revisions by not only acknowledging the biological and genetic aspects of a person in human development, but also psychological aspect (Bronfenbrenner, 1977, 1986, 1989, 2006). Bronfenbrenner initial theory focused on the importance of place, and during various theory revisions, Bronfenbrenner also focused on the interrelatedness of the ecological-stressing person-context (Bronfenbrenner, 1989).

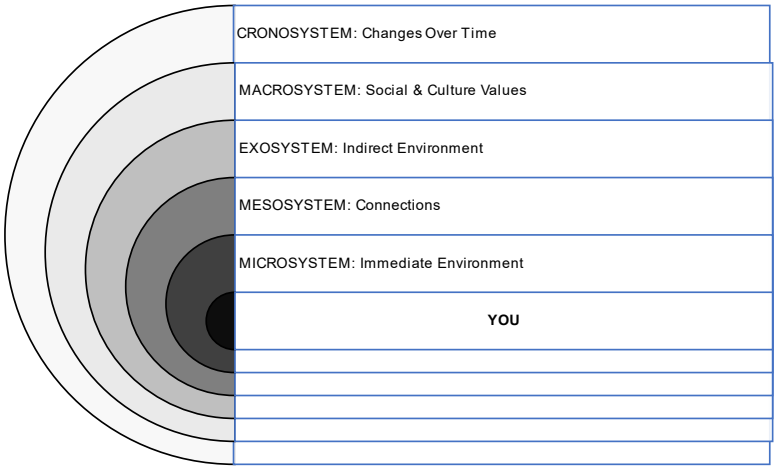
To better understand human development, Bronfenbrenner purported ecological systems theory to explain how everything in a person's environment affects how a person grows and develops, from a child perspective (Wolfe & Mash, 2019). Bronfenbrenner insisted that the entire ecological system was relevant and that they were socially organized subsystems that support and aid human growth development, in which each system influences each other (Bronfenbrenner, 2005). In today's era, regarding new technological developments, Bronfenbrenner's theory can still be applied to adapt to the new technologies of today's exosystem [e.g., social media, video gaming, and other

modern-day interaction within the ecological system] to support and aid human growth development (Bronfrenbrenner, 2005; Hayes et al., 2017).

As the initial model acknowledged the many contributors to human development, subsequent revisions and adoptions of SEM were used to represent multilevel approaches in various areas, such as public health promotion, violence prevention, healthy college campuses, geriatric preventive health, and colorectal cancer prevention (American College Health Association, n.d.; Centers for Disease Control and Prevention, n.d.; Polit & Beck, 2012; see Figures 12 and 13).

Figure 12

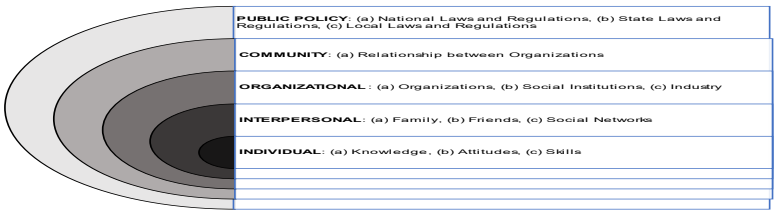
Urie Bronfenbrenner's Ecological Theory



Note. Adapted from, "The Ecology of Human Development", *Harvard University Press*, 2006. Copyright 2024 by Presidents and Fellows of Harvard College.

Figure 13

Ecological Model: Five Levels of Influence on Health Behavior



Note. Adapted from, *Ecological Models*: *Five Levels of Influence on Health Behavior* by Stokols, 1996. https://doi.org/10.4278/0890-1171-10.4.282. Copyright 2024 by American Psychology Association.

Factors of the Social Ecological Model

Bronfenbrenner proposed that the total ecological system that influence human growth and development was comprised of five subsystems for aiding human growth and development, in which each subsystem is dependent on the person's relative nature for advancing exposure to variety of options for growth and development, through the dynamic interactions among subsystems (Bronfenbrenner, 1999).

Microsystem. In effort to understand human growth and development from a child's perspective, a child's first encounter with structure, relationships, and interaction are demonstrated in the microsystem (Bronfenbrenner, 1999; Kilanowski, 2019). The SEM for Health views the microsystem as the intrapersonal/individual factor for the five

levels of influence on health behavior (Rural Health Information Hub, 2002-2021). Immediate organizations such as family, school, churches, peers, health services, neighborhoods are structures that impacts growth and development, and serves as a learning resource for establishing the necessary relations and interactions to achieve trust, healthy personalities, and understanding of the world (Berk, 2000; Pipher, 1996; Rogoff, 2003; Swick, 2004).

Mesosystem. The mesosystem is the second subsystem in which the child begins to experience connectedness with the structures, relations, and interactions of the microsystem, like a child/parent, church/neighborhood, or child/peer connection (Kilanowski, 2017; Swick & Williams, 2006). The SEM for health views the mesosystem as the interpersonal factor for the five levels of influence on health behavior (Rural Health Information Hub, 2002-2021). This factor served as intermedium facilitator of a child's immediate interaction with various personal and non-personal relationships.

Exosystem. The exosystem is a subsystem that encompasses a larger system that is not immediately or actively encountered by a child, and often indirectly impacts the child's development through imposing structures [e.g., industry, community, politics, social networks] that influence connectedness and/or interaction with their immediate systems (microsystems and mesosystems; [Bronfenbrenner, 1994; Galinksky, 1999; Kilanowski, 2017]). The SEM for Health views the exosystem as the organizational factor for the five levels of influence on health behavior (Rural Health Information Hub, n.d.). The exosystem is an external factor that indirectly serves as a major influencer the manifestation of health behavior.

Macrosystem. The macrosystem is a subsystem that refers to the larger cultural context [e.g., social conditions, attitudes, social classes, ethnic groups, and/or religious affiliates] among a child's environment that induces the child's nature to fulfil relations; (Belgrave & Brevard, 2005; Bronfenbrenner, 2005; Garbino, 1992; Kilanowski, 2017; McLaren & Hawe, 2005; Swick, 2004). The SEM for Health views the macrosystem as the community factor for the five levels of influence on health behavior (Rural Health Information Hub, n.d).

Cronosystem. The cronosystem is the last subsystem that refers to the aspect of time that serves as an external [e.g., laws and policies pertaining to health] and/or internal [family dynamics, psychological changes] element effecting a child's welfare (Bronfenbrenner, 1989; Bronfenbrenner, 2006; Kilanowski, 2017). The SEM for Health views the cronosystem as the public policy factor for the five levels of influence on health behavior (Rural Health Information Hub, 2002-2021).

SEMs' (Bronfenbrenner, 1989, 1999, 2005, 2006) focus is to illuminate interactions among a person's environmental interaction, and to progress related person-environmental transaction to foster human growth and development according to various environmental contexts (Golden & Earp, 2012; Scarneo et al., 2019). The interaction and interdependence of the subsystems of SEM has an impact on health behaviors, and often serve as the root of most health problems through personal interactions with their physical and sociocultural environments (Rimer et al., 2005). Social determinants of health and health disparities are key social conditions that are attributed to the myriad of

socioeconomic, behavior, environmental, and policy influences described in the subsystems of SEM (Ferrer, 2018).

The Social Ecological Model and Health Outcomes

The factors of the SEM influence daily decisions and health. According to Belgrave & Brevard, 2005; Berk, 2000; Bronfenbrenner, 1994; Bronfenbrenner, 2005; Galinksky, 1999; Garbino, 1992; Golden et al., 2015; Kilanowski, 2017; McLaren & Hawe, 2005; Pipher, 1996; Rogoff, 2003; Scarneo et al., 2019; Swick, 2004; and Swick & Williams, 2006, the decisions that impact personal health are influenced by personal beliefs [miscrosystem/intrapersonal], the influences of family and friends [mesosystem/interpersonal], work environment, [exosystem/organizational], advocacy from the organizations we are a part of or engage with [macrosystem/community], and confidence in the organizations that we trust [cronosystem/public policy]. Rural communities often demonstrate a plethora of underserved and vulnerable populations that are impacted the most by factors of the SEM (Bentley Brymer et al., 2020). Due to our country's previous mistreatment of medical trust [e.g., Tuskegee experiment] that were imposed on vulnerable and/or minority populations in the past, less active participation in various research studies and frequent engagement with healthcare providers is still apparent (Park, 2017).

Evidence reveals that the factors of the SEM influence health behaviors and community health (Golden & Earp, 2012; Salmon et al., 2020). Within the health promotion field, contextual forces that influence health are occasionally ignored (Golden & Earp, 2012). The SEM recognizes individuals being a part of a larger social systems

that interact with their environments as additional drivers that underlie health outcomes (Golden & Earp, 2012). In other words, knowledge, attitudes, beliefs, and personality influences health behavior; interactions with other people [serving as a support or a barrier] influences health behavior; informal structures can influence health behavior; social norms among organizations can influence behavior; and policies and laws that either support or regulate health actions and practices for prevention also influence health behavior (Rural Health Information, 2002-2021).

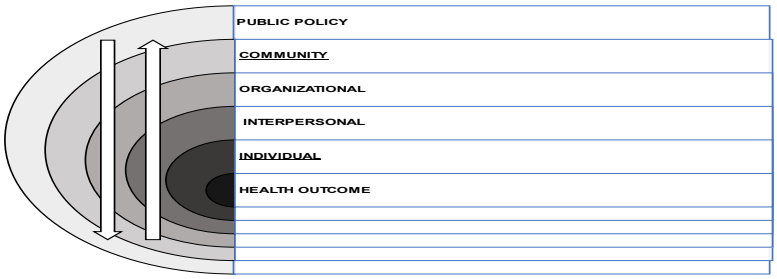
It is also important to understand the value of the geographical context of a community, and its role on impacting health outcomes. In general, no matter who we are, our daily engagement with places in which we live, work, and play will influence the lives we lead, the opportunities available to us, and the personal and communal happiness, identity, and sense of belonging (Montgomery, 2013; Speck, 2012). The quality of places is fundamental to sense of well-being and health outcome (Barton, 2017; Cozier, 2017). The physical environment accounts to ten 10% of health outcomes (Remington et al., 2015). A 2012 report by the Bipartisan Policy Center, similarly, mentioned that between 40% and 50% of health outcomes were linked to the social and physical environment (Bipartisan Policy Center, 2012). Depending on the context and environmental condition of a geographical area, [and its organizational members and individual constituents], can act either as a positive or negative conduit for influencing health outcomes.

Stokols (1992, 1996) and Guy-Evans (2020) similarly argued that along with the physical aspect of an environment, the social and cultural aspects of an environment can

also have a cumulative effect on health outcomes. At the core of SEM, health outcomes often result from the unique combination of personal, interpersonal, and community attributes, along with the contextualization of the reciprocal interdependence of individuals and their environment (Harvey et al., 2016). The SEM has been adopted in dealing with many health behaviors and health outcomes, as they provide useful frameworks for achieving a better understanding of the multiple factors [e.g., housing, financial security, community safety, employment, education, and environment], social conditions [e.g., characteristics of both social and physical environments at the individual, household, and community levels] and barriers [e.g., transportation, geography, income, and access to health resources], that impact on health outcomes (Guy-Evans, 2020; Stokols, 1996; see Figure 14).

Figure 14

Example of the Reciprocal Interdependence of Individuals and Their Environment



Note. Created by content from, Ecological Models: Five Levels of Influence on Health Behavior" by Rural Health Information Toolkits. ruralhealthinfo.org/toolkits/healthpromotion/2/theories-and-models/ecological, Copyright

2002-2024 by Rural Health Information Hub; and from “Translating Social Ecological Theory into Guidelines for Community Health Promotion” by D. Stokols. American *Journal of Health Promotion*. Copyright 2024 by American Psychological Association.

Although past studies have used SEM in developing conceptual models to investigate of interventions on community health, there are none [or very few] studies that have investigated FLs and their capacity to impact community health. This study will also address the lack of understanding of how FLs perceive and experience their roles for social change in advancing collaborative healthcare partnerships that focus on community health outcomes in rural areas through a SEM perspective. In concern with rural health, SEM provides a unique opportunity to address the gaps in leadership research and practice by understanding the implication of leadership style and collaborative healthcare partnerships of FLs, and their related action that address the implications of health inequities and health disparities on community health.

Summary and Conclusions

History reveals that health disparities and health inequities have been around, due to demonstrated differences and various social conditions of health experienced by populations and geographical location (Gibbons, 2005; Hammonds & Reverby, 2019; Institute of Medicine, 2002, McLeroy et al., 1988). Stakeholder leadership and health and social researchers and scholars, as well as numerous case studies have contributed to numerous models, and theories to understand the driving forces of this phenomenon.

Rural areas have demonstrated some of the worse conditions and indicators that impact health, when compared to non-rural areas (Garcia et al., 2019; Harrington et al., 2020; Kochanek et al., 2019; Marselle, et al., 2019; Nelson et al., 2017; Prasanth et al., 2019; Quinn et al., 2019; Sequist et al., 2011). The Delmarva region is an example of a region that entails numerous rural health issues among various localities of the region and exhibits an extent of health disparities and health inequities being prevalent in the region. This review of literature provides the complex and dynamic nature of the various drivers that have led to unfavorable health outcomes in rural areas.

FBOs continue to serve as a major resource for rural areas to better the well-being of their communities (Faith-based Organizations, n.d.; Khafagy, 2020). Opportunities exist for FLs to become engage to address health outcome concerns in their communities. Communities in rural areas are often influenced by the conditions of their environment and which provoke FLs to address issues and concerns that impede the well-being of the people and communities.

Transformational leadership has a capacity to produce social change in rural areas, especially in areas that exhibit health concerns that impact vulnerable and underserved populations (Burns, 1978, 2003; Muralidharan & Pathak, 2018). The application of the four dimensions of TL can enhance livelihoods and communities (Awang et al., 2020). FLs who demonstrate transformational leadership could be one of the best interventions to address health outcomes in rural areas.

SEM provides a context to understand the nature of various systems and environment that contribute to the manifestation of health disparities, health inequity,

determinants of health (Bronfenbrenner, 1976, 1989, 1999, 2005, 2006). Understanding the interdependences and interrelationship among the five factors of SEM, provides leadership and management with fundamental insight on the drivers of health outcomes in rural areas. FLs who demonstrate transformational leadership characteristics, could serve as a resourceful medium to enhance community health in the Delmarva region through attributes of SEM. Having an awareness of SEM and their effect will provide FLs with an understanding on how to engage with other community leaders and organizations to address health outcomes in rural communities.

Even though there has been substantial research and case studies revealing how leadership and the SEM improves health, there is minimum studies on how FLs use leadership to improve health outcomes in rural areas. This study provides an opportunity to understand how FLs provide leadership in their communities, and how they engage in various partnerships for contributing efforts to enhance community health in the Delmarva region.

Chapter 3: Research Method

Introduction

The purpose of this qualitative interpretive description research study is to explore how FLs perceive and experience their roles as agents for social change in collaborative healthcare partnerships that focus on community health in a rural setting. As was demonstrated in chapters one and two, there is an important social problem concerning the continual occurrence of unfavorable health outcomes in rural areas, and an analysis of relevant professional and academic literature suggests that there is a specific managerial problem regarding the lack of understanding of how FLs perceive and experience their roles for social change in advancing collaborative healthcare partnerships that focus on community health in rural areas [specifically the Delmarva region] that will be addressed through this research study.

The primary research question that ties back to both the general social problem and the specific managerial problem that addresses known gaps in the literature is: How do FLs experience their role as agents for social change within collaborative partnerships that seek to improve local healthcare outcomes in rural settings? The nature of this research question aligns with qualitative research approaches, and specifically, fits the use of an interpretative description research design, which supports the understanding that human experiences are comprised of complex interactions between psychosocial and biological phenomena and where inference to professional practice is appropriate (Thorne, 2016a; Thorne, 2016b). The research method for this study includes the research design and rationale, my role as a researcher, methodology, and issues of trustworthiness.

The components of the research method provide the necessary framework to support the findings of the study.

Research Design and Rationale

Qualitative research is a type of research that allows researchers to explore rich data about people's perceptions and experiences in life, and to try to better understand the how and why questions that underly complex human phenomena. A qualitative approach suits the nature of this study, which is to explore how FLs experience collaborative partnership activity through the identification and analysis of the subsystems of SEM that contribute to rural health outcomes, and to facilitate the interactive interplay of the induction [comparative analysis] and deduction [coding of data] analytical process of the qualitative data (Aspers & Corte, 2019). Qualitative research allows researchers to collect data through observation and/or interviews (Aspers & Corte, 2019), and it enables me to engage in social interaction [e.g., participant/research engagement] to establish rapport among me and participant, as well as to establish and conduct necessary logistics and interview settings to acquire feedback that would be generated from the behavior, perception, and judgement of FLs (Becker, 2017).

Common Qualitative Research Designs

There are many approaches to conducting qualitative research, depending on the specific goals and focus of the research. In the remainder of this section, I briefly review some of these approaches and support the choice of interpretive description as the qualitative research approach that will guide this study.

Phenomenological Research

A phenomenological design encapsulates the way an occurrence or experience was lived by people who participated in that occurrence or experience (Reitmeijer & Veen, 2021). This research design is applicable for understanding the nature or meaning of an occurrence or experience through those who are involved or engaged in that occurrence or experience. The phenomenological research design was not selected for this study because the aim of its design doesn't support the generation of new knowledge for application and solution development, whereas the aim of a phenomenological research design is to only describe the meaning of experience from the perspective of those who have experienced it (Hunt, 2009; Neubauer et al., 2019; Teodoro et el., 2018). The purpose of this study is to explore FLs perceptions and experience for contributions regarding solution development, not to understand the essential nature or meaning of FLs perceptions and experience (Husserl, 2012; Kozin & Medvedeva, 2019; Suddick et al., 2020) or other seminal phenomenological reference which explains how the phenom is about essence).

Ethnographic Research

An ethnographic design revolves around the culture aspects [e.g., social interaction, behaviors, beliefs, and language] of groups of people and their patterns (Harwati, 2019). This design is applicable to understand the connection with people and their environment (Hallet & Barber, 2014). This design was not selected for utilization for this study, because this study does not focus on the relationship of FLs with their environment.

Grounded Theory Research

According to Geertz (2008), a grounded theory research design focuses on the goal of the development of new theory, based on an analysis that compares current theory, if any, with emerging theoretical ideas that come from the analysis of emic [in-the-field] perspectives. This design is most effective when there is a lack of information about an occurrence or experience, which drives the production of an explanatory theory (Tie et al., 2019). Even though there is a lack of studies about how FLs perceptions and experience their roles as agents for social change in collaborative healthcare partnerships that focus on community health in a rural setting, a grounded theory research design is not applicable to support the exploration of FLs perceptions or experience. (Tie et al., 2019). The intent of the study is not geared to new theory development.

Historical Research

A historical research design tends to the investigation of sources to attain connections and links between events, people, and places over time (Blake & Kristel, 2018; Chikati et al., 2019). The intention of historical data is to derive facts and conclusions from past events, occurrences, and/or experience that supports a current event, occurrence and/or experience. Most historical studies are concerned with the identification, location, evaluation, and synthesis of data from the past (Blake & Kristel, 2018). This research design was not selected for this study because there is little need to consider the importance of time and/or previous events/occurrences or experiences to execute the purpose of the study.

Case Study Research

A case study research design focuses on the in-depth examinations of people or groups of people, and/or institutions to make a unit generalization of those examinations (Gustafsson, 2017). Within a qualitative research context, this design aids an exploration of a phenomenon within a particular context and time, through various data sources to reveal multiple aspects of a phenomenon (Baxter & Jack, 2008). This research design was not selected due to possibilities to not attain enough variation of perspectives to better understand the FLs perceptions and experiences, whereas an interpretative description research design could capture in-depth contextual analysis to support future research through a case study research design (Rashid et al., 2019; Yin, 2017). Additionally, the required time it would take to conduct the study, as well as a possibility to decrease study participation serves as another reason why a case study research design was not selected.

Action Research

An action research design seeks action to improve practice and ascertains the effect of the action that was taken (Lari et al., 2019). This research design pursues theory and practice, through active engagement with participants to identify practical solutions about an occurrence, experience, or concern (Abdullayeva et al., 2019). Action research involves the me to build a collaboration with those involved in the research [e.g., stakeholders] by defining the problem, collecting needed data, analyzing the data, determine the needed action, implement the action, collecting additional data while using different research method, and finally implementing the results to determine if the action

was successful (Antonellis & Berry, 2017). The action research design was not selected for this study because the aim of the study is to contribute to the generation of new knowledge and inquire about how FLs perceptions and experience their roles as agents for social change in collaborative healthcare partnerships that focus on community health in a rural setting; not to build collaboration with those involved in the research.

Interpretative Description Research

According to Berterö (2015) and Thorne (2008), Interpretive Description [ID] Research is a useful methodology for all disciplines. Interpretive description borrows aspects from grounded theory, naturalistic inquiry, ethnography, and phenomenology when presenting designs, samples, data collection, and analysis (Berterö, 2015). However, in general, an ID approach is non-categorical and could be applied to various contexts, concept, and analytical frameworks for a qualitative research study (Thorne et al., 2004). Therefore, an ID approach is valuable for qualitative inquiries across various professions, especially when a study's focus is to obtain the subjective experience of a specific group/population for practice applicability (Burdine et al., 2020). Even though both action research and ID research designs foster ways to improve practice, an Interpretive description research design also undertakes not only ways to improve practice, but also inherits flexibility to ground conceptual linkages that are specific to a specific disciplinary knowledge (Thorne, 2016). Focusing on the implementation of corrective actions is not the intention for this study.

An ID research design has been chosen for this research study because it supports the understanding that human experiences are comprised of complex interactions between

psychosocial and biological phenomena and learning about these interactions may lead to an improvement in both theoretical understanding and practice (Thorne, 2016a & 2016b). ID is appropriate for this study to understand the experience and perceptions of FLs through the study's components of the conceptual model [TL and SEM]. The exploration of recurrent patterns and shared realities of FLs' experiences will be the main intent of ID for this study (Burdine et al., 2020). The applicability of ID in this study will be to obtain the subjective experience of FLs in the Delmarva region to support management and leadership decisions to alleviate community health issues through FBO participation.

Role of the Researcher

When considering qualitative research, researchers collect data captured in a participant's natural setting by interacting with individuals (Aspers & Corte, 2019). As the researcher of this study, it was helpful to have a diverse education background [bachelor's degree in general studies with a minor in rehabilitation services; masters of sport science degree in sports medicine; master of philosophy degree in management; and previous doctoral course work in organizational leadership]. Having previous positions within an allied health [rehabilitation technician at northshore regional hospital; Auburn University athletic trainer; and New York Jets athletic trainer] industry was also helpful. Serving various roles and capacity [e.g., administration and oversight, management, health disparity research, health prevention, and community health outreach] in the federal government [United States Environmental Protection Agency; United States Food and Drug Administration; and Uniformed Services University of the Health Sciences Center for Health Disparities] provided insight on various federal government oversight,

administration, and regulation concerning key priorities and interest of the United States. During my tenure as a program manager and research associate for the United States Department of Defense, Uniformed Services University of the Health Sciences Center for Health Disparities, I managed numerous health disparity research activities for the principal investigator that consisted of research activities and support involving FBOs in Montgomery County, Maryland for several weight management studies. Working with FLs of FBOs of Montgomery County, Maryland sparked a passion to further explore the potential and capacity of FLs in a rural area to enhance community health in rural areas.

According to Lipson (1989) and Pukis (1994), the quality of the process and the product is dependent my integrity in accounting for the mechanisms by which the eventual outcomes can be. Throughout my federal government experience, I have been inspired to explore health disparities in rural areas. As I reflect on my tenures in the federal government [e.g., United States Department of Defense; United States Environmental Protection Agency; United States Food and Drug Administration; and United States Executive Office of the President], even though there are federal national government programs, projects, and policies in place that focus on alleviating health disparities, I come to realize that health disparities continue to impact underserved and vulnerable populations in rural areas, and that collaborative community efforts are just as important than government actions to address health disparities. During my tenure at the Uniformed Services University of Health Science, Center for Health Disparities, while conducting weight management studies for outreach participants of churches in Montgomery County, Maryland, the research concluded that church members were

influential resources to influence health behavior of a community, and that this phenomenon could be further researched in a rural area.

I am grateful to partake in doctoral research to expand the potential and capacity of FLs to contribute to new knowledge concerning the realms of community health, faith leadership, and rural health. However, due to my diverse experience and allied health education background, I will not have a participatory role in this study. In my role, I will solely operate as the interviewer to eliminate any bias with study participants. To reduce potential interviewer and participant bias, the following will be employed: (a) perform a pre-test, (b) use follow-up and probing questions, and employ triangulation of interview data (Brinkmann & Kvale, 2015; Sands & Krumer-Nevo, 2006).

Qualitative research is a type of research that allows researchers to explore rich data about people's perceptions and experiences in life, and to try to better understand the how and why questions that underly complex human phenomena. A qualitative approach suits the nature of this study, which is to explore how FLs experience collaborative partnership activity through the identification and analysis of the subsystems of SEM that contribute to rural health outcomes, and to facilitate the interactive interplay of the induction [comparative analysis] and deduction [coding of data] analytical process of the qualitative data (Aspers & Corte, 2019). Qualitative research allows me to collect data through observation and/or interviews (Aspers & Corte, 2019), and enables me to engage in social interaction [e.g., participant/research engagement] to establish rapport among the me and participant, as well as to establish and conduct necessary logistics and

interview settings to acquire feedback that would be generated from the behavior, perception, and judgement of FLs (Becker, 2017).

Methodology

This section will entail the following methodology components: participation selection logic; instrumentation; procedures for recruitment, participation, and data collection; data analysis plan, and issues of trustworthiness. These components provide additional detail regarding the techniques applied to identify, select, process, and analyze information about the topic of the study. These components also support interpretations and approaches to allow for close alignment with the research problem and purpose (Guadet & Robert, 2018).

Participant Selection Logic

The target population and area for this study is FLs in the Delmarva region. A purposive sampling strategy will be selected to identify the appropriate study location and find prospective participants based on characteristics of the target population and location that fit the phenomenon being studied. The Delmarva region was identified as an appropriate study location due to the region exhibiting alarming health indicators, underserved populations, and unfavorable health outcomes among rural areas of the region. The identified study location [Delmarva region] and participants [FLs] represent the characteristics of the target population and location to support the phenomenon being studied [exploring the capacity of FL leadership in rural areas to improve community health]. The inclusion criteria for participation for this study include: (a) FLs being at least 21 years old (b) FLs having five years of experience as a lead minister, deacon,

rector, or pastor of a church, (c) FLs [or their church] being a part of a collaborative healthcare partnership, and (d) FLs demonstrating demonstrate evidence of performing health outreach activity in their surrounding communities. To warrant the quality of the research, these criteria were considered to acquire participation adherence to eligibility requirements to capture in-depth information about participant experiences (Casteel & Bridier, 2021; Sutton & Austin, 2015).

Purposive sampling will be employed as the sample strategy. Baker and Edwards (2012) purported that in qualitative research, there is no exact sample size, due to the number of factors [e.g., scope of study, nature of topic, quality of the data, and study design] involved for its determination. Malterud et al. (2015) had stated that if a large amount of information is attained, then a smaller sample size would be sufficient. According to Braun and Clarke (2013), Fugard and Potts (2014), and Vasileiou et al., (2018) even though most qualitative studies suggested a sample size of at least 12 participants, the final sample size would be contingent upon the attainment of demonstrated data saturation.

Instrumentation

Regarding qualitative research, the common methods of data collections are document study, participant observations, semi-structured interviews, and focus groups (Busetto et al., 2020). Interviews are necessary to explore matters of the interviewees for attaining differences of phenomena of interest by which there are perceived and experienced (McGrath et al., 2018). Semi-structured interviews allow me to collect open-ended and closed-ended data, to explore participant thoughts, feelings, and beliefs about a

particular topic (DeJonckheere & Vaughn, 2019). Semi-structured interviews gather information from persons who have personal experiences, attitudes, perceptions, and beliefs related to a topic of interest (DeJonckheere & Vaughn, 2019). Semi-structured interviews will be employed in this study to acquire data about the personal experience and perception of FLs through exploration of participant thoughts, feelings, and beliefs about FLs' roles as agents for social change in collaborative healthcare partnerships that focus on community health in a rural setting.

To ensure that the interview questions of the study were appropriate and in compliance with the Institutional Review Board policies of Walden University, an interview protocol, process and bank of potential interview questions will be developed and will undergo a review process by both qualitative research experts and by FL experts that demonstrates prior collaborative healthcare experience working with other faith communities, community organizations, and other federal/state/local government organizations. Emphasis will be given to those with relevant experiences as pastors, ministers, and/or deacons of churches. An email communication will be sent out to each FL expert to review the interview protocol and interview question bank to seek achieve validity. According to Hayashi et al. (2019), the most common types of validity for a qualitative study are descriptive, interpretative, and theoretical, whereas for this study descriptive validity will be achieved by ensuring that the interviewers' responses are not distorted and that the responses are derived from what will be seen and/or heard. Next, a revised interview protocol will be developed to guide the in-field interviews for the sample of FL participants; again, to help maintain type of validity and reliability of the

interview questions. According to Jacob and Furgerson (2012, 2013) and Stofer (2019), an interview protocol is conducive to provide an interviewer with an applicable guidance document that encompasses interview questions to support a qualitative inquiry.

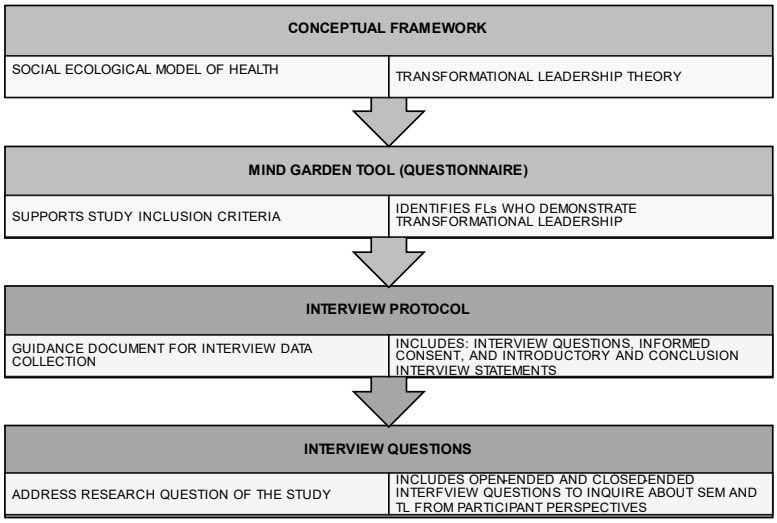
In this study, I will use a mix of both in-depth open-ended interview questions, and more targeted, structured questions as necessary. All interviews will be recorded through video or audio teleconferencing software to understand FLs' insight concerning their efforts to improve community health in rural areas through collaborative healthcare partnerships. However, emails would be considered as a secondary option for FLs that do not have access to video or audio teleconference software. The use of a mix open-ended and structured interviews questions will provide an opportunity for participants to share their experiences in the own way with the receipt of rich data, while also allowing for focused questions relevant to the study.

The Mind Garden Tool, interview protocol, and interview questions are the instrumentation for the study. The mind Garden tool identifies participants who reflect characteristics of transformational leadership. The interview protocol will serve as an instrument to conversate about the research inquiry (Patton, 2015; Stofer, 2019). Interview questions will gain feedback from participants concerning the research question of the study. The mind Garden tool is applicable to acquire transformational FLs for inclusion with the study in effort to acquire their experience and perceptions to improve community health in rural areas. Transformational leadership is the theoretical component of my conceptual framework to provide insight on participant leadership characteristics. The open-ended and closed-ended interview questions will dive into the

SEM aspects to explore potential linkages with SEM and TL through the experiences and perceptions of FLs [see Figure 15]. Interview protocol will include the following criteria: (a) introductory statement (b) semi-structured interview questions, (c) concluding statements, and (d) closing statement [see Appendix G].

Figure 15

The Relationship of the Conceptual Framework to the Instrumentation



Procedures for Recruitment, Participation, and Data Collection

This section of the methodology will focus on the procedures for recruitment, study participation, and data collection. These elements will provide specific detail about the steps and source of recruitment, and how the study participation and data collection will be executed. The procedures will implement the methodology to reach the aim of the research study.

Recruitment

The internet was the main source for identifying potential participants. A total of one hundred and forty churches were identified in the Delmarva region from a general google search of churches in the Delmarva region [10 churches were identified in each county], and a composite list was constructed and used as a source to assist with contacting FLs of FBOs [refer to Appendix H]. Faith-based groups in linkedin.com and facebook.com will also be utilized as a complimentary source to identify additional churches in the Delmarva region.

From various google searches concerning churches in the Delmarva region [according to state and county], I explored the specific church web links to acquire contact information. An Excel spreadsheet was developed to list the identified FBOs and was used as an informational source to contact FLs. Follow-up phone calls will be made to assist with anticipated correspondence, as well as to assist with the scheduling of anticipated interviews. Recruitment will be executed in a manner to minimize researcher bias through two conditions: (a) candidates who meet the inclusion criteria, and (b) selecting the respondents that provided correspondence to voluntarily participate in the study. According to Johnson et al., (2020), not incorporating a solid research plan to alleviate researcher bias will generate judgement errors that will impact the trustworthiness and validity of the study.

The procedure for recruiting candidates to participate in the study is the following: (a) send out a study summary to points of contacts of the total number of churches identified; (b) proceed with respondents who agree to participate that meet the

inclusion criteria of the study; (c) provide Mind Garden Tool to identify those respondents who reflect characteristics of transformational leadership; (d) proceed with the first 12 respondents who reflect characteristics of transformational leadership and inclusion criteria to interview; and (e) identify additional churches through social media platforms [e.g., LinkedIn.com and Facebook] and repeat the procedure if data saturation is not achieved. All interviews will be conducted through Microsoft Office Teams videoconference software. The data collected during each interview will occur on an agreed date and time established by both me and FL. Each FL interview will last no longer than an hour to an hour and a half in length.

Data Collection

All interviews will be conducted in the form of either a video or audio teleconference. According to Iran (2019) and Gray et al., (2020), video teleconferencing provides advantage to attain potential participants that are disperse among geographical location to virtually meet; whereas teleconference serves as a platform to alleviate expenses associated with conducting in-person interviews such as time and travel. Selection of the type of conferencing will be arranged according to the research and participant schedule and preference. All teleconferences will be recorded and transcribed and signed informed consent forms will be completed and attained by me, prior to interviews. However, due to possible timing constraints for conducting teleconference interviews, I may also consider conducting interviews through email as an alternative option for collecting data when needed. During the beginning of each interview, an introductory statement will be conveyed to orientate the participant for interview

readiness. At the conclusion of the introductory statement, participants will be provided an opportunity to ask questions before the beginning of teleconference recording. According to (2018), an introductory statement prepares participants for interview readiness, and aids researcher-participant rapport for generating better feedback (Yeong et al., 2018).

The goals of the research will be communicated to potential participants and will be explained that the study is voluntary. An introductory statement document will be provided to potential participants describing the eligibility process. FLs who met the inclusion criteria of the study and who demonstrate characteristics of transformational leadership will be accepted as study participants. Potential participants that do not meet the inclusion criteria will be informed through either an email or telephone communication to discontinue. I will convey to all participants of the study that all information will be kept private and secure, and that they would be given the opportunity to review their transcript upon request. Information from potential participants will be shredded to ensured confidentiality and security of personal identifiable information. However, after conclusion and participant review of all interviews, all transcriptions will be stored in a secure location [refer to Appendix G].

Data Analysis Plan

Reflecting journaling will require bracketing to attain validity of the data analysis process, and assists with mitigating bias (Weatherford & Maitra, 2019). My context will provide useful insight on the effects of the conclusion, and gives feedback from observable contextual cues, and intangible inputs from interviews. Having a personal

reflection by bracketing will support data analysis to arrive at a big picture of the experience being described (Weatherford & Maitra, 2019).

Comparative analysis will be the analytical approach for this study. Comparative analysis involves an inductive process to categorize and compare qualitative data to support interpretations (Burdine et al., 2020). According to Burdine et al. (2020) and Olsen et al., (2013), comparative analysis involves six methodological steps:

1. Engagement in the data.
2. Construction of an initial thematic template.
3. Organization of the data.
4. Condensing of the data and reflecting on the data.
5. Comparing the data within similar participant categories.
6. Contrasting data with different participant categories.

The analysis of transcription will entail the following: (a) creation of a data repository, (b) creation of codes, (c) generation of reports, and (d) generation and linkage of final propositions with codes (Burdine et al., 2020).

Content analysis entails the following analytic process: (a) identification of units of meaning, (b) labeling units through code, (c) grouping codes into a category, and (d) describing categories with a theme (Kleninheksel et al., 2020). Content analysis will initially code specific word or phrase of the participant data to summarize an attribute of a portion of text (Charmaz, 2014; Kleinheksel, et al., 2020). Once patterns of codes are recognized, they will be grouped in categories and sub-categories (Graneheim et al., 2017; Joffe & Yardley, 2004). Comparison strategies will be employed to establish

characteristics of categories, along with the underlying circumstances that foster categories. Comparisons will support the interpretation of data (Burdine et al., 2020). Transcriptions from the semi-structured interviews will serve as the main data repository. Quirkos computer software will transcribe semi-structured interviews.

Transcriptions from the semi-structured interviews will serve as the main data repository. Quirkos computer software will transcribe semi-structured interviews. Quirkos, field notes [reflective journaling], and summary of discussions of identified patterns will support the creation of categories. Themes will be derived from assessing participant interpretation, which will further support explanation in other participant interviews. Template analysis will be applied to support the coding template for utilization with subsequent data. Quirkos computer software will provide organization and visual display of qualitative data for highlighting similarities and differences of FLs perceptions and experiences.

Issues of Trustworthiness

To support the contention regarding the topic of the study, a rationale must be apparent for the findings to be accepted. Acceptance for future research and practice, requires attention to the following elements: credibility, transferability, dependability, confirmability, and ethical procedures. Attention to these elements will support the trustworthiness of the research method and collected data of the study.

To authenticate trustworthiness in qualitative research, researchers must build trust and rapport with their participants to acquire detailed responses (Cope, 2014; Guillemin et al., 2018). Qualitative researchers should allot adequate time to gather data

and attain an understanding of the individuals and phenomenon (Cope, 2014). To sustain the quality, trustworthiness, and credibility of this study, the following will be considered: (a) transcribe interviews with high quality, (b) achieve and assess reliability, (c) achieve dependability by obtaining results through repeatable techniques, (d) achieve flexibility by incorporating research actions that alleviate research bias, (e) follow reflective journaling protocols and be mindful of identified areas of potential bias, and (f) ensure transferability through data management and analysis, and record keeping. According to Noble and Smith (2018), assessing reliability allows me to fashion judgments about the thoroughness, in relation to the application and relevance of the methods accepted, and the assurance of final conclusions. The benefit of reliability is useful to enhance the field notes and analysis from the interviews, through quality recording and transcribing (Rose & Johnson, 2020).

To alleviate potential researcher bias, such as those identified earlier in this chapter [which include interviewer, participant, and researcher bias], the following will be considered and/or employed to execute the study's methodology: (a) utilize multiple people to code the data, (b) have participants review results, (c) verify with more data sources, (d) check for alternative explanations, and (e) review with peers. These considerations will alleviate interviewer bias, participant bias, and researcher bias by decreasing the possible impact of the perceptions of the interviewer's identity (Frey, 2018); avoid questions that focus on health, income, politics, and religion (Brito, 2017); and develop and adhere to interview and coding protocols (Wadams & Park, 2018).

Utilizing additional resources to code data also prevents confirmation bias by employing partners [e.g., faculty members, coresearchers, and other colleagues] as code checkers to serve as another set of eyes to analyze and code raw data (Shufutinsky, 2020). Using participants to review results decreases misinterpretation and inaccuracy of data. According to Chernyak-ai & Tzinder, 2014; Fush et al., (2018), and P. Fusch & Ness, 2015, utilizing more than one data source [e.g., literature review, interviews, and study participants] enhances reliability of results to fulfill the purpose of any exploratory study, which is to answer the research question through the gathering of evidence and literature review to compare existing knowledge and the conceptual framework to the study results. Ruling out alternative explanations can also generate trust in research finding. Developing open conceptual and/or theoretical frameworks that are derived from prior research while highlighting research gaps can create new space for research contribution, which can signal alternative explanations for findings to be unlikely (Cuervo-Cazurra et al., 2020). The review of data [especially during the initial coding phase of data analysis] provides structure to the data to support meaningful thematic development. Intercoding reliability will be employed for this study by me and reviewers to categorize nominal data to promote reliability through coding frames that captures the significant features of the data for data reduction, in effort to support the conceptual framework of the study, and to provide consistency and transparency of the coding process (O'Connor & Joffe, 2020).

Credibility

The aim of credibility in a qualitative research study is to attain truth-value derived from strategies of engagement, observation, triangulation, and member checking (Lincoln & Guba, 1985; Korstjens & Albine, 2018). To assure credibility, I will provide descriptive data [e.g., research setting, sample, sample size, demographic and participant characteristics, inclusion, and exclusion criteria], and changes in interview questions [when needed] based on the iterative research process, and excerpts from the interview guide (Korstjens & Albine, 2018). The data will be collected from FLs and will be interpreted verbatim to detail experiences relevant to the interview question of the study. As mentioned by Korstjens & Moser (2018), the information that will be derived from participants will present findings that will indicate reasonable details from original data to amass accurate interpretation of experiences. I will also authenticate participants to understand the interview questions once read to account for possibilities of literacy barriers that may hinder the understanding of the interview questions, taking into consideration all possible levels of literacy hardships.

Transferability

Transferability of a qualitative study concerns with the results of a study, and its ability to be transferred to other contexts or settings with other respondents, which is often supported by not only the behavior and experience of participants, but also by their context as well (Korstjens & Moser, 2018; Lincoln & Guba, 1985). I will acquire context of participants experience by attaining research about the social conditions of the Delmarva region, as well as identifying and selecting transformational leaders for the

study. Transferability was captured by receiving the shared experiences of participants. Detailed records of all the research, emerging themes, processes, and analyses will be collected information of the study (Korstjens & Moser, 2018).

Dependability

Dependability of a qualitative study was achieved through the evaluation of findings, interpretation, and recommendations of the study that were supported by the data received from the participants (Lincoln & Guba, 1985). Providing a description of research steps from start to finish of the research study to the development of the findings will ensure adherence to the research process had yielded consistency and effective data management (Korstjens & Moser, 2018). Transparency will be demonstrated to Walden University Institutional Review Board by describing the needed steps to conduct the research (Korstjens & Moser, 2018). Efforts will be made to confirm interpretations and recommendations by the data that will be received from each participant (Christenbery, 2017). The correct number of participants will reach the goals of the study through different views of FLs' experience. Also, evaluating the findings to corroborate the data during the coding process will achieve a deeper awareness of the patterns and themes determined (Christenbery, 2017).

Confirmability

Confirmability of a qualitative study proports the extent to which the findings are confirmed by me regarding establishing data and interpretations of findings that are absent from researcher bias, imagination, and intersubjectivity (Korstjens & Moser, 2018; Lincoln & Guba, 1985). Quirkos software, Microsoft Office Word, and Microsoft Office

Excel will be used to store detailed transcriptions, field notes, and reflective journals with coding markers to evaluate the findings, by capturing viewpoints and evaluating the data. Confirming the results of the study will be obtained from the data and will be necessary to encapsulate the findings of the research (Christenbery, 2017). The results of the study will ensure the quoted responses will be upheld by the rendered analysis (Connelly, 2017). Audio recordings of each interview, field notes, reflective journalizing, and transcripts will contribute to analyzing data, and will be kept for at least five years, as required by Walden University, and will be accessible upon request.

Ethical Procedures

To achieve no harm or risk to participants, the study will be conducted after receipt of approval from the Walden University Institutional Review Board. An informed consent form will be provided to each participate before the interview. The participants will be ensured that all information will remain confidential and anonymous. Anonymity will be achieved by excluding name and personal characteristics from the study to eliminate any form of personal identifiers. The data will be password protected and stored electronically and will comply to Walden University polices for the timeframe to remain on file.

Summary

The goal of this chapter was to delineate the research method used to answer the research question of the study. A discussion of the procedure, study participants, data collection, and interview questions provided the particulars of how the study was conducted, and who participated in the study. An interpretative description research

design was applied for this study to understand the experience and perceptions of FLs through the study's components of the conceptual model [TL and SEM]. The exploration of recurrent patterns and shared realities of FLs' experiences will be the main intent of the interpretative description research design for this study (Burdine et al., 2020). The goal of Chapter 4 is to provide study results and demonstrate that the methodology described in Chapter 3 was followed.

Chapter 4: Results

Introduction

The purpose of this qualitative interpretive description research study was to explore how FLs perceive and experience their roles as agents for social change in collaborative health care partnerships that focus on community health in a rural setting. The research question—How do FLs experience their role as agents for social change within collaborative partnerships that seek to improve local health care outcomes in rural settings? —was closely aligned to the study purpose. In this chapter I will present the results of the interpretive description research design analysis (Thorne, 2016) and will focus on presenting the "emic", or participant-focused results of the analysis, which respond directly to the purpose of the research. I will provide some general background and demographic information about the study and its participants, will briefly review how the data was collected and analyzed, will address what steps were taken to ensure trustworthiness of the data and analysis, using methods within the interpretive description design, and I will present the emic-focused results that reflect the voice of the participants.

Research Setting

FLs who participated in the study were from the Delmarva region. All FLs who participated in the study did not represent all the counties in the Delmarva region. Reasons why all counties were not represented in the study were due to the following conditions: (a) lack of feedback from various attempts to make contact, (b) FLs not meeting inclusion criteria, and (c) time conflicts to interview. After completion of mind

Garden questionnaires [in conjunction with follow-up emails], there were instances in which those that did meet inclusion criteria chose not to participate.

Demographics

Participants represented different counties of the Delmarva region. These included Caroline, Dorchester, Queen Anne, Somerset, and Talbot counties of Maryland, as well as Kent and Sussex counties of Delaware [see Table 1].

Table 1

Participants' County of Residence

Participant	Queen Anne County, MD	Dorchester County, MD	Somerset County, MD	Caroline County, MD	Kent County, DE	Sussex County, DE	Talbot County, MD
1	X						
2		X					
3			X				
4	X						
5				X			
6					X	X	
7			X				
8							X
9							X

Note. The data in the table were derived from the Quirkos report and the Mind Garden Tool. Participant 9 was interviewed twice. The church for Participant 6 is geographically located in two counties. (The church is in a town that is a part of two counties.) There were no participants from North Hampton and Accomack counties of Virginia, New Castle County of Delaware, or Kent and Worcester counties of Maryland.

There were six male and three female participants. Most of the interviews were conducted via a scheduled video teleconference call; one interview was conducted via email. Microsoft Office Teams was the videoconferencing platform. The longest participant interview was 45 minutes 9 seconds, and the total time for all interviews was 3 hours 11 minutes. The total number of counties represented in the Delmarva region was seven, and the total number of states represented in the Delmarva region was two. The total number of participant interviews was 11, with Participants 8 and 9 interviewed twice. Interviews consisted of in-depth open-ended questions [see Table 2 and Appendix I].

Table 2

County, State, and Gender of Participants

Participant	County and state	Gender
1	Grasonville, MD Queen Anne County, MD	Male
2	Cambridge, MD Dorchester County, MD	Female
3	Princess Anne, MD Somerset County, MD	Male
4	Centreville, MD Queen Anne County, MD	Female
5	Preston, MD Caroline County, MD	Male
6	Milford, DE Kent and Sussex counties, DE	Male
7	Princess Anne, MD Somerset County, MD	Female
8	Easton, MD Talbot County, MD	Female
9	Easton, MD Talbot County, MD	Male

Note. The data in the table were derived from public websites of participants' churches.

Data Collection

Interviews were conducted through the forms of video teleconferences and email [one participant interview conducted through email]. Interviews were transcribed and reviewed by each participant to ensure accuracy and finalization for each transcription. Each transcribed interviewed was entered into Quirkos to produce details of the interview for reliability. The word count and number of quotes were calculated for each participant [Refer to Appendix J]. Intercoding reliability was also performed by categorizing data through a data coding frame to capture key features of data that was consistent with conceptual framework of the study [see Figure 16].

The first tier of data collection involved the utility of the mind Garden tool. The sole purpose of this tool helped with identifying FLs who reflected characteristics of transformational leadership to meet the inclusion criteria of the study. The tool provided a tailored multi-factor leadership questionnaire that measured criteria of transformational leadership. Questions of the multi-factor leadership questionnaire were statements that reflected content concerning the four dimensions of transformational leadership. A likert scale provided measurements to participant responses of the questionnaire [with a blank response indicating 'Unsure', '0' response indicating 'Not at all', 1 response indicating 'Once in a while, 2 responses indicating 'Sometimes', 3 responses indicating 'Fairly often, and a 4 response indicating 'Frequently, if not always']. Only FLs who had a

resulting score higher than 2.5 were allowed to proceed with interviews [refer to Appendices K through M].

Data Analysis

Quirkos computer software was used to transcribe semi-structured interviews of the participants of the study. Interviews from Microsoft Office Teams were uploaded in Quirkos. Quirkos transcribed video teleconference data into text. Microsoft Office Word provided documentation of Quirkos transcription and provided manual editing support for required grammar and spelling corrections and provided word count for each interview transcription. Each edited Word document was reviewed and confirmed [both by me and interview participant] to ensure interview responses were accurately captured. After reviews, each Word document was entered into Quirkos and documented by chronological order according to completion of interviews by each participant. A labeling convention was applied to effectively manage participant interview documents in Quirkos. Quirkos also provided spelling, grammar, and editing as additional assistance for identification of grammatical that were not initially corrected after my initial and interview participant reviews. Some of the participants produced repetitive words, unrecognizable pronunciations, and incomplete sentences [which were recognized as errors by the Quirkos and omitted from transcriptions]. Quikos provided word count for each interview participant Microsoft Office word document [refer to Appendix J]. Demographical data and characteristics of participants was captured to highlight each interview participant according to their geographical location. This data indicated the number of counties among the Delmarva region that were represented in the research

study [refer to Tables 1 and 2] for characteristics and demographic detail of participants who were interviewed.

Initial coding analysis from the Quirkos report revealed 1,497 codes and 703 coding titles [refer to Appendix N]. Participant Number 1, 4, and 8 yielded the most quotes among all interviewers [refer to Appendix J]. The data analysis plan presented in Chapter 3 was applied to guide further data analysis of the study. The data analysis plan consisted of two phases: (a) a systematic process of data review [transcription derived from video teleconference participant interviews], reflective journaling [refer to Appendix O], and (b) formal coding guided by content analysis.

Data was initially grouped by Quirkos according to the completion of participant completing interviews by chronological order. Additional naming convention was applied to control identification in which only I would be able to know. Phase one was completed by both me and participants for reviewing and confirming transcriptions as final transcribed interview documents. Microsoft Office Word and Quirkos provided additional editing reviews. Thereafter, field notes [memoing] were documented for each interview transcription for the recording my thoughts. According to Bingham (2023), memoing is a qualitative research analysis that allows me to record their thoughts and notes. Field notes of the study lead to the production of reflective journal entries for each participant and provided additional inspection of quotes from Quirkos report.

Initial coding by Quirkos applied emic coding to accurately capture the voice of interview participants [refer to Appendix N]. All repetitive words and phrases emerged emic parent codes [refer to Appendix Q]. This inductive approach of emic coding by

Quirkos conceptualized participants perspectives on associated description to reflect how FLs perceive and experience their roles as agents for social change in collaborative healthcare partnerships that focus on community health in a rural setting (Bowling et al., 2021). Parent codes were assigned to grandfather codes. This inductive coding approach by Quirkos grouped parent codes according to their similarity and connection with grandfather codes. However, there were instances for multiple parent codes being under one grandfather code.

Quirkos also reported In-Vivo codes [quirk titles]. These codes were direct quotes from participants and were coded as phrases and/or words. In-vivo coding used the words or phrases of the participant's quotes as codes (Saldaña, 2021). In-Vivo coding approach directly captured the quotes of the participants. In-Vivo codes provided insight into field notes and reflective journal entries for subsequent analysis. Phase 2 of data analysis entailed deductive analysis. Content analysis identified patterns among grandfather codes, parent codes, and in-vivo codes. Themes were established from the grandfather codes, parent codes, in-vivo codes, and their relative categories [refer to Appendix R].

Evidence of Trustworthiness

To build trustworthiness in qualitative research, I must build trust and rapport with their participants to acquire detailed responses (Cope, 2014; Guillemein et al., 2018). To sustain the quality, trustworthiness, and credibility of this study, the following was considered: (a) transcribe interviews with high quality, (b) achieve and assess reliability, (c) achieve dependability by obtaining results through repeatable techniques, (d) achieve flexibility by incorporating research actions that alleviate research bias, (e)

follow reflective journaling protocols and be mindful of identified areas of potential bias, and (f) ensure transferability through data management and analysis, and record keeping.

Interviews were conducted in the form of video/teleconferences, along with one participant interview conducted through email. Interviews were transcribed and reviewed by each participant to ensure accuracy and finalization for each transcription. Each transcribed interviewed was entered into Quirkos to produce details of the interview for reliability. The word count and number of quotes were calculated for each participant [refer to Appendix J] for word count and number of quotes produced by each participant. Intercoding reliability was also performed by categorizing data through a data coding frame to capture key features of data that was consistent with conceptual framework of the study [see Figure 16]. This approach contributed to the thoroughness of reflective journaling through quality recording and transcription.

The interview protocol provided structure for participant interviews and provided dependability for conducting multiple interviews. The Institutional Review Board of Walden University reviewed and accepted interview protocol prior to use to maintain the privacy and safety of participants involved in the study. Interview protocol contributed to the dependability for conducting multiple interviews.

Research bias was alleviated by utilizing Quirkos software for additional assistance with inductive coding analysis [Emic Coding]. Participants were also given opportunities to review interview transcriptions to either add and/or delete content of transcriptions prior to their confirmation for accepting interview transcriptions. In effort to alleviate interviewer, participant, and researcher bias, the interview protocol contained

no questions or inquiries concerning health, income, politics and/or religion. Confirmation bias was also performed to decrease misinterpretation and inaccuracy of data. Coding data was reviewed by dissertation committee members to enforce confirmation bias and provides the necessary support for thematic development.

Transferability of data was achieved by utilizing proper data management and analysis, and record keeping. Files for each interview was secured and maintained on password protected drives on a personal computer. These files were also backed-up on the cloud of personal computer for additional security. Quirkos also provided security of data through password protection and can only be accessed by me. The mind Garden tool also provided similar security with participant responses and scores from the multi-factor leadership questionnaire.

Credibility

The aim of credibility in a qualitative research study is to attain truth-value derived from strategies of engagement, observation, triangulation, and member checking (Lincoln & Guba, 1985; Korstjens & Albine, 2018). Credibility of the findings were assured by providing regarding the research setting, sample, sample size, demographics and participant characteristics, inclusion, and exclusion criteria. The research setting involved participants from the Delmarva region. Video teleconferences were the method of interaction among me and interviewers. A purposive sample strategy was applied to support the phenomenon being studied and characteristics of the desired participants within the Delmarva region to acquire relevant experience and perceptions from FLs regarding their engagement with collaborative healthcare partnerships to improve

community health in rural areas. Data saturation was achieved with nine participants. Basic demographics and participant characteristics were attained to acquire basic detail of participants [refer to Tables 1 and 2]. Inclusion and exclusion criteria were embedded in the study to warrant the quality of the research [refer to Appendix S]. Introductory emails were sent to participants of the study with an overview of the study in effort to answer any questions or inquiries from participants prior to their participation in the study.

Transferability

Context of the study was established by acquiring necessary information about the demographics of the Delmarva region to better understand the existing social conditions [see Figures 12–15]. The mind Garden tool assisted with the identification and selection of transformational FLs among the Delmarva region. Shared perceptions and experiences of FLs were captured through detailed records of coding and themes derived from emic coding data, adherence to interview protocol and execution of efficient data analysis.

Dependability

Dependability was achieved through the evaluation of findings derived from the interview transcriptions of the participants. Following the research steps of the research study led to the to the development of the findings, due to the application of data management. Transparency was demonstrated by describing the needed steps to conduct the research (Korstjens & Moser, 2018). Semi-structure interview guide, concluding statements, invitation email, informed consent was a part of the approved interview proctor that served as a guide for conducting interviews [refer to Appendix G]. Participants of the study provided review and confirmation of interview transcriptions to

achieve dependability for the findings and results of the study. Reflective journaling was performed after each interview to conclude a deeper awareness of patterns and themes of transcriptions.

Confirmability

I used Quirkos, Microsoft Office Word, and Microsoft Office Excel for storing store detailed transcriptions, field notes, and reflective journals with coding markers to evaluate the findings. Confirming the results of the study was encapsulated the findings of the research (Christenbery, 2017). The results of the study ensured the quoted responses were upheld by rendered analysis, in conjunction with reflective journalizing for additional analytical support [refer to Appendix N–R]. Field notes served as a key input into developing reflective journaling. Recording and transcription participant interviews, and notations of field note, and reflective journal entries contributed to the analysis of data, and will be kept for at least five years, as required by Walden University to respond to anticipated request that require further discovery.

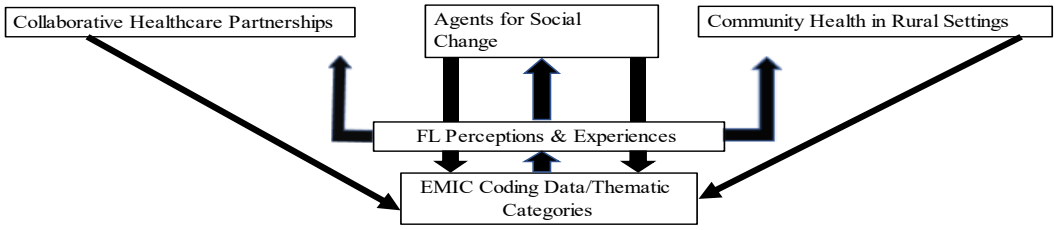
Study Results

This interpretative qualitative study involved one research question [How do FLs perceive and experience their role as agents for social change within collaborative partnerships that seek to improve local healthcare outcomes in rural settings?]. The interview protocol encompassed in-depth open-ended questions concerning FL leadership style, how FLs meet the health needs of communities, impact of FL leadership, and effectiveness of FL collaborative partnerships among the Delmarva region. The data

analysis format provided a basis for organizing the collected data into themes [see Figure 16].

Figure 16

Data Analysis Format



Note. The thematic analysis categories were the basis for the format.

The deducted thematic analysis identified connectivity among inductive analysis [grandfather codes, parent codes, and in-vivo codes] with deductive analysis [categories and themes]. Refer to Appendix R. The following themes emerged from analysis of the data: (a) collaborative health care partnerships, (b) agents for social change, (c) community health in rural settings, and (d) FL perceptions and experiences. By following the thematic analysis protocol, I was able to integrate the findings of the inductive analysis [e.g., grandfather codes, parent codes, and in-vivo codes] with those of the deductive analysis [e.g., categories and themes], as shown in Table 3. Appendix Z.2

provides more details concerning the connection between the inductive and deductive analyses.

Table 3

Categories and Themes

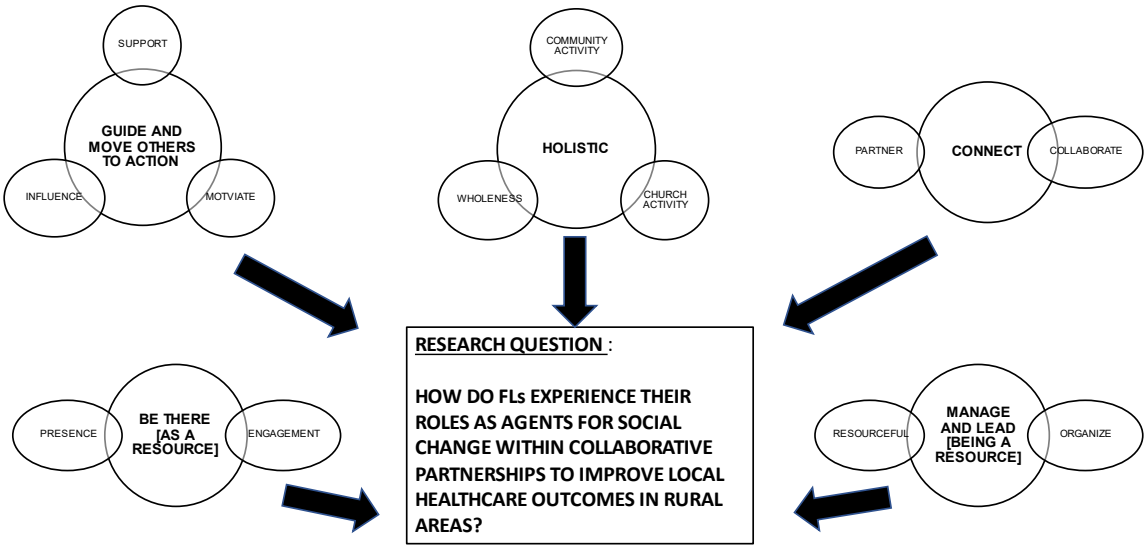
Category	Theme
Barriers within SEM, problematic situations, community health requirements, areas of concern, SEM conditions, strategic interventions	Community health in rural areas
Useful experiences	FL experience and perceptions
FL and FBO actions, various FL and FBO interventions, transformational leadership, leadership capacities	Agent for social change
Community organizing, partnering organizations	Collaborative health care partnerships

Note. SEM = social ecological model; FL = faith leader; FBO = faith-based organization.

The data analysis yielded 12 core themes that answered the research question. The themes were resourceful, community activity, engagement, church activity, support, motivate, partner, collaborate, presence, influence, wholeness, advocate, and organize. Figure 17 provides a visual illustration of the themes.

Figure 17

Visualization of Themes



Note. The themes were derived from data analysis of codes and in-vivo quotes.

Manage and Lead [Being Resourceful]: Resourceful

FLs demonstrated being resourceful as social agents to improve local healthcare outcomes in communities among the Delmarva region. In effort to satisfy followers' well-being and organizational outcomes, leadership researchers have observed the following characteristics/qualities of FLs: (a) intrinsic motivation [emphasizing individual needs of others]; (b) religious [care and compassion for others], (c) ethics [facilitating responsibilities to achieve mutual outcomes]; (d) values [supportive organizational environments that ascertain meaningful work], and (e) corporate social

responsibility (Fry, 2003; Fry et al., 2005; Oh & Wang, 2020). FLs utilized their internal and external church environments, personal talents, and organizational capital to manage and lead others in becoming healthy. FLs also served as a valuable community resource in the Delmarva region by applying leadership and management from their leadership style, bridge building capacity, and collaborative partnership activity to achieve personal and organizational objectives, which can affect community health outcomes (Idler et al., 2019). I will discuss FLs as a resource for the Be There category in a later part of the Study Results section. FLs are key resources in the community and display a resource capacity to improve health outcomes in the Delmarva region. Quotes of participant FLs demonstrating resourceful efforts to improve health outcomes are provided in Table 4.

Table 4

Participant Responses Associated with Manage and Lead [Being Resourceful]:

Resourceful Theme

Participant	Interview excerpt
1	"I have been working with the county health department, and local universities to identify ways to provide services through our church."
	"And to ensure that the gathering of people and resources has an ability to embark the needed change."
2	But my eyes are open to it too, and…just trying to figure out when…there are places that would align with Ministry and mission of my church with the needs of the community to step into that space."
	"I am also a board member of the Eastern Shore Long Term Recovery program, which was driven by the occurrence of Hurricane Sandy. Sometimes freakish storms often flood the areas and produce infrastructure devastations in the county. And most of the time these freakish storm incidents don't make regional or national news. Houses were flooded. The Recovery program has been assessing houses and getting funding to help repair and build new homes."
	"And if I know of ways to help others to connect with healthcare providers or health resources, I do share that."
5	"Utilizing people's gifts to help others allows us to work with what we have to produce results that impact community health."
	"Another example of my value was recognizing the need for feeding children and adults. The food insecurities and inefficiencies in the area has been something that I've been actively involved with, along with the homeless populations."
	"But I am also a registered nurse. And so, there's been times where if there's a health crisis my folks will come, and they will talk to me and ask me questions. But in general, when I see someone encountering health difficulties, I often conduct my own general health assessment of their health condition and situation. It's just how I was taught and trained."
	"Coincidentally, it worked out that one of our folks that works at the local Hospice was in the building. I asked if she could chat with them because of her community connection as a church member as well as being a key member in the community that help others."
6	"I have been picking people up, taking them to the doctors for appointments, and other personal obligations taking them to handle personal needs, such as trips to Walgreens and CVS, things of that sort."

Participant	Interview excerpt
	"For occasion that they need rides, we arrange transportation. We have specific persons to pick them up and drive them to where they need to go, like to local stores, doctor's appointments, or even to Dept. of Health for frequent and/or routine health checkups."
	"We have one lady who generally keeps an abreast of those things that are going on in the community and she'll bring in pamphlets for making sure that you test yourself for a different thing that might be coming up or visit your doctors or she'll bring in pamphlets. And we keep them inside of the building."
7	"For our communities and we're looking at creating a farm to share among places that have food disparities in in the cities and in the towns of that are around us. We're in a rural section and because we have land, I think we need to use it properly."
	"Actually, gathering people to understand what you see as the leader and communicating that appropriately to the people who can cause any kind of change."
8	"I try to acquire people who are well-versed and educated to serve as guest speakers at the church to talk to the congregation; whether these people are Christian, or Jewish or Catholic, secular is not important. Is what they have to say going to be beneficial to the congregation. That's what's important."
9	"What I try to do is be resourceful. I utilize my environment and identify people and organizations that can help me and the church to help others. Connectivity. Or another good word is ecumenicalism."
	"Right now, the only mechanism we have is financial support. As we grow numerically, we'll be able to expand our support. But our financial support helps keep the organizations operating so they can continue to serve the community. Our funding comes solely from the generosity of our attenders. The finances we give goes toward operation costs of the church and community organizations to better serve their intended function in the community [e.g., Facility rent, utilities, and payroll]."

Manage and Lead [Being Resourceful]: Organize

FLs and FBO demonstrated organizing efforts as social agents within their collaborative partnerships to improve local healthcare outcomes in communities in the Delmarva region. FLs recognized the importance of organizing in communities, due to limitations of health resources in the Delmarva region. FLs can be capable role models

with the removal of barriers and roadblocks in communities that impair the livelihoods of others (Heward-Mills et al., 2018). FLs have an ability to supply the necessary intervention to meet the needs of a rural community and will be required to address health outcomes that are exacerbated by social determinants of health, health disparities, and health inequities for constituents in their communities (Schoenberg & Swanson, 2017). FLs in rural areas have opportunities to organize with other stakeholders to meet the health needs of rural populations Quotes of participant FLs pertaining to their organizing efforts to improve health outcomes in the Delmarva region are provided in Table 5.

Table 5

Participant Responses Associated with Manage and Lead [Being Resourceful]: Organize Theme

Participant	Interview excerpt
1	"Gathering people and resources to observe and understand what is taking place and what is occurring in a community is essential for me to communicate that to community stakeholders and constituents in the community."
2	"Organizing and communication between all partners, that help children in Somerset County has done a really great job. Organizations offer opportunities to address health, mental, physical, and education concerns, so there's a lot of partnering."
	"Being open in having the church assist with the health department, along with participating with the relief program with housing initiatives, I have been involved with making connections with funding among other churches and nonprofit organizations."
	"My experience has also helped me launch communication and establish relationships with pastors of other denominations that will hopefully lead to a county ministerial association."
6	"We also provide general health checkups that we perform at times and make sure that people have what they need, something that we're working on, making sure that the health ministry interacts with community health organizations like Red Cross to coordinate blood drives and things of that sort."
	"But yeah, those are the methods that we use. We also seek professionals among and outside the church and health organizations in the area that care for the elderly."
	"In one instance, we had a gentleman who was ill. And his wife was elderly. It was difficult for his wife to take care of him. Me and my wife assisted by making phone calls to the county's local Dept. of Health and Aging to enable needed services."
	"For occasion that they need rides, we arrange transportation. We have specific persons to pick them up and drive them to where they need to go, like to local stores, doctor's appointments, or even to Dept. of Health for frequent and/or routine health checkups."
9	"I'm working toward helping unite churches and to work together to reach our city."

Be There [as a Resource]: Presence

FLs demonstrated visibility as social to improve local healthcare outcomes in communities among the Delmarva region. FLs and FBOs established unique applications of social presence and engaged in various ways to increase their capacity to meet community health needs. FLs and FBOs can establish social presence through community engagements, service, and relationship building (Puppo, 2020). FLs were a key resource in rural communities and have capacities to either receive or give support to improve health outcomes in the Delmarva region. Quotes illustrating FL presence in communities in effort to improve health outcomes in the Delmarva are provided in Table 6.

Table 6

Participant Responses Associated with Be There [as a Resource]: Presence Theme

Participant	Interview excerpt
1	"Especially, during occurrence of tragic events and emergencies experienced by the community, as well as among constituents, the church always serves as an outlet to provide the necessary presence of support."
	"Even being present at a high school football game provides a sense of presence. I had an opportunity to attend a community parade that also gave me more visibility in the community. It's importance to perform and serve the community outside of Sunday morning worships."
	"I would say the secret sauce is establishing positive presence in the community and being there for others in times of need. And this also applies to activities that you may not be expected to be present for."
	"Attending a school play is also just as pivotal to reach the youth and being present in such events provides positive assurance for the community that the church is supportive of community events, welfare, and outcomes."
4	"But I think uh, with her it's just the opposite. My visitation with her is more of just listening. However, I think just by being present by active listening does her a lot of good."
	"One has a very…uh, you know terrible disease. She can't talk and can't respond. I'm in close contact with her, with her husband. And he says other than his wife not being able to talk/respond or move, she can listen and hear. He said that just my presence and voice while visiting, is important."
7	"I would say the secret sauce is presence and showing up and being there for. Things that they may not expect you to be present."
	"But events that are pivotal showing up at the school board meetings showing up at the at the. A County Council meeting is a key place or maybe for a play that that that the school is having or something that's going on pivotally events I think."
8	"I am also present at the church throughout the day and week. Having an 'open-door' policy is a benefit to those in the congregation and community that need attention. I think me establishing daily visibility of the church in the community continuously promotes the right image and message by letting them know that the church cares about their welfare and that the church and I are constantly available in times of need for the community."

Be There [as a Resource]: Engagement

FLs and FBOs demonstrated visibility as social agents within their collaborative partnerships to improve local healthcare outcomes in communities among the Delmarva region. FLs increased their organizational boundary by engaging in various ways to improve health outcomes in the Delmarva region. FLs and FBOs in rural communities can perform various forms of outreach and engagement to respond to various social and community dilemmas that benefit the well-being of underserved and vulnerable populations in rural areas (Huff, 2020). The common organizational boundaries of FBOs can inherit connections with community and religious organizations (Christens et al., 2021; Watson, 2012). Quotes illustrating FL engagement in communities for efforts to improve health outcomes in the Delmarva region are provided in Table 7.

Table 7

Participant Responses Associated with Be There [as a Resource]: Engagement Theme

Participant	Interview excerpt
1	"Since my inception as an appointment pastor, I have engaged myself to focus on these specific health concerning areas in my community [effects of COVID, crime, and drug abuse but particularly drug abuse]."
	"Also, since I used to teach elementary, I have been engaged in Greensboro, MD with other church leaders to onset the development of an educational center."
	"I have interests in building an early childhood development center in effort to change this phenomenon in elongating to the future."
	"Improving health outcomes involves demonstrating inclusive efforts to engage everybody, not just one specific group in the community. Especially, for both those who do don't have a lot of access to resources to address their needs."
	"Being engaged in the county's school board and council meetings is important due to the level of influence and impact that the engagement could generate."
	"I think when people see you engaged and supportive of the community, they will begin to trust you and work with you because they will realize that you care."
	"As a member of the Community Center, I was able to acquire members from the clergy to also join and participate. Participating in community events and being aware of community happenings allows the church to provide a faith-based voice for community solutions."
2	"Being open in having the church assist with the health department, along with participating with the relief program with housing initiatives, I have been involved with making connections with funding among other churches and nonprofit organizations."
	"So, I am also becoming more active with publicity of the weathering issue for which not too many people knew about."
	"I think Faith-based Leaders have a unique position in the culture to be able to say things that maybe some other people can't. One of the positives is that…I end up sometimes being an advocate for families and patients in the hospital system just trying to translate what the doctors and nurses are saying, or if I am sitting with the family and I'm like they didn't hear the doctors or nurses properly, you know, kind of let them know you're going to have to talk to this family again or they're not hearing what you said or just some clarification. So…kind of where I see the connection is in my position."
	"If somebody doesn't have a home, then that is a health concern too. So that part is important. I sometimes feel like as a pastor, I'm uniquely

Participant	Interview excerpt
	positioned, cause people will tell me they're ills and feelings. And as a chaplain. I can go into hospitals and other spaces where others can't."
4	"One of the things that I'm involved with right now is court related, in which I serve as a witness at hand for a person that has Alzheimer's. I provide support to his family with daily activities and visitation. Due to the person's Alzheimer's condition, I help with communicating his feelings during court. I also serve as a mediator with his family as they continue to go through this unfortunate experience. The law and the family members to try to do what is best for him. So as a concerning pastor, I'm trying to do everything I can."
5	"Again, it's just the matter of making connections and talking in the community to find out ways to help and serve, to make people feel and do better with their lives. You know, even if I cannot help or be the solution to their needs, I can engage by reaching out to others to gather insight on possible solutions."
	"Previously, I engaged with a homeless woman that feared going to the doctor, due to her disability. She needed to see a doctor to receive SSI. So, I took her to the doctor and sat with her during her SSI interview so that she can acquire SSI."
	"To me, it's very important that we're active and involved in the community, getting to know people, supporting the different levels of care as well. So…whether it's going to our nursing home, that's across the street, going around and/or singing Christmas carols and taking treats out within the community for Valentine's Day, we just wanted them to know that they were remembered and tended to. And so, we didn't just do that for the residents, we did for the staff as well."
	"And the health arena is one of those arenas that I like to be involved with due to my healthcare background and the impact it has on other aspects of people's lives."
	"Another example of my value was recognizing the need for feeding children and adults. The food insecurities and inefficiencies in the area has been something that I've been actively involved with, along with the homeless populations."

Connect: Partner

FLs and FBOs demonstrated connective efforts to improve local healthcare outcomes in communities among the Delmarva region. Partnering was paramount for FL's and FBO's to manage the delivery and accessibility of health resources for constituents who needed them. Within the last 2 decades, stakeholders have expressed interest with FLs and FBOs as a resource to contribute to related health outcome efforts (Harmon et al., 2020; Jansen, 2019; Powers et al., 2019; Withers, 2020). FBOs and their partnering organizations can provide and access healthcare services for underserved and vulnerable populations, and their value is more acknowledged with their interest in treating underserved and vulnerable populations with more dignity, respect, and trust (Haslam et al., 2017; Schlesinger et al., 2005; Schlesinger & Gray, 2009. Table 8 includes quotes from participating FLs regarding their partnerships in communities to improve health outcomes in the Delmarva region.

Table 8

Participant Responses Associated with Connect: Partner Theme

Participant	Interview excerpt
1	"My collaboration with the local VFW provides a yearly donation to address the needs of the local church and the Grasonville community. Working together with the Grasonville Community Center and the NAACP create other opportunities to collectively solve some of our challenges."
2	"Other than just people in my congregation that I'm attending to, I'm in a place downtown, and we have an education building and so we've partnered with the public health department to provide COVID shots earlier. And we've also partnered with the local YMCA. They were looking for a place to do a diabetes class."
	"And so, we have partnered, we have official partnerships with thee organizations here in Princess Anne, MD."
	"We also have an informal partnership with Lower Shore Shelter, which is the homeless shelter here in town."
	"And the third partnership program is the Judy Center of Somerset County, which is a Maryland state program, but each county has an umbrella organization called the Judy Center that helps."
	"So, they gave out car seats and they also made sure that we put them in properly. So, it's kind of car seat safety check. And that was through partnering with the Judy Center."
	"During COVID we partnered with the Somerset County Health department to get vaccines out to people."
	"Being open in having the church assist with the health department, along with participating with the relief program with housing initiatives, I have been involved with making connections with funding among other churches and nonprofit organizations."
	"And we've also partnered with the local YMCA. They were looking for a place to do a diabetes class."
3	"We also collaborate with community partners like social services and other local partners that offer mobile buses that provide a range of services that also contribute to improvements of personal well-being."
	"Regarding the physical aspect, we try to work with different communities, partner with health agencies to offer a range of services, like COVID testing and kits. In terms of what areas need to be redeemed."
	"The testing kits and following the health department guidelines were also practical ways in which we were being partners and doing what's correct for the community. The testing kits and following the health

Participant	Interview excerpt
	department guidelines were also practical ways in which we were being partners and doing what's correct for the community."
	"As an example, again during the whole COVID thing, it was very important for us to be in partnership with the local health department to make sure people were getting correct information about vaccines to be vaccinated."
7	"We connected with the Grasonville Community Center, and they came out and other entities within Grasonville in the area came in and did workshops and things and it was a great time."
9	"We partner with the Food Bank of Delaware, New Day Pregnancy Center, Adult and Teen Challenge in Seaford."
	"Collaborative partnerships allow us to expand our reach and interact with more people, meeting more needs. The main organizations we collaborate with are The Food Bank of Delaware, New Day Pregnancy, and Adult and Teen Challenge in Seaford. Our collaborations are informal and voluntary. Our collaborative partnerships meet the needs of the community by combining our efforts to reach more people."

Connect: Collaborate

FLs and FBOs demonstrated collaborative efforts to improve local healthcare outcomes in communities among the Delmarva region. Collaborative efforts were essential for FLs and FBOs to connect with key stakeholder and health resources who needed them. FLs of FBOs normally engage in healthcare collaborative partnerships in underserved communities (Schoenberg & Swanson, 2017). Community organizing to achieve health equity encourages community organizing to frame advances to achieve equitable outcomes around key health measures (Pastor et al., 2018). Some practitioners may find FLs and FBO ministries to be natural allies in health promotion and disease prevention efforts through the connection of individuals and organizations to meet their overall health needs (Schoenberg & Swanson, 2017). Table 9 includes quotes illustrating collaborations between FLs and FBOs to improve health outcomes in the Delmarva region.

Table 9

Participant Responses Associated with Connect: Collaborate Theme

Participant	Interview excerpt
1	"I have been working with the county health department, and local universities to identify ways to provide services through our church."
	"Also, since I used to teach elementary, I have been engaged in Greensboro, MD with other church leaders to onset the development of an educational center."
	"My collaboration with the local VFW provides a yearly donation of $1,200 to address the needs of the local church and the Grasonville community."
	"Internally, there are members of the congregation that are connected to the community through their professional relationship…either as nurses, or as another related professional in the health field. So, they bring professional knowledge, skills, and experience to lead some of the church activities that are useful in our community."
	"For the parade, we connected with the Grasonville Community Center and other community entities to provide workshops and things of that sort."
	"In particular, the Cambridge ministry of my church involves getting churches to work together. We have a ministry center location that provides folks with food, as well as useful information, resources, and counseling to improve personal well-being."
2	"I guess like the example that the one that we could use for collaboration was the Somerset County Public Health Department and coming in and using our facility for COVID vaccine shots."
	"Oh, I'm definitely a collaborator. Collaborator tends to be me. One of my strengths is bridge building. I hear different things and I know who to connect with."
	"And at this point, that's kind of what I'm doing trying to just you know make as many contacts with other church and Faith Leaders as much as possible…with other local, state, and public service entities and individuals."
3	"In the face setting, we have always tried to collaborate with different stakeholders in the community and some of the ways was providing health fairs through the church…such as blood pressure and chest screening, and things of that nature."
	"We also collaborate with community partners like social services and other local partners that offer mobile buses that provide a range of services that also contribute to improvements of personal well-being."
4	"Again, it's just the matter of making connections and talking in the community to find out ways to help and serve, to make people feel and

Participant	Interview excerpt
	do better with their lives. You know, even if I cannot help or be the solution to their needs, I can engage by reaching out to others to gather insight on possible solutions."
5	"Again, it's just the matter of making connections and talking in the community to find out ways to help and serve, to make people feel and do better with their lives. You know, even if I cannot help or be the solution to their needs, I can engage by reaching out to others to gather insight on possible solutions."
	"Sometimes I will contact somebody to acquire monetary resources to help people with their concerns."
	"Coincidentally, it worked out that one of our folks that works at the local Hospice was in the building. I asked if she could chat with them because of her community connection as a church member as well as being a key member in the community that help others."
	"Again, it's just the matter of making connections and talking in the community to find out ways to help and serve, to make people feel and do better with their lives."
	"For instance, with us being able to get COVID tests while we were out, just virtually coming together, it was an opportunity to reach out to local health departments and organizations, but we had to know people, we had to go there and be able to collaborate with them to get what we needed."
6	"It's different Faith Leaders from Delmarva area that come together and discuss events and ways they can serve in the community even with food drives and things of that nature."
	"The supplies for the COVID test and mask and things of that sort, but those things were a blessing because when the masks were in a shortage, we were able to get what we needed through connections that were made with the health department and health organizations."
	"We also provide general health checkups that we perform at times and make sure that people have what they need, something that we're working on, making sure that the health ministry interacts with community health organizations like Red Cross to coordinate blood drives and things of that sort."
7	"I think we're more of a partner to community and we collaborate with, Umm, collaborate with other entities in the Community to actually get things done."
	"We connected with the Grasonville Community Center, and they came out and other entities within Grasonville in the area came in and did workshops and things and it was a great time."
9	"So, our church collaborating with other churches and organizations to care for and reach our city is the only way we do ministry."

Participant	Interview excerpt
	"I'm working toward helping unite churches and to work together to reach our city."
	"So, our church collaborating with other churches and organizations to care for and reach our city is the only way we do ministry."
	"Collaborative partnerships allow us to expand our reach and interact with more people, meeting more needs. The main organizations we collaborate with are The Food Bank of Delaware, New Day Pregnancy, and Adult and Teen Challenge in Seaford. Our collaborations are informal and voluntary. Our collaborative partnerships meet the needs of the community by combining our efforts to reach more people."

Holistic: Wholeness

FLs demonstrated holistic health awareness to improve local healthcare outcomes. FBOs continue to serve as a major resource for rural areas to better the well-being of their communities (Faith-based Organizations, n.d.; Khafagy, 2020). FLs can improve the well-being of others and health outcomes by intrinsic motivation, values, ethics, and corporate social responsibility (Fry, 2003; Fry et al., 2005; Oh & Wang, 2020). FLs among the Delmarva region displayed an interest to promote holistic health. Table 10 includes quotes illustrating participating FLs' holistic health awareness and capacity to improve health outcomes in the Delmarva region as social agents.

Table 10

Participant Responses Associated with Holistic: Wellness Theme

Participant	Interview excerpt
2	"As a pastor and a Faith Leader, the health, and the holistic health of people is my concern. Not just their spiritual health, but also their emotional and physical health needs to be tight."
	"Umm, so I feel like spiritual health of a person isn't just spiritual. It's also emotional and physical. All those other parts, and they all work together, so I'm kind of a holistic pastor. I like to tend to the soul."
3	"So, the vision of course, is to bring wholeness and healing through the name of Jesus Christ. So, we bring Shalom to complete peace and well-

Participant	Interview excerpt
	being. There are the spiritual, physical, and mental components of every person that needs attention."
7	"As a faith leader, I'm concerned about the total well-being of the individual, and that includes health as well as the physical health, mental health, spiritual health, emotional health, and all of those things have been a focal point for the church for many years"
8	"I really believe that the mental and physical health, along with spiritual health is the best path forward to attain and sustain good overall health."
	"I am constantly reminded on the importance of these factors to achieve good health we are connected: mind, body, and spirit. If one area is suffering the other two will suffer as well."
	"So, in other words, Christianity should be more than just talking, but should also be about the physical and mental aspects of health as well. This could lead to physical improvements for individuals and their families, which in turn can impact the health of a community."
	"Being involved with the church and community is the spiritual component I'd like to think I bring that is just as important to total body health. Having all three core factors [spirit, mind, and physical health] is what I express from the pulpit and exhibit in my life."
	"When approaching health, we must not only consider the mind and body, but also need to consider the importance of the spirit as well, because all the factors are a part of one wholeness."

Holistic: Church Activity

FLs and FBOs demonstrated church activity to improve local healthcare outcomes among the Delmarva region. Various services and support were demonstrated by FLs and FBOs. FLs were implemental for meeting needs of their constituents through specific church actions. In the health sector, FBOs were known to engage with service delivery, and were very active in remote areas among the world (Global Health News, 2018). With religious institutions being a key construct in rural communities, they can offer access to rural ethnic/racial groups in specific geographical areas (National Center for Cultural

Competence, n.d.). Quotes illustrating efforts by FLs and FBOs to improve health outcomes through church activity are provided in Table 11.

Table 11

Participant Responses Associated with Holistic: Church Activity Theme

Participant	Interview excerpt
1	"I have been working with the county health department, and local universities to identify ways to provide services through our church."
	"My church provides economic empowerment activity, specifically for younger congregants of the church. And for the elderly congregants of the church, estate planning activities are provided."
	"And to think about it, during Lent season turned out to be health focus because it influenced congregants to give up unhealthy food for a short period of time. Congregants during this time lost a lot of weight."
	"As far as activities of the church that are more health specific, the church provides awareness about various health conditions, such as diabetes, heart impediments, and stroke, along with the value of exercise."
	"Another example was our food bank activity, in terms of using the church as an entity to gather various folks from the community and to provide opportunities to network amongst each other."
	"In particular, the Cambridge ministry of my church involves getting churches to work together. We have a ministry center location that provides folks with food, as well as useful information, resources, and counseling to improve personal well-being."
2	"Having the local health department provide local vaccinations through the church really helped residents get vaccinated especially for those who have trouble getting rides to the local health department for similar and other health services and needs."
3	"Church ministries in general, as well as my church, we do a lot of community outreach by working with underrepresented and underserved populations that are impacted my various social conditions, such as poverty."
	"So, they bring professional knowledge, skills, and experience to lead some of the church activities that are useful in our community."
	"Other practical ways were just the health fairs that we've have held for getting the health experts to help. Maintaining the health of my congregation, as well as their friends and families is another way to reach the health needs of the community."
	"We do have a specific health ministry that operates annually for folks in need of medical devices such as walkers, canes, wheelchairs, elevated stools for toilets, bed rails, and things of that nature."
	"Regarding the elderly population, we have a lot of donated items that we lend. We often either release those donated items to people really need them, or we provide those items through a lease."

Participant	Interview excerpt
	"In the face setting, we have always tried to collaborate with different stakeholders in the community and some of the ways was providing health fairs through the church, such as blood pressure and chest screening, and things of that nature."
4	"Part of my ministry is to provide visitation to the homebound on a regular basis to bring communion to them and just to be a friend and support them in life struggles that they encounter."
	"We have the services through the church, but I think one of the most important parts of my ministry is to meet those who can't really get out, which is in most cases the elder population."
5	"There is also a food ministry at my church. In fact, today we had a food pantry. We had 34 people that were served which enabled them to provide for their families."
6	"Mostly activity consisted of offerings for our local people and congregants, whether that's delivering food to them when they needed or even delivering communion or picking up offering things of that sort within our community."
	"We also provide general health checkups that we perform at times and make sure that people have what they need, something that we're working on, making sure that is having a health ministry to interact with community health organizations like Red Cross to coordinate blood drives and things of that sort."
7	"Oh, I think as a faith-based leader the best thing that I can do is provide awareness to the congregation and the community of what works and what makes you healthy. What makes you better and communicate to them what's the latest thing out there that is help people."
8	"The church also provides seminars and special meetings at the church that focus on various areas of life. My intention is to me multi-dimensional in providing various services and needs that focus on enhancing the mind, body, and spirit for the congregation and community."
	"My intention is to me multi-dimensional in providing various services and needs that focus on enhancing the mind, body, and spirit for the congregation and community."

Holistic: Community Activity

FLs and FBOs demonstrated community church activity to improve local healthcare outcomes among the Delmarva region. The common organizational

boundaries of FBOs inherits connections with community and religious organizations, (Christens et al., 2021; Watson, 2012). FBOs are actively involved with national development, and disaster assistance through partnerships and investments that are focused with saving lives and reducing poverty (Global Health News, 2018). FLs displayed a variety of health support and services among communities in the Delmarva region through both FLs and FBOs. Quotes concerning FL and FBO community church efforts to improve health outcomes are provided in Table 12.

Table 12

Participant Responses Associated with Holistic: Community Activity Theme

Participant	Interview excerpt
1	"Currently, we are striving to create shared farms to provide and offer produce in neighboring areas that exhibit food disparities."
	"As an example, the church was used as a setting to have group meetings for community members and organizations."
	"Especially, during occurrence of tragic events and emergencies experienced by the community, as well as among constituents, the church always serves as an outlet to provide the necessary presence of support."
	"Another example was our food bank activity, in terms of using the church as an entity to gather various folks from the community and to provide opportunities to network amongst each other."
2	"Other than just people in my congregation that I'm attending to, I'm in a place downtown, and we have an education building and so we've partnered with the public health department to provide COVID shots earlier. And we've also partnered with the local YMCA."
	"I guess like the example that the one that we could use for collaboration was the Somerset County Public Health Department and coming in and using our facility for COVID vaccine shots."
	"Having the local health department provide local vaccinations through the church really helped residents get vaccinated especially for those who have trouble getting rides to the local health department for similar and other health services and needs."
	"Being open in having the church assist with the health department, along with participating with the relief program with housing initiatives, I have been involved with making connections with funding among other churches and nonprofit organizations."
3	"We also had, for a long time ran a food pantry. We now moved it to a different location, but we had a food pantry to provide the food needs of the community. And that was also a way for us to touch base with folks and see what else is going on in their lives and helping them to connect with resources they need."
	"Church ministries in general, as well as my church, we do a lot of community outreach by working with underrepresented and underserved populations that are impacted my various social conditions, such as poverty."
	"Regarding the elderly population, we have a lot of donated items that we lend. We often either release those donated items to people really need them, or we provide those items through a lease."

Participant	Interview excerpt
	"Several things I could touch on…As an example, again during the whole COVID thing, it was very important for us to be in partnership with the local health department to make sure people were getting correct information about vaccines to be vaccinated."
	"Other practical ways were just the health fairs that we've have held for getting the health experts to help. Maintaining the health of my congregation, as well as their friends and families is another way to reach the health needs of the community."
	"We do have a specific health ministry that operates annually for folks in need of medical devices such as walkers, canes, wheelchairs, elevated stools for toilets, bed rails, and things of that nature."
	"In particular, the Cambridge ministry of my church involves getting churches to work together. We have a ministry center location that provides folks with food, as well as useful information, resources, and counseling to improve personal well-being."
	"We provide blood pressure checks on a regular basis throughout the year. Having that opportunity for folks that were recently engaged in hospital care, enables them to sustain their health by having their blood pressure checked on a frequent basis. This service also enables me to have productive communication with local health departments."
	"We also had, for a long time ran a food pantry. We now moved it to a different location, but we had a food pantry to provide the food needs of the community."
4	"When we go to the nursing home, for those residents that are severely handicapped [physically, mentally, emotionally] my visitation serves as a means of communication to acquire what they need, whether it's via talking or listening."
5	"We also provide outreach that enables us to coordinate and facilitate meals for the homeless shelter and other related services. One of our outreach programs that also helps is the Backpack Feeding Program for children."
	"Making sure that children who are food insecure get meals for the weekend is one of our essential services. This service serves three schools that effectively reach 80 kids. And its ran by volunteers from the church and community. Volunteers take meals to the school, and the school coordinates the delivery of meals anonymously to children…in effort to protect the identity of the children."
6	"Mostly activity consisted of offerings for our local people and congregants, whether that's delivering food to them when they needed or even delivering communion or picking up offering things of that sort within our community."
	"We also provide general health checkups that we perform at times and make sure that people have what they need, something that we're

Participant	Interview excerpt
	working on, making sure that the health ministry interacts with community health organizations like Red Cross to coordinate blood drives and things of that sort."
7	"Such as some type of using the church as a place to have group meetings, provide food bank, and a place to gather. Doing times of tragic events or different types of emergencies."
	"We connected with the Grasonville Community Center, and they came out and other entities within Grasonville in the area came in and did workshops and things and it was a great time."
8	"The church also provides seminars and special meetings at the church that focus on various areas of life. My intention is to me multi-dimensional in providing various services and needs that focus on enhancing the mind, body, and spirit for the congregation and community."
	"My intention is to me multi-dimensional in providing various services and needs that focus on enhancing the mind, body, and spirit for the congregation and community."
9	"We work with the Food Bank of Delaware, New Day Pregnancy Center, Adult and Teen Challenge in Seaford to assist with meeting the needs of the community."
	"Our vision is to be a community of hope for all people and the way we see this vision become reality is by accomplishing our mission. We believe that meeting the needs of the community is the responsibility of the Church [body of Christ] and this is one of the best ways to make God known. We do our best to give financially to organizations that support the community (e.g., food banks, pregnancy and crisis centers) and physically serve in these places as well."
	"We support organizations that are dedicated to caring for the health of the community and we make ourselves available to serve where needed. We support the organizations through financial offerings and volunteer labor, when possible. We partner with the Food Bank of Delaware, New Day Pregnancy Center, Adult and Teen Challenge in Seaford."

Guide and Move Others to Action: Influence

FLs and FBOs provided guidance to improve local healthcare outcomes among the Delmarva region. FLs among the Delmarva region were instrumental for establishing accessibility with health services, health information, and other related health assistance to improve health outcomes in their communities. FLs can serve others through their

professional practice [religion, discipline, education, and stewardship] and are prominent leaders in communities as sources of diverse expertise for meeting specific needs of a populations (Heward-Mills et al., 2018; Levin, 2016). FL organizations have a unique position to address various community issues [e.g., social determinants of health, environmental injustices, and health disparities] through active involvement with other stakeholders, community healthcare organizations and key leaders (Rivera-Hernandez, 2015). FLs can be influential assets in their communities of the Delmarva region, due to their level of attention to the health needs of constituents and community. Quotes concerning FLs' influential efforts to improve health outcomes in the Delmarva region are provided in Table 13.

Table 13

Participant Responses Associated with Guide and Move Others to Action: Influence Theme

Participant	Interview excerpt
1	"And to think about it…during Lent season turned out to be health focus because it influenced congregants to give up unhealthy food for a short period of time. Congregants during this time lost a lot of weight."
	"Being engaged in the county's school board and council meetings is important due to the level of influence and impact that the engagement could generate."
	"Well, primarily as a pastor, I seek to make a significant change in others and in the surrounding community of the church."
	"My efforts to impact troublesome behavior patterns is to focus my efforts on being consistent and establish a recurrent routine. Also, creating a conducive helping culture in the community through the church enables some form of impact."
	"As a member of the Community Center, I was able to acquire members from the clergy to also join and participate. Participating in community events and being aware of community happenings allows the church to provide a faith-based voice for community solutions."

Participant	Interview excerpt
3	"In terms of what areas need to be redeemed, I utilize a leadership style that prevents division, and to lead by example by going out to serve others. But more importantly, quipping folks and identifying those in the congregation that have the skills, talents, and gifts, to support the coordination of gathering these folks."
5	"As I had mentioned in the food insufficiency areas people benefit and it motivates and inspire people to help even more. Utilizing people's gifts to help others allows us to work with what we must produce results that impact community health."
6	"I'm just really a facilitator and try to be the role model that I can with helping people see that they can do more than what they thought they could."
8	"I must constantly inspire others through my actions and words because these influence people."

Guide and Move Others to Action: Motivate

FLs provided guidance to improve local healthcare outcomes among the Delmarva region. FLs play an important role to motivate others (Podaskoff et al., 1990). Burns concluded that transforming leadership was a process in which leaders and followers support each other to advance to a higher level of morale and motivation (Burns, 1978, 2003). Resource scarcity in rural areas may motivate community leaders to partner with other community organizations to prevent disease, and even improve the health of rural Americans (Harrington et al., 2020). FLs of FBOs are involved with collaborative partnership activity with other community organizations and FLs through the four dimensions of transformational leadership (Rela et al., 2020): idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration. Transformative FLs can motivate others to achieve performance, due to the transformation of followers' attitudes, beliefs, and values (Bass et al., 1987, Yukl, 1989). FLs and FBOs had demonstrated various methods on motivating others. Quotes

concerning the capacity of FLs and FBOs to motivate others to improve health outcomes in the Delmarva region are provided in Table 14.

Table 14

Participant Responses Associated with Guide and Move Others to Action: Motivate Theme

Participant	Interview excerpt
1	"Well, primarily as a pastor, I seek to make a significant change in others and in the surrounding community of the church."
	"Also, creating a conducive helping culture in the community through the church enables some form of impact."
	"And to think about it, during Lent season turned out to be health focus because it influenced congregants to give up unhealthy food for a short period of time. Congregants during this time lost a lot of weight."
	"Whether it involves going an extra mile or making an extra phone call. Gathering people and resources to observe and understand what is taking place and what is occurring in a community is essential for me to communicate that to community stakeholders and constituents in the community. And to ensure that the gathering of people and resources has an ability to embark the needed change."
	"Another example was our food bank activity, in terms of using the church as an entity to gather various folks from the community and to provide opportunities to network amongst each other."
	"Being engaged in the county's school board and council meetings is important due to the level of influence and impact that the engagement could generate."
	"I think when people see you engaged and supportive of the community, they will begin to trust you and work with you because they will realize that you care. This approach would also enable conversations among entities and stakeholders in the community to address various needs."
	"Even though I cannot directly change government systems or pharmaceutical processes of the health industry, I can still do my part to influence people in my local congregation or community from a faith-based organization standpoint to address health issues and community."
3	"Well, I try to demonstrate a holistic way of living just by giving my time and my talents to better the community, and hopefully that is something that motivate others to do the same."
	"Internally, there are members of the congregation that are connected to the community through their professional relationship…either as nurses, or as another related professional in the health field. So, they bring professional knowledge, skills, and experience to lead some of the church activities that are useful in our community."
	"I tend to try to set a vision before the church, but then have others come along to help carry out the vision."

Participant	Interview excerpt
	"In terms of what areas need to be redeemed, I utilize a leadership style that prevents division, and to lead by example by going out to serve others. But more importantly, equipping folks and identifying those in the congregation that have the skills, talents, and gifts, to support the coordination of gathering these folks."
5	"It's a long journey but witnessing certain activities making a difference gives promise to continue. As I had mentioned in the food insufficiency areas people benefit and it motivates and inspire people to help even more. Utilizing people's gifts to help others allows us to work with what we must produce results that impact community health."
6	"I'm just really a facilitator and try to be the role model that I can with helping people see that they can do more than what they thought they could."
8	"This attitude of preparation and maintenance I hope will rub off on the health of youth and elderly populations in the community. We want to meet those needs."
9	"My goal is to build and grow my congregation with new insights and knowledge so that they can be successful (and prepared) in fulfilling any personal or career aspiration that they may have and to not only survive but thrive."

Guide and Move Others to Action: Support

FLs and FBOs provided support to improve local healthcare outcomes among the Delmarva region. Rural regions in the United States demonstrate a unique relationship with FLs and FBOs and have the capacity to support opportunities to utilize current and future organizational and community connections to increase health behaviors (Martin et al., n.d.) Through constructive support, FLs could meet the needs of others, and their communities (Jandeska, 2019). It is necessary to set up a connection between the community and professionals in public health to reinforce actions of educational institutions, student associations, government officials, and other professionals, with the aim of supporting public health initiatives that will help a community (Bonilla & Gomez, 2020). FLs and FBOs demonstrated supportive personal, church, and community

activities and behaviors to improve health outcomes among the Delmarva region. Quotes concerning the capacity of FLs to inspire others to improve health outcomes in the Delmarva region are provided in Table 15.

Table 15

Participant Responses Associated with Guide and Move Others to Action: Support Theme

Participant	Interview excerpt
1	"Especially, during occurrence of tragic events and emergencies experienced by the community, as well as among constituents, the church always serves as an outlet to provide the necessary presence of support."
	"Being a leader in the community by being supportive of community events, community welfare, and constituent well-being is just as important as providing Sunday worship."
	"Attending a school play is also just as pivotal to reach the youth and being present in such events provides positive assurance for the community that the church is supportive of community events, welfare, and outcomes."
	"I think when people see you engaged and supportive of the community, they will begin to trust you and work with you because they will realize that you care. This approach would also enable conversations among entities and stakeholders in the community to address various needs."
	"Internally, there are members of the congregation that are connected to the community through their professional relationship either as nurses, or as another related professional in the health field. So, they bring professional knowledge, skills, and experience to lead some of the church activities that are useful in our community."
	"In particular, the Cambridge ministry of my church involves getting churches to work together. We have a ministry center location that provides folks with food, as well as useful information, resources, and counseling to improve personal well-being."
2	"If somebody doesn't have a home, then that is a health concern too. So that part is important. I sometimes feel like as a pastor, I'm uniquely positioned, cause people will tell me they're ills and feelings. And as a chaplain. I can go into hospitals and other spaces where others can't."
	"I think Faith-Based Leaders have a unique position in the culture to be able to say things that maybe some other people can't. One of the positives is that I end up sometimes being an advocate for families and patients in the hospital system just trying to translate what the doctors and nurses are saying, or if I am sitting with the family and I'm like they didn't hear the doctors or nurses properly, you know, kind of let them know you're going to have to talk to this family again or they're not hearing what you said or just some clarification. So…kind of where I see the connection is in my position."
	"Being open in having the church assist with the health department, along with participating with the relief program with housing initiatives, I

Participant	Interview excerpt
	have been involved with making connections with funding among other churches and nonprofit organizations."
3	"In terms of what areas need to be redeemed, I utilize a leadership style that prevents division, and to lead by example by going out to serve others. But more importantly, equipping folks and identifying those in the congregation that have the skills, talents, and gifts, to support the coordination of gathering these folks."
	"So, it's not just about me doing everything. We have some talented and gifted folks in the congregation."
4	"Part of my ministry is to provide visitation to the homebound on a regular basis to bring communion to them and just to be a friend and support them in life struggles that they encounter."
	"One of the things that I'm involved with right now is court related, in which I serve as a witness at hand for a person that has Alzheimer's. I provide support to his family with daily activities and visitation. Due to the person's Alzheimer's condition, I help with communicating his feelings during court. I also serve as a mediator with his family as they continue to go through this unfortunate experience. The law and the family members to try to do what is best for him. So as a concerning pastor, I'm trying to do everything I can."
	"My visitation experiences over the years have taught me the important skills of dealing with the home bound and nursing home patients that I visit on a regular basis."
	"One activity that is my strength is providing visitation to those that are homebound."
	"I think it's important to reach the unreachable in a community, because in essence, that is what Ministry is about…reaching to the people. I am needed wherever they are, in whatever and/or whenever condition they are in. That's the commandment of Christ. You know, Christ did most of his ministry to the poor by healing people where their needs were."
	"So, in terms of health needs, it's not only confined to the homebound. When we go to the nursing home, for those residents that are severely handicapped [physically, mentally, and emotionally] my visitation serves as a means of communication to acquire what they need. whether it's via talking or listening."
5	"To me, it's very important that we're active and involved in the community, getting to know people, supporting the different levels of care as well."
	"I do home and hospital visitations to provide emotional and spiritual support as well."
	"One of the supportive mechanisms is our food pantry that operates on the 1st and 3rd Wednesday of every month. We also provide outreach that enables us to coordinate and facilitate meals for the homeless shelter

Participant	Interview excerpt
	and other related services. One of our outreach programs that also helps is the Backpack Feeding Program for children."
	"We also helped by serving as a resource to help people fulfill other needs that are not health related as well. Some of our folks also volunteered to help others by identifying needs to develop solutions for them."
	"Previously, I engaged with a homeless woman that feared going to the doctor, due to her disability. She needed to see a doctor to receive SSI. So, I took her to the doctor and sat with her during her SSI interview so that she can acquire SSI."
	"I also visited her when she was admitted to the emergency room and thereafter, I was chosen by her to be her person of contact, for which I didn't even know that she had did that. I didn't know that was going to happen, but when I reached out to the hospital to find out how she was one of the hospital members that shared that with me. So that experience made me aware of my value."
	"Another example of my value was recognizing the need for feeding children and adults. The food insecurities and inefficiencies in the area has been something that I've been actively involved with, along with the homeless populations."
9	"We support organizations that are dedicated to caring for the health of the community and we make ourselves available to serve where needed. We support the organizations through financial offerings and volunteer labor, when possible. We partner with the Food Bank of Delaware, New Day Pregnancy Center, Adult and Teen Challenge in Seaford."
	"Right now, the only mechanism we have is financial support. As we grow numerically, we'll be able to expand our support. But our financial support helps keep the organizations operating so they can continue to serve the community. Our funding comes solely from the generosity of our attenders."
	"Our vision is to be a community of hope for all people and the way we see this vision become reality is by accomplishing our mission. We believe that meeting the needs of the community is the responsibility of the Church [body of Christ] and this is one of the best ways to make God known. We do our best to give financially to organizations that support the community [e.g., food banks and pregnancy crisis centers] and physically serve in these places as well."
	"Being engaged in the county's school board and council meetings is important due to the level of influence and impact that the engagement could generate."
	"Whether it involves going an extra mile or making an extra phone call. Gathering people and resources to observe and understand what is taking place and what is occurring in a community is essential for me to communicate that to community stakeholders and constituents in the

Participant	Interview excerpt
	community. And to ensure that the gathering of people and resources has an ability to embark the needed change."

Summary

In summary, the results of the study provided evidence for FLs serving as social agents for social change within collaborative partnerships for improving local healthcare outcomes among the Delmarva region. FLs demonstrated attributes of a social agent by engaging with community organizations that have influence on social behavior and conditions. FLs can play a significant as resources for social change within their communities and organizations (Idler et al., 2019). Below are the some of the notable quotes from the themes that offer evidence of FLs' social agent activity among the Delmarva region:

- "Being engaged in the county's school board and council meetings is important due to the level of influence and impact that the engagement could generate."
- "I am also a board member of the Eastern Shore Long Term Recovery program, which was driven by the occurrence of Hurricane Sandy. Sometimes freakish storms often flood the areas and produce infrastructure devastations in the county. And most of the time these freakish storm incidents don't make regional or national news. Houses were flooded. The Recovery program has been assessing houses and getting funding to help repair and build new homes."

- “Another example of my value was recognizing the need for feeding children and adults. The food insecurities and inefficiencies in the area has been something that I've been actively involved with, along with the homeless populations.”
- “Gathering people and resources to observe and understand what is taking place and what is occurring in a community is essential for me to communicate that to community stakeholders and constituents in the community.”
- “Being open in having the church assist with the health department, along with participating with the relief program with housing initiatives, I have been involved with making connections with funding among other churches and nonprofit organizations.”
- “Since my inception as an appointment pastor, I have engaged myself to focus on these specific health concerning areas in my community [effects of COVID, crime, and drug abuse, but particularly drug abuse].”
- “My collaboration with the local VFW provides a yearly donation to address the needs of the local church and the Grasonville community. Working together with the Grasonville Community Center and the NAACP create other opportunities to collectively solve some of our challenges.”
- “Church ministries in general, as well as my church, we do a lot of community outreach by working with underrepresented and underserved populations that are impacted my various social conditions, such as poverty.”

FLs of FBOs demonstrated connective actions to collaborate and partner with other organizations in their communities to contribute to positive health outcomes among the Delmarva region. FLs were engaged with other community organizations to increase their effectiveness to address various social conditions that impact well-being. Historically and presently, FLs have been engaged with a variety of community health organizations to alleviate the impact and cause of social conditions (Idler et al., 2019). FLs of FBOs can provide social support, locations to facilitate intervention delivery, and outreach to serve their congregants and community constituents who have limited access to health resources and services (Berkley-Patton et al., 2024). See quotes below concerning FL and FBO actions to improve health outcomes in the Delmarva region:

- "I have been working with the county health department, and local universities to identify ways to provide services through our church."
- "In particular, the Cambridge ministry of my church involves getting churches to work together. We have a ministry center location that provides folks with food, as well as useful information, resources, and counseling to improve personal well-being."
- "I guess like the example that the one that we could use for collaboration was the Somerset County Public Health Department and coming in and using our facility for COVID vaccine shots."
- "We also collaborate with community partners like social services and other local partners that offer mobile buses that provide a range of services that also contribute to improvements of personal well-being."

- “For instance, with us being able to get COVID tests while we were out, just virtually coming together, it was an opportunity to reach out to local health departments and organizations, but we had to know people, we had to go there and be able to collaborate with them to get what we needed.”
- “We also provide general health checkups that we perform at times and make sure that people have what they need, something that we're working on, making sure that the health ministry interacts with community health organizations like Red Cross to coordinate blood drives and things of that sort.”
- “Collaborative partnerships allow us to expand our reach and interact with more people, meeting more needs. The main organizations we collaborate with are The Food Bank of Delaware, New Day Pregnancy, and Adult and Teen Challenge in Seaford. Our collaborations are informal and voluntary. Our collaborative partnerships meet the needs of the community by combining our efforts to reach more people.”

FLs yield abilities to guide and move others to action to produce positive health outcomes among the Delmarva region. FLs can exhibit dimensions of transformational leadership, due to their level of influence and motivation on and for others. Not only are transformational FLs often perceived as effective role models in communities, FLs are also uniquely positioned to address concerns other than their own, and initiate actions to carry them out (Deo & Shitote, 2023). FLs of FBOs are often responsive to the complex needs by utilizing internal and external organizational leaders that can produce a

transformational effect on outcomes (Willis, 2020). See quotes below concerning FL transformational leadership capacities:

- “Well, primarily as a pastor, I seek to make a significant change in others and in the surrounding community of the church.”
- “Whether it involves going an extra mile or making an extra phone call. Gathering people and resources to observe and understand what is taking place and what is occurring in a community is essential for me to communicate that to community stakeholders and constituents in the community. And to ensure that the gathering of people and resources has an ability to embark the needed change.”
- “Even though I cannot directly change government systems or pharmaceutical processes of the health industry, I can still do my part to influence people in my local congregation or community from a faith-based organization standpoint to address health issues and community.”
- “Well, I try to demonstrate a holistic way of living just by giving my time and my talents to better the community, and hopefully that is something that motivate others to do the same.”
- “I tend to try to set a vision before the church, but then have others come along to help carry out the vision.”
- “It’s a long journey but witnessing certain activities making a difference gives promise to continue. As I had mentioned in the food insufficiency areas people benefit and it motivates and inspire people to help even more. Utilizing

people's gifts to help others allows us to work with what we must produce results that impact community health."

- "I'm just really a facilitator and try to be the role model that I can with helping people see that they can do more than what they thought they could."
- "My goal is to build and grow my congregation with new insights and knowledge so that they can be successful [and prepared] in fulfilling any personal or career aspiration that they may have and to not only survive but thrive."
- "In terms of what areas need to be redeemed, I utilize a leadership style that prevents division, and to lead by example by going out to serve others. But more importantly equipping folks and identifying those in the congregation that have the skills, talents, and gifts, to support the coordination of gathering these folks."

Results of the study demonstrate consistency with the conceptual framework of the study. The Social Ecological Model supplies a framework to understand leadership and collaborative partnership of FLs within a continuum of micro-, meso-, and macro-levels, through a range of individual, social, and community influences (Bronfenbrenner, 1976, 1989; 1999; 2005; 2006; Long et al., 2020). FLs navigate the subsystems of SEM to contribute to various interventions for alleviating unfavorable health outcomes in communities among the Delmarva region [see Figure 1]. FLs of FBO among the Delmarva region demonstrated innovative actions within and among their organizational environments to alleviate unfavorable health outcomes. FLs exhibited transformational

leadership characteristics by serving as social agents to address various social conditions of communities through the resulting themes of the study: (a) managing and leading, (b) guiding and move others to action, (c) connecting, (d) be there, and (e) holistic [see Figure 17].

FLs of the study revealed quotes that demonstrated characteristics of transformational leadership. FLs demonstrated transformational leadership to guide and move others to actions as social agents. See quotes below from the 'Guide and Move Others to Action' theme for some examples:

- "Well, primarily as a pastor, I seek to make a significant change in others and in the surrounding community of the church." [Intellectual stimulation]
- "Even though I cannot directly change government systems or pharmaceutical processes of the health industry, I can still do my part to influence people in my local congregation or community from a faith-based organization standpoint to address health issues and community." [Inspirational Motivation]
- "Well, I try to demonstrate a holistic way of living just by…giving my time and my talents to better the community, and hopefully that is something that motivate others to do the same." [Inspirational Motivation]
- "I tend to try to set a vision before the church, but then have others come along to help carry out the vision." [Inspirational Motivation]
- "In terms of what areas need to be redeemed, I utilize a leadership style that prevents division, and to lead by example by going out to serve others. But

more importantly equipping folks and identifying those in the congregation that have the skills, talents, and gifts, to support the coordination of gathering these folks." [Idealized Influence/Inspirational Motivation]

- "It's a long journey but witnessing certain activities making a difference gives promise to continue. As I had mentioned in the food insufficiency areas people benefit and it motivates and inspire people to help even more. Utilizing people's gifts to help others allows us to work with what we must produce results that impact community health." [Intellectual Stimulation/Idealized Influence/Inspirational Motivation]
- "I'm just really a facilitator and try to be the role model that I can with helping people see that they can do more than what they thought they could." [Idealized Influence/Inspirational Motivation]
- "My goal is to build and grow my congregation with new insights and knowledge so that they can be successful [and prepared] in fulfilling any personal or career aspiration that they may have and to not only survive but thrive." [Individualized Consideration]
- "Being a leader in the community by being supportive of community events, community welfare, and constituent well-being is just as important as providing Sunday worship." [Individualized Consideration]
- "I think when people see you engaged and supportive of the community, they will begin to trust you and work with you because they will realize that you care. This approach would also enable conversations among entities and

stakeholders in the community to address various needs." [Individualized Consideration]

- "In particular, the Cambridge ministry of my church involves getting churches to work together. We have a ministry center location that provides folks with food, as well as useful information, resources, and counseling to improve personal well-being." [Individualized Consideration]
- "If somebody doesn't have a home, then that is a health concern too. So that part is important. I sometimes feel like as a pastor, I'm uniquely positioned, cause people will tell me they're ills and feelings. And as a chaplain. I can go into hospitals and other spaces where others can't." [Individualized Consideration]
- "I think Faith-Based Leaders have a unique position in the culture to be able to say things that maybe some other people can't. One of the positives is that I end up sometimes being an advocate for families and patients in the hospital system just trying to translate what the doctors and nurses are saying, or if I am sitting with the family and I'm like they didn't hear the doctors or nurses properly, you know, kind of let them know you're going to have to talk to this family again or they're not hearing what you said or just some clarification. So, kind of where I see the connection is in my position." [Individualized Consideration]
- "One of the things that I'm involved with right now is court related, in which I serve as a witness at hand for a person that has Alzheimer's. I provide support

to his family with daily activities and visitation. Due to the person's Alzheimer's condition, I help with communicating his feelings during court. I also serve as a mediator with his family as they continue to go through this unfortunate experience. The law and the family members to try to do what is best for him. So as a concerning pastor, I'm trying to do everything I can." [Individualized Consideration]

FLs of the study revealed quotes that demonstrated healthcare collaborative partnership activity by partnering and collaborating with others as social agents to contribute to positive health outcomes among the Delmarva region. See quotes below from the 'Connect', Manage and Lead', and 'Be There' themes for examples.

- "I have been working with the county health department, and local universities to identify ways to provide services through our church." [Collaborate]
- "My collaboration with the local VFW provides a yearly donation of $1,200 to address the needs of the local church and the Grasonville community." [Collaborate]
- "In particular, the Cambridge ministry of my church involves getting churches to work together. We have a ministry center location that provides folks with food, as well as useful information, resources, and counseling to improve personal well-being." [Collaborate]

- “I guess like the example that we could use for collaboration was the Somerset County Public Health Department and coming in and using our facility for COVID vaccine shots.” [Collaborate]
- “We also collaborate with community partners like social services and other local partners that offer mobile buses that provide a range of services that also contribute to improvements of personal well-being.” [Collaborate]
- “Other than just people in my congregation that I’m attending to, I’m in a place downtown, and we have an education building and so we’ve partnered with the public health department to provide COVID shots earlier. And we’ve also partnered with the local YMCA. They were looking for a place to do a diabetes class.” [Partner]
- “Being open in having the church assist with the health department, along with participating with the relief program with housing initiatives, I have been involved with making connections with funding among other churches and nonprofit organizations.” [Partner]
- “We also collaborate with community partners like social services and other local partners that offer mobile buses that provide a range of services that also contribute to improvements of personal well-being.” [Partner/Collaborate]
- “Collaborative partnerships allow us to expand our reach and interact with more people, meeting more needs. The main organizations we collaborate with are The Food Bank of Delaware, New Day Pregnancy, and Adult and Teen Challenge in Seaford. Our collaborations are informal and voluntary.

Our collaborative partnerships meet the needs of the community by combining our efforts to reach more people." [Partner]

- "I have been working with the county health department, and local universities to identify ways to provide services through our church." [Being Resourceful]
- "But my eyes are open to it too, and…just trying to figure out when…there are places that would align with Ministry and mission of my church with the needs of the community to step into that space." [Being Resourceful]
- "I am also a board member of the Eastern Shore Long Term Recovery program, which was driven by the occurrence of Hurricane Sandy. Sometimes freakish storms often flood the areas and produce infrastructure devastations in the county. And most of the time these freakish storm incidents don't make regional or national news. Houses were flooded. The Recovery program has been assessing houses and getting funding to help repair and build new homes." [Being Resourceful]
- "Utilizing people's gifts to help others allows us to work with what we have to produce results that impact community health." [Being Resourceful]
- "For occasion that they need rides, we arrange transportation. We have specific persons to pick them up and drive them to where they need to go, like to local stores, doctor's appointments, or even to Dept. of Health for frequent and/or routine health checkups." [Being Resourceful]

- For our communities and we're looking at creating a farm to share among places that have food disparities in in the cities and in the towns of that are around us. We're in a rural section and because we have land, I think we need to use it properly. [Being Resourceful]
- “Gathering people and resources to observe and understand what is taking place and what is occurring in a community is essential for me to communicate that to community stakeholders and constituents in the community.” [Organize]
- “Organizing and communication between all partners, that help children in Somerset County has done a really great job. Organizations offer opportunities to address health, mental, physical, and education concerns, so there’s a lot of partnering.” [Organize]
- “Being open in having the church assist with the health department, along with participating with the relief program with housing initiatives, I have been involved with making connections with funding among other churches and nonprofit organizations.” [Organize]
- “But yeah, those are the methods that we use. We also seek professionals among and outside the church and health organizations in the area that care for the elderly.” [Organize]
- “For occasion that they need rides, we arrange transportation. We have specific persons to pick them up and drive them to where they need to go, like

to local stores, doctor's appointments, or even to Dept. of Health for frequent and/or routine health checkups." [Organize]

- "I would say the secret sauce is establishing positive presence in the community and being there for others in times of need. And this also applies to activities that you may not be expected to be present for." [Presence]
- "One has a very uh, you know terrible disease. She can't talk and can't respond. I'm in close contact with her, with her husband. And he says other than his wife not being able to talk/respond or move, she can listen and hear. He said that just my presence and voice while visiting, is important." [Presence]
- "I am also present at the church throughout the day and week. Having an 'open-door' policy is a benefit to those in the congregation and community that need attention. I think me establishing daily visibility of the church in the community continuously promotes the right image and message by letting them know that the church cares about their welfare and that the church and I are constantly available in times of need for the community." [Presence]
- "Since my inception as an appointment pastor, I have engaged myself to focus on these specific health concerning areas in my community [effects of COVID, crime, and drug abuse, but particularly drug abuse]." [Engage]
- "Improving health outcomes involves demonstrating inclusive efforts to engage everybody, not just one specific group in the community. Especially,

for both those who do don't have a lot of access to resources to address their needs." [Engagement]

- "If somebody doesn't have a home, then that is a health concern too. So that part is important. I sometimes feel like as a pastor, I'm uniquely positioned, cause people will tell me they're ills and feelings. And as a chaplain. I can go into hospitals and other spaces where others can't." [Engagement]
- "Again, it's just the matter of making connections and talking in the community to find out ways to help and serve, to make people feel and do better with their lives. You know, even if I cannot help or be the solution to their needs, I can engage by reaching out to others to gather insight on possible solutions." [Engagement]
- "Another example of my value was recognizing the need for feeding children and adults. The food insecurities and inefficiencies in the area has been something that I've been actively involved with, along with the homeless populations." [Engagement]

FLs of the study revealed quotes that demonstrated efforts to generate positive health outcomes as social agents among the Delmarva region. See quotes below from the 'Holistic' theme for examples:

- "As a Faith Leader, I'm concerned about the total well-being of the individual, and that includes health as well, physical health, mental health, spiritual health, emotional health, and all those things have been a. I have been a focal point for the church for many years." [Wholeness]

- “Being involved with the church and community is the spiritual component I’d like to think I bring that is just as important to total body health. Having all three core factors [spirit, mind, and physical health] is what I express from the pulpit and exhibit in my life.” [Wholeness]
- “My church provides economic empowerment activity, specifically for younger congregants of the church. And for the elderly congregants of the church, estate planning activities are provided.” [Church Activity]
- “And to think about it, during Lent season turned out to be health focus because it influenced congregants to give up unhealthy food for a short period of time. Congregants during this time lost a lot of weight.” [Church Activity]
- “As far as activities of the church that are more health specific, the church provides awareness about various health conditions, such as diabetes, heart impediments, and stroke, along with the value of exercise.” [Church Activity]
- “In particular, the Cambridge ministry of my church involves getting churches to work together. We have a ministry center location that provides folks with food, as well as useful information, resources, and counseling to improve personal well-being.” [Church Activity]
- “Church ministries in general, as well as my church, we do a lot of community outreach by working with underrepresented and underserved populations that are impacted by various conditions, such as poverty.” [Church Activity]
- “Other than just people in my congregation that I’m attending to, I’m in a place downtown, and we have an education building and so we’ve partnered

with the public health department to provide COVID shots earlier. And we've also partnered with the local YMCA." [Community Activity]

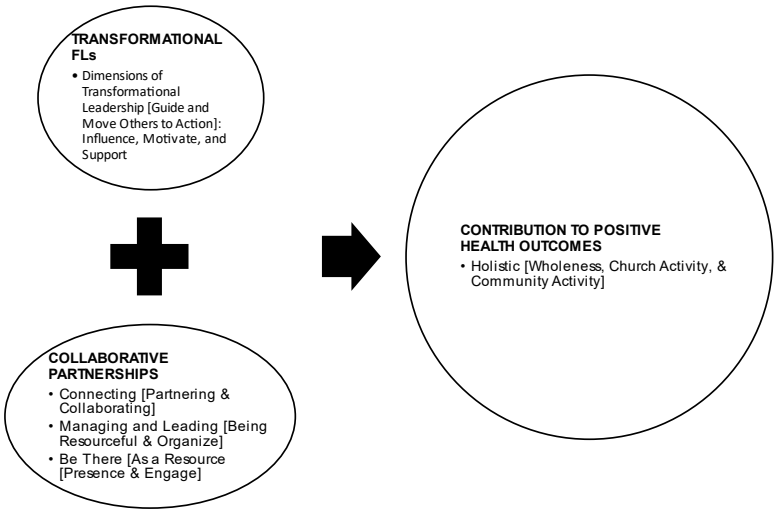
- "In particular, the Cambridge ministry of my church involves getting churches to work together. We have a ministry center location that provides folks with food, as well as useful information, resources, and counseling to improve personal well-being." [Community Activity]
- "We also provide outreach that enables us to coordinate and facilitate meals for the homeless shelter and other related services. One of our outreach programs that also helps is the Backpack Feeding Program for children." [Community Activity]
- "Making sure that children who are food insecure get meals for the weekend is one of our essential services. This service serves three schools that effectively reach 80 kids. And its ran by volunteers from the church and community. Volunteers take meals to the school, and the school coordinates the delivery of meals anonymously to children…in effort to protect the identity of the children." [Community Activity]
- "We also provide general health checkups that we perform at times and make sure that people have what they need, something that we're working on, making sure that the health ministry interacts with community health organizations like Red Cross to coordinate blood drives and things of that sort." [Community Activity]

- "The church also provides seminars and special meetings at the church that focus on various areas of life. My intention is to me multi-dimensional in providing various services and needs that focus on enhancing the mind, body, and spirit for the congregation and community." [Community Activity]
- "We work with the Food Bank of Delaware, New Day Pregnancy Center, Adult and Teen Challenge in Seaford to assist with meeting the needs of the community." [Community Activity]
- "We support organizations that are dedicated to caring for the health of the community and we make ourselves available to serve where needed. We support the organizations through financial offerings and volunteer labor, when possible. We partner with the Food Bank of Delaware, New Day Pregnancy Center, Adult and Teen Challenge in Seaford." [Community Activity]

Participants provided examples of their perceptions and experience, and how their efforts were aligned with activities that promote holistic health through the themes of the study [see Figure 18].

Figure 18

Connection of the Themes to Positive Health Outcomes



Note. The social ecological model, which was the study's conceptual framework, also informed the development of this figure.

In summary, results of the study indicated FLs as useful social agents for addressing not only community health issues through healthcare collaborate partnerships, but as instrumental forces for tending to personal care of constituents of their communities. FLs who utilize internal and external organizational environments to spearhead healthcare resources [e.g., health information, health access, health services, health products] are capable to respond to various congregant and community needs. FLs displayed ability to innovate and intervene within [and among] their FBO boundaries as social agents through various obligations among the Delmarva region. The resulting

themes of the study established the context on how FLs contribute to positive health outcomes in a rural area.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

In this exploratory qualitative study, I examined the perceptions and experiences of FLs in their roles in advancing collaborative healthcare partnerships that focus on community health. The research question of the study was: How do FLs experience their role as agents for social change within collaborative partnerships that seek to improve local healthcare outcomes in rural settings? The purpose of the study was to explore how FLs perceive and experience their roles as agents for social change in collaborative healthcare partnerships that focus on community health in the Delmarva region. From the results of multi-factor leadership questionnaire, nine participants were identified and selected for interviews. Interviews were guided by the interview protocol of the study [refer to Appendix G]. Interview protocol provided guidance on the interview process and content for interview. Interview protocol entailed the following information: interview questions, concluding statements, and letter of consent. Questions of the interview were geared toward the conceptual framework of the study and constructs of the study.

Analysis of the data resulted in five themes [see Figure 16]. These findings support the conceptual framework of the study. These findings are consistent with the conceptual framework of the study. The conceptual framework supplied the context of leadership and environment, and how a specific community resource could influence health outcomes in rural areas. These findings are illustrated through Bronfenbrenner's

(1989; 1999; 2005; 2006) research on the Social Ecological Model, and Burn's (1978, 2003) research on TL.

Interpretation of Findings

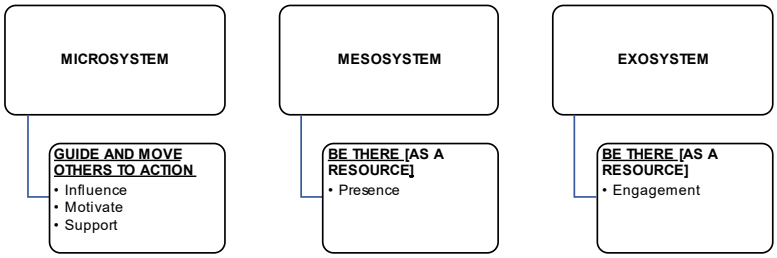
In this section, I will provide interpretations of key findings in the context of the conceptual framework and how the findings confirm, disconfirm and/or extend the body of knowledge within the literature review. To interpret the meanings of the themes, I will discuss the perspectives from the conceptual framework and Transformational Leadership Theory that informed my research.

Social Ecological Model

According to the work of Bronfenbrenner (1989; 1999; 2005; 2006), the interplay of the SEM factors and social conditions can influence the attitudes and beliefs, interactions with other people, rules/regulations that impact healthy behavior, group norms that impact healthy behavior, and policies and laws that regulate or support healthy actions for disease prevention. Participants of the study demonstrated perceptions and experiences as agents for social change within collaborative partnerships to improve local healthcare outcomes in the Delmarva region. Participants of the study were instrumental as social change agents within the first three subsystems of the SEM [microsystem, mesosystem, and exosystem] for contributing to positive health outcomes in their communities. 'Guide and move others to action' and 'Be There' were the resulting themes of the study that were most apparent among the microsystem, mesosystem, and exosystem of SEM [see Figure 19].

Figure 19

Connection of the Themes to the Social Ecological Model Subsystems



Microsystem

The SEM for health [see Figure 13] views the microsystem as the intrapersonal/individual factor for the five levels of influence on health behavior (Rural Health Information Hub, 2002-2021). FLs of the study demonstrated social change agent activity within the microsystem, due to FLs impact on health behaviors of constituents in their communities. FLs among the Delmarva region frequently guided and moved others to action through influence on impacting health outcomes among their communities. FLs of FBOs in the Delmarva region are instrumental with influencing the health behavior of constituents [e.g., congregants, families, and residents of the community] through organizing health sources to provide specific health activities to better the well-being of constituents in their communities. Providing health information, workshops, and health

fairs were some of the many examples demonstrated by FLs of the study to influence health behavior of constituents in their communities.

FLs of FBOs among the Delmarva region were instrumental for motivating others to action by being consistent with fulfilling personal and organizational visions and goals, and by establishing visibility in communities for various community affairs. FLs of the study provided examples of community engagement and participation with civic organizational affairs, as well as being active with community interventions that can benefit community well-being.

FLs of FBOs among the Delmarva region were also instrumental for supporting others to action, by interacting with other professionals in their congregations and communities for providing health resources to support key health activities and affairs. FLs of the study provided examples of utilizing members from their congregants who had health education and experience backgrounds to assist with the provision of health activities and affairs of churches, as well as being able to acquire related assistance from health organizations in the community.

Mesosystem

The mesosystem is the second subsystem of SEM in which the individual experience connectedness with the structures, relations, and interactions of the microsystem (Kilanowski, 2017; Swick & Williams, 2006). The SEM for health views the mesosystem as the interpersonal factor for the five levels of influence on health behavior (Rural Health Information Hub, 2002-2021). FLs of the study demonstrated

social agent activity within the Mesosystem, due to FLs impact on health behaviors of constituents in their communities.

FLs among the Delmarva region served as a resource through their presence to impact health outcomes among their communities. FLs of FBOs connected with other individuals and community organizations through community affairs, events, and affiliations. FLs of the study demonstrated visibility in their community [e.g., attendance of plays, football games, and school board meetings] as means for building relationships and trust that contributed to positive health outcomes, as well as churches being available for constituents to various personal and community ills. FLs who are visible in communities can provide resources through their organizational boundaries to meet community needs. FLs in the Delmarva region also served as a resource by engaging with personal affairs to impact health outcomes. FLs of churches connected with other individuals through opportunities serving as effective apparatuses to better the well-being of others. FLs of the study demonstrated examples of engaging in community affairs by observing the happenings among the community and personal and family health affairs for tending to the needs of underserved and underrepresented populations and engaging in community health initiatives.

Exosystem

The exosystem is a subsystem that encompasses a larger system that is not immediately or actively encountered by a child, and often indirectly impacts the child's development through imposing structures [e.g., industry, community, politics, and social networks] that influence connectedness and/or interaction with their immediate systems

microsystems and mesosystems; (Bronfenbrenner, 1994; Galinksky, 1999; Kilanowski, 2017). The SEM for health views the exosystem as the organizational factor for the five levels of influence on health behavior (Rural Health Information Hub, n.d.). The exosystem is an external factor that indirectly serves as a major influencer the manifestation of health behavior.

FLs among the Delmarva region served as a resource through engagement to impact health outcomes among their communities. FLs of the Delmarva region were engaged in personal affairs of constituents, community affairs, and church/community activity for contributing to positive health outcomes. FLs of the study demonstrated examples as effective utility by having served as an advocate for families with healthcare access, engaged with community governing boards and organizations by providing a faith-based voice for community health concerns, provided financial resources to community organizations that served the community, spearheaded community development opportunities to address education and food disparities, and engaged with other community health organizations for providing health products and services during emergency and non-emergency situations. FLs who are focused on the well-being of constituents in their communities can navigate various industries and social networks within their communities to have an indirect influence on community health.

In conclusion, even though all resulting themes have the potential to be utilized among all SEM subsystems, FLs among the Delmarva region demonstrated the ‘manage and lead others’ and ‘be there’ themes as the most effective. For efforts to contribute to positive health outcomes in communities among the Delmarva region, FLs served as

social agents of change through their collaborative partnerships by guiding and moving others to action and by serving as an effective resource in their communities through visibility and engagement with various personal and community affairs.

Transformational Leadership

FLs have the capacity to supply effective leadership due to their premise to serve as allies and social change agents to represent and shepherd their communities to make positive health-related changes, (Idler et al., 2019). TL (Burns, 1978, 2003) in this study provides intuition on how the leadership characteristics of FLs are involved in collaborative partnership activity with others through TL's four dimensions: idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration.

Idealized Influence

Idealized influence refers to leaders who act as solid role models for their followers, due to their capabilities and ethical conduct (Avolio & Gardner, 2005). Leaders who demonstrate transformational leadership attain admiration, trust, and respect from their followers (Avolio & Gardner; Bass, 2006). These leaders provide a clear vision and mission for their followers and/or organization which results in high levels of respect and trust from their followers (Avolio & Gardner, 2006; Meit et al., 2018). Transformational FLs and churches are uniquely positioned to be most effective in the microsystem, due to its idealized influence on basic organizational structures in the community [e.g., families, peers, parents, neighborhoods, and churches] for impacting health behavior of individuals.

FLs of the Delmarva region portrayed idealized influence by guiding and moving others to action to impact positive health outcomes. FLs of churches are viewed as trustworthy and prominent resources in rural communities, due to their convenient geographical locations for constituents, and as well as FLs being among community stakeholders that have decision making influence and resource allocation influence for impacting community health. FLs of the study demonstrated idealized influence through: (a) traditional church activities to influence congregants to lose weight [e.g., Lent], (b) participated in county council meetings to address community behavior problems, (c) utilized the gifts, talents, and skill sets of others to assist with helping others in the community, (d) influenced community culture through service and visibility, and (e) lead by example.

FLs of the Delmarva region utilized idealized influence to motivate others to action to impact positive health outcomes. FLs of the study demonstrated motivative actions by: (a) providing health information and awareness to enhance positive health behaviors, (b) serving as role models for others to mimic positive health behaviors, (c) attaining trust from community members through provisions of church and community health related activities, (e) having an ‘open-door’ policy for motivating others to do the same for addressing various health issues in the community, (f) utilizing gifts and talents of others to assist with health-related activities, (g) having others carry out visions of FLs, and (h) leading by example for motivating others to perform necessary actions to better health outcomes.

FLs of the Delmarva region also provided support by guiding and moving others to action to impact positive health outcomes. FLs respond to various ills in the community by supporting constituents and their families with adequate resources to better their well-being. FLs of the study demonstrated related examples by: (a) getting churches together to address community needs, (b) collaborating with other health organizations in the community in response to housing and emergency need in communities, and (c) involvement and participation with other community organizations to support community welfare aside from church service/worship obligations.

Inspirational Motivation

Inspirational motivation entails the leaders' ability to motivate followers to perform beyond expectation (Jain, 2015, Meit et al., 2018). The aim for this dimension is to raise the consciousness of followers about the organization's mission and mission, encourage, and making followers commit to the organization (Kirkbride, 2006). These leaders who are motivated to fulfill goals with this dimension tend to demonstrate a cooperative vision that are rational to followers (Metwally & El-bishbishy, 2014). This dimension also enables leaders to align individual and organizational goals to achieve organizational goals for the benefit to also achieve personal goals (Seloane, 2010). Transformational FLs of churches are uniquely positioned in their communities for being effective in the microsystem and mesosystem, due to their individual interactions with constituents and their families, as well as interacting with organizations within the community for managing and leading others to actions for efforts to influence positive

health outcomes by connecting constituents [and families] with the appropriate health resources that can benefit the well-being of the community.

FLs among the Delmarva region displayed resourcefulness and organized action for managing and leading others to impact positive health outcomes. Transformational FLs interact with other stakeholders in their communities to carry out their personal and church missions and goals for serving others. FLs of the study demonstrated inspirational motivation to others by: (a) aligning with other community organizations that have similar missions to meet community needs, (b) utilizing people's gift to help others, (c) acquiring volunteers from congregation for responding to the health needs in the community, and (d) acquiring people who are competent in healthcare to better well-being.

FLs among the Delmarva region demonstrated organizing action to inspire and motivate others by: (a) organizing and communicating between all partners for responding to opportunities to address health and education concerns, (b) being open in having the church assist with local health department to support housing initiatives, (c) establishing organizational relationships to spearhead a ministerial association for addressing community concerns, (d) seeking health professionals outside the church to care for the older adult population, and (e) making phone calls to support families and loved ones to attain needed health services. FLs who are resourceful and display organizing action for contributing positive health outcomes usually require a level of inspiration and motivation to acquire the necessary health resources from stakeholders to meet community needs.

Intellectual Stimulation

The intellectual stimulation dimension focuses on effort to question expectations, reframing impediments, and forecast new ideas (Bass, 2006, Meit et al., 2018). Leaders who demonstrate this dimension stimulates followers to critically think through issues and problems for themselves for developing their own abilities (Kirbride, 2006). Followers are encouraged to engage in new approaches without the worrisome of criticism (Bass, 2006). Intellectual stimulation generates empowerment and continuous improvement to followers or people (Reza, 2018). Transformational FLs of churches who display intellectual stimulation are uniquely positioned in their communities for being effective among the mesosystem, and exosystem due to their organizational interactions and implementation influences within the community for managing and leading others to devise actions that contribute to positive health outcomes.

FLs of the Delmarva region focused on holistic health in their communities through community activity, church activity, and wholeness of health emphases to impact positive health outcomes. Transformational FLs often provide health resources, products, and services to better the well-being of others in the community. FLs of the study demonstrated intellectual stimulation through innovative community activities by: (a) onsetting the creation of farms to provide and offer produce in neighborhoods that exhibit food disparities, (b) serving as an entity of support during the occurrence of tragic events and emergencies, (c) partnering with health organizations and community organizations to offer vaccine shots, (d) performing community outreach for addressing social conditions of underrepresented and underserved populations, (e) utilizing church

ministries to provide food, health information, resources, and counseling to improve well-being; (e) facilitate meals for the homeless through structured programs, (f) working with local health departments and universities to identify ways to provide services in the community, and (g) connecting with community centers to coordinate health workshops. FLs of churches among the Delmarva were involved with various community activities that displayed innovation and intervention for producing tailored activities that were beneficial to the well-being of constituents and community.

FLs of the study also demonstrated intellectual stimulation through specific church activities by: (a) working with local health departments and universities to identify ways to provide services through the church, (b) providing various workshops [e.g., economic empowerment and estate planning] through the church; (c) traditional church activities [Lent season], (d) providing health information activities for congregants and community through the church, (e) administering food bank activity through the church; (f) having church ministry for offering food, resources, and counseling to improve well-being; (g) providing vaccinations through the church, (h) collaborating with various community stakeholders to provide health fairs, and (i) donating health-related items and devices to older adults.

FLs among the Delmarva also provided innovative church activities that were beneficial to the well-being of constituents and community. FLs of the study demonstrated intellectual stimulation for focusing on wholeness health by attaining an awareness on the importance of holistic health and its relation to individual and community health and placing the wholeness health of people as a priority of the church.

Due to FLs' awareness and understanding of holistic health among the Delmarva region, interventions can be stimulated among stakeholders to ensure all components [e.g., mental, physical, emotional, and spiritual] are being met.

Individual Consideration

The individualize consideration dimension provides attention to followers' needs for self-actualization and growth by acting as a coach or mentor (Bass, 2006, Meit et al., 2018). Individualized consideration is enacted when new learning opportunities are upheld with a supportive climate (Avolio & Bass, 1995; Bass, 2006). Transformational FLs who display individualized consideration participate in partnering and collaborating activity in effort to facilitate and coordinate resources among stakeholders that address uncommon community health issues that are nuances to meet specific needs of constituents. Transformational FLs who provide individualized consideration are uniquely positioned in their communities for being effective among the microsystems, mesosystem, and exosystem by focusing on partnering and collaborating among individuals [health professionals/church leaders], organizational partnerships [churches/local health organizations], and community organizations [VFWs/universities/other organizations] for meeting health needs of constituents for pursuits in contributing to positive health outcomes.

FLs of the Delmarva region portrayed partnering and collaborative actions for connecting with others to impact positive health outcomes. FLs provide individual consideration to the health and well-being of their constituents and community, due to their need to acquire health resources to meet specific health needs. FLs among the

Delmarva region demonstrated individual consideration for constituents and community through partnering activity by partnering with public health departments to provide COVID shots and partnering with YMCA to provide diabetes classes, (b) partnering with community organizations to provide homeless shelters, (c) partnering with social services to provide mobile buses for those that do not have reliable transportation to acquire health services, (d) partnering with community organizations to provide food, counseling, and (e) human development resources for young adults, and (f) partnering with community organizations to expand organizational reach to interact with more populations to meet health needs.

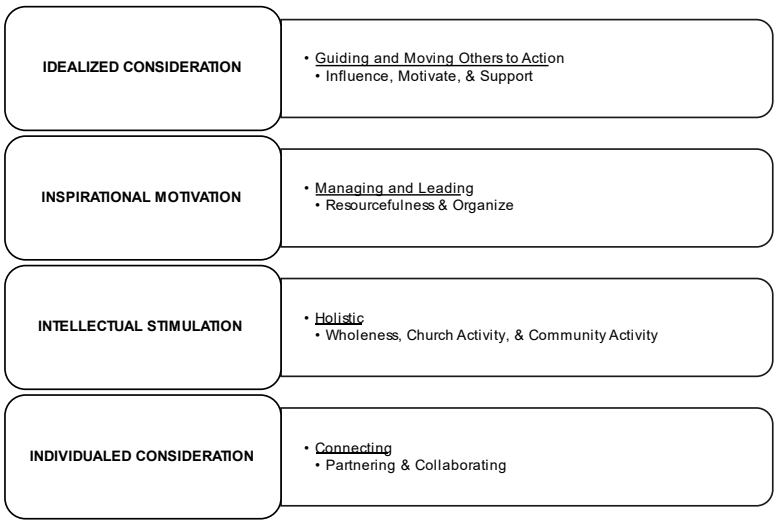
FLs of the Delmarva region also portrayed collaborative actions for connecting with others to impact positive health outcomes. FLs displayed individual consideration to the health and well-being of their constituents and community, due to their need to identify potential organizations that can offer resources that can benefit the agendas of FLs and churches with meeting unique health needs of their constituents and communities. FL among the Delmarva region collaborate by (a) working with county health departments and local universities to identify innovative ways to provide services through churches, (b) engaged with other church leaders to onset the development of an education center, (c) providing annual donations from local VFW to address the needs of the church and community, (d) utilizing church members to connect to the community, (e) utilizing church ministry to assemble other churches to provide food, health information and resources to improve well-being, (f) exchanging resources among the church and health department to provide COVID vaccine shots, (g) establishing

organizational relationships with others, and (h) identifying organizations to acquire monetary resources to help people with their concerns.

Transformational FLs displayed actions that resembled the four dimensions of transformational leadership. The resulting themes of the study were expressed among each dimension for FLs to contribute to positive health outcomes among the Delmarva region [see Figure 20].

Figure 20

Connection of the Themes to the Four Dimensions of Transformational Leadership



Transformational FLs among the Delmarva region exhibited idealized consideration by guiding and moving others to action as social change agents to contribute to positive health outcomes. Transformational FLs were engaged in the microsystem of SEM by exhibiting idealized influence on basic organizational structures

in the community [e.g., families, peers, parents, neighborhoods, and churches] for impacting health behavior of individuals. Transformational FLs among the Delmarva region exhibited inspirational motivation by guiding and leading others to action as social agents to contribute to positive health outcomes. Transformational FLs were engaged in the microsystem and mesosystem of SEM by exhibiting inspirational motivation due to their individual interactions with constituents and their families, as well as organizational interactions within the community for managing and leading others to actions with efforts that influence positive health outcomes by connecting constituents [and families] with the appropriate health resources that can benefit the well-being of the community. Transformational FLs among the Delmarva region served as social change agents by exhibiting intellectual stimulation that focused on holistic health as social agents to contribute to positive health outcomes. Transformational FLs were engaged in the mesosystem and exosystem, due to their awareness of holistic health and its importance to overall well-being, as well as understanding the needed involvement of community organizations for necessary interventions and implementation to maximize their impact on positive health outcomes.

Transformational FLs among the Delmarva region exhibited individualized consideration actions for connecting with others to impact positive health outcomes. Transformational FLs who provided individualized consideration was uniquely positioned in their communities for being effective among the microsystem, mesosystem, and exosystem by focusing on collaboration with individuals [e.g., health professionals/church leaders], organizational partnerships [e.g., churches/local health

organizations], and community organizations [e.g., VFWs/universities/other organizations] for meeting health needs of constituents for pursuits in contributing to positive health outcomes. Transformational FLs exhibited the four dimensions of transformational leadership as social agents through the Microsystem, Mesosystem, and Exosystem of SEM for meeting health needs of their constituents and community.

Limitations of the Study

As a main limitation of the research study, the results are not generalizable to other populations. Rural areas in the Delmarva region may not show similar population characteristics and demographics in other rural areas. Other rural geographical locations [urban, suburban, regional, national, and/or international] serves as delimitations of the study because they may restrict the replicability of study results and findings. Results and findings from the study may not be consistent with urban populations among an urban region.

Another limitation of the research study is the small sample size. Having a small sample size may not best represent desired participants. Participants of the study mostly represented Maryland counties among the Delmarva region. A large representation was not from Delaware and Virginia counties of the Delmarva region. Having participants self-assess their transformational leadership characteristics was a limitation in the study. Participants may not have been honest with their answers. Scores may not truly reflect their transformational leadership abilities, due to their responses being driven by their own perceptions and judgement. Without having an external assessment, objectivity of participant responses could not be performed.

Effects from the COVID-2019 pandemic, time management, conflict of availability among me and participant, and influence of participant bias served as challenges during the study. Some participants had to be interviewed twice due to conflict of availability. The coordination of days and times for semi-structured in-depth interviews were cumbersome. Scheduling interviews for participants were difficult, due to inabilities to adapt to availability among me and participants. One interview was conducted through email, due to this limitation. Time constraints could have compromised potentials for attaining more participants if more time was available to collect more data.

The barriers of conducting the study will be the attainment of sufficient financial resources to support the study [e.g., research equipment and participation Incentives]. Data analyzing software, computer, and related supplies may not be accessible when needed to perform the research study. Gift cards and/or monetary incentives for participants may be difficult to provide to maximize study participation.

Recommendations

There were four key findings that support the recommendations for this study:

- FLs were social agents for addressing community health issues through healthcare collaborative partnerships for contributing to positive health outcomes.
- FLs were social agents for addressing personal health issues through healthcare collaborative partnerships for contributing to positive health outcomes.

- FLs utilized internal and external organizational environments to spearhead healthcare resources [e.g., health information, health access, and health services] for contributing to positive health outcomes.
- FLs innovate and intervene within [and among] their FBO boundaries as social agents for contributing to health outcomes.

These findings will provide the context for recommendations and serve as the main driver for the recommendations on how to effectively utilize FLs among the Delmarva region as social agents for change to address social conditions, health disparities, and health inequity commons for fostering positive health outcomes in rural areas.

FLs in rural areas often utilize partnerships with community health organizations to better the well-being of the community. FLs have been known as prominent leaders in their communities, and their churches have also served as a major resource for spiritual and community support in times of need and social change. The results of the study revealed innovative ways for FLs utilizing their church members who have health backgrounds and experience to make connections with community health organizations for meeting needs of the community. As a recommendation, this approach could be fostered to establish sustainable church/health organizations among all churches to meet community health needs in rural areas. Church members who have healthcare background and experience could reach various population groups [e.g., underserved, underrepresented, youth, and older adults] more effectively within rural communities, as opposed to seeking external entities. Working with internal resources of churches could create a trusting environment because they are constituents of rural community, as well as

being familiar with the area culture, and have social relationships among various social groups within rural areas. Internal church members who have health background and experience may already have comradery, friendships, family, and organizational ties with constituents among rural areas that could be beneficial for reaching various social groups to meet health needs. FLs can utilize these individuals as key stewards to establish productive collaborative health partnerships for the church, as well as for establishing their own independent collaborative healthcare partnerships. FLs could manage and lead these individuals, due to FLs already having awareness of key stakeholders in the community.

FLs in rural areas also utilize partnerships with community health organizations to better the well-being of others at a personal level. Most churches in rural areas have smaller churches and less members which enables FLs to interact with church members on a more personal level. These FLs are more ingrained with families and peers of their congregants and have more trust and respect from them. FLs in rural areas are also more engaged in the livelihoods of their congregants. The results of the study demonstrated actions of FLs tending to personal health needs of their congregants by taking out time aside from the church to provide transportation for healthcare appointments and monetary assistance for paying for health and non-health related bills. Another result of the study demonstrated FLs serving as a personal advocate as assistance for attaining specific health services. As a recommendation, FLs in rural areas could serve as healthcare system managers for their congregant members. This approach could enable FLs in rural

areas to serve as trustworthy health resources for congregants, due to their awareness of community affairs and social relationships with health stakeholders in the community.

As social change agents, FLs in rural areas who utilize internal church resources and external healthcare resources are capable to create and utilize existing collaborative healthcare partnerships to better community health. Whether these resources are health professionals among their congregations, or health organizations among local communities, FLs have opportunities to identify health resources necessary for partnering and collaborating with others to meet health needs of the community. The resulting themes of the study demonstrated FLs health professionals among their churches, and local health departments for assistance with providing COVID vaccines for constituents in the community. As a recommendation, due to the usefulness capacity of FLs in rural areas, FLs could also be used as Public Health managers in rural communities to enhance community health. FLs in rural areas are more familiar with the organizational landscape and in rural communities and could be sought as key stakeholders [among others] for allocating resources to address the impact of social conditions, health disparities, and health inequities. FLs in rural areas could be included in the local public health workforce as key resources for addressing community ills. Describe recommendations for further research that are grounded in the strengths and limitations of the current study as well as the literature reviewed in Chapter 2. Ensure that recommendations do not exceed the study boundaries.

Implications

Community ills and shortage of health resources in rural areas establish opportunities for innovation and intervention from FLs to embark social change. Current community ills and shortage of health resources could give attention to improve policy [e.g., environment, health, and justice areas] and health service promotion [e.g., campaigns, marketing, and communication methods] for rural populations. FLs who engage in social change efforts to alleviate community ills and shortage of health resources will undergo necessary strategy development to improve policy and health promotion by seeking community health improvements. Leadership style and partnership perspectives of FLs in rural areas could become useful for executing social change efforts. Key findings provide evidence for FL value as social agents for contributing to positive health outcomes through engagement and involvement with local healthcare organizations. In effort to contribute to positive health outcomes, FLs of the study engaged in managing and leading others, whether they were congregants, constituents, or any other organization outside their church.

The first key finding implicates a need for instituting training and accredited education programs for FLs in rural areas. Accredited secondary education programs could offer bachelor, master, and doctorate level degrees in management, leadership, public health, or divinity with emphases on community collaboration, FL Leadership, or FL Management. Degree programs could offer more opportunities to produce FLs with competency, skill, and aptitude for addressing community ills in rural areas. Also, due to FLs engagement and involvement with congregants, constituents, and community

organizations among rural areas, training, and education programs could be established to further support FLs for leading and managing others. This implication could contribute to better health outcomes in rural regions. Furthermore, this development could offer insight with refining management and leadership practice and theory, due to the value of collaboration and its effect on meeting objectives and goals, as well as potential for driving social change imperatives.

The second key finding implicates a need public health industry with spearheading the development of FL/Public Health organizations among rural areas. Even though there are existing federal government programs, grant funding opportunities, and existing partnerships, establishing non-profit, for-profit, local, private FL/Public Health organizations could serve great value with addressing social conditions of health, health disparities, and health inequity issues in rural areas. Having members of the community that are closest to the concerns and issues of the constituents are more knowledgeable, capable, and trusted to provide health services and support to constituents in rural communities. Also, manifesting collaborations into formal organizations/entities could allow more control and access to health resources, as well as organizational power to embark needed social change. This implication could support local economies in rural areas and maximize social relationships, involvement, and engagement among population groups, as well as produce sustainable eco-systems due to its capacity to acquire social cohesion among major community stakeholders that impact health behaviors [e.g., education, food, housing, and transportation].

The third key findings implicate a need restructure the healthcare system in rural areas for being more effective and efficient with addressing community ills. The current healthcare system does not effectively contribute to positive healthcare outcomes, due to not only the complex nature of health and its impact on various community silos; the current healthcare system is not sustainable and applicable for the underrepresented and underserved populations. Stakeholders need to understand the subsystems of SEM and its impact on community health to devise the proper healthcare system for rural areas for becoming more sustainable, efficient, and effective. This implication could serve either as an effective organizational strategy design, map, or model for key stakeholders to employ for allocating health resources in rural areas.

The last key finding suggests a need for more FBO collaboration with higher learning institutions, local private sector organizations, non- and for-profit organizations, other local FLs and public health officials concerning research and development opportunities for solution development concerning community health in rural areas. Research in general can serve as an information provider to support decision making and practical application for rural health stakeholders who are focus on the well-being of rural constituents and enhancement of positive health outcomes in rural communities. Qualitative research can serve as a precursor to guide, and support needed innovation and interventions necessary for developing solutions for community health and desired health outcomes. FBO and higher learning institution collaboration could also spur mentor/trainee relationships [e.g., faith leader/primary investigator], which could support

short- and long-term benefits for both involved collaborative members. This implication could have a potential to support multiple outcomes:

- acquiring FLs and FBOs in rural health community research,
- creating solutions to address social conditions of health, health disparities, and health inequity in rural areas;
- awareness of the implications concerning rural community health,
- support social and organizational relationship building in rural areas that are geographically located in distressed jurisdiction,
- support and maintain positive health outcomes in rural areas,
- stakeholder sponsorship for rural health programs, and
- provide training concerning community health collaboration for rural FLs.

Management and Leadership

Results of the study provide implications for management and leadership application. The core premise of management is to plan, organize, lead, and control (Griffin, 2022). There are many common management theories [e.g., decision theory of management, management science theory, systems theory of management, and contingency theory of management]. However, the most applicable management theory that applies to this study would be the contingency theory of management. This theory focuses on a leader's ability to adapt to different situations through the core principles of management (Shala et al., 2021). FLs are indulged in situations in their communities that require some form of planning, organizing, leading, and controlling for responding to various community ills.

On the other hand, the core premise of leadership is to influence or guide others (Northouse, 2021). There are many common leadership theories [e.g., great man theory, trait theory, behavioral theory, transactional theory, transformational leadership theory, and situational leadership theory]. However, the most applicable leadership theory that applies to this study is situational leadership theory. This theory [ironically like the contingency approach] also depends on a leader's ability to adapt their leadership style according to conditions [or context] of their environment (Northouse, 2021). FLs influence and guide others through according to conditions [or context] of their environment to respond to various community ills.

Managing and leading was highlighted as one of the resulting themes of the study. FLs among the Delmarva region exhibited managing and leading through organizing and as serving as a resource in their community. This not only implicates FLs as being capable managers, but also provides awareness on their transformational abilities to respond to specific situations in their communities [e.g., addressing unfavorable health outcomes] through a perspective of being a focal point in rural communities to organize health resources according to their style and community situation. The contingency theory of management suggests that leaders who utilize a contingency approach are likely driven by style and relationship (Shala et al., 2021). Transformational FLs are driven by their professional discipline [style], internal and external individual and organizational relationships [relationships] to seek collaborations with other entities and leaders in the communities to produce a form of change in communities. Faith leadership of the Delmarva region exhibited this style for utilizing their disciplines to engage in efforts to

better the well-being of their congregants and community. The situation of FLs among the Delmarva region entailed the need to address unfavorable health outcomes among rural communities through leader/follower relations, task structure, and from their unique leader-position in their communities. Due to the fact that FLs of churches are considered trusted and valuable resources in communities, as well as the ongoing demand to meet a specific community requirement [task – improve health outcomes], and the level of authoritative influence FLs have on others [e.g., congregant members and constituents in the community], FLs of the Delmarva region demonstrated characteristics of high levels of leader-member relations, task structure, and position power. This implicates that FLs in rural areas could employ the contingency theory of management approach to address unfavorable health outcomes in their communities.

Guiding and moving others to action is another theme exhibited in this study. FLs among the Delmarva region demonstrated guiding and moving others to action through influencing, supporting, and motivating actions. This not only implicates FLs as being capable leaders, but also provide insight on their transformational abilities to provide effective leadership within the first three subsystems of SEM among rural areas. The social ecological model provides a context of environmental influences on the growth and development of an individual (Bronfenbrenner, 77, 86, 89, 94, 99, 2005, 2006). Transformational FLs are driven by their ability to exercise the four dimensions of TL within the first three subsystems of SEM to embark change in their communities. FLs among the Delmarva region demonstrated levels of influence, support, and motivation to [and for] others within the microsystem, mesosystem, and exosystems of SEM to advance

the well-being of individuals, community, and organizations as a contribution to produce positive health outcomes. This implicates that FLs among rural areas who are transformational could apply influence, support, and motivational actions as means to guide and move others to within specific subsystems of SEM [particularly the microsystem, mesosystem, and exosystem] to generate positive health outcomes.

Conclusion

Given the status of health outcomes among the Delmarva region, and continual occurrences of unfavorable health indicators in the region, as well as the lack of health resources in the region, the aim of this study was to explore how FLs perceived and experienced their roles as agents for social change in collaborative healthcare partnerships that focused on community health in the Delmarva region. From the results of the multi-factor leadership questionnaire, all participants reflected a higher-than-average rating of transformational leadership.

Participants of the study also demonstrated actions of transformational leadership through each of the four dimensions of transformational leadership. From the results of transcriptions, I learned that majority of the participants demonstrated the following: (a) transformational leadership among their collaborative healthcare partnerships, (b) exhibited social change agent actions, and (c) contributed to health outcomes for communities among the Delmarva region. Participants of the study also revealed active participation among three subsystems of SEM [microsystem, mesosystem, and exosystem]. Results of the study supported the conceptual framework of the study, due to

FLs demonstrating transformational leadership characteristics within specific subsystems of SEM.

Participants of the study yielded five themes and four key findings. Participants demonstrated examples for each theme, and key finding were concluded from the resulting themes. The five themes: (a) guide and move others to action, (b) holistic, (c) connect, (d) be there [as a resource], and (e) manage and lead [being a resource], provided insight on how FLs perceived and experienced their roles as agents for social change in collaborative healthcare partnerships that focused on community health in the Delmarva region.

The four key findings demonstrated evidence of FLs in rural areas as significant resources for contributing to healthcare outcomes. First, FLs were social agents for addressing community health issues through healthcare collaborative partnerships to positive health outcomes for contributing to positive health outcomes. Second, FLs were social agents for addressing personal health issues through healthcare collaborative partnerships to positive health outcomes. Third, FLs utilized internal and external organizational environments to spearhead healthcare resources [e.g., health information, health access, health services] for contributing to positive health outcomes. Fourth, FLs innovated and intervened within [and among] their FBO boundaries as social agents for contributing to health outcomes. This study provides opportunities for transformational FLs to become more engaged and involved in rural health through health and education industries for providing better management and leadership for optimizing community health in their communities. Additionally, the results of the study indicate potential

opportunities for revising leadership and management roadmaps with the community health discipline for addressing community ills in rural areas.

In conclusion, not only do transformational FLs can engage as social change agents, but also demonstrate organizational leadership through their effectiveness with collaborative partnering to better community health. Health stakeholders should utilize FLs more effective by allowing them to establish independent and self-sufficient community organizations that entail FLs and health officials to enhance community health outcomes. This approach could be more productive, due to the capacity of transformational FLs to provide appropriate leadership and management through collaboration partnering activity to address various community health issues among rural areas.

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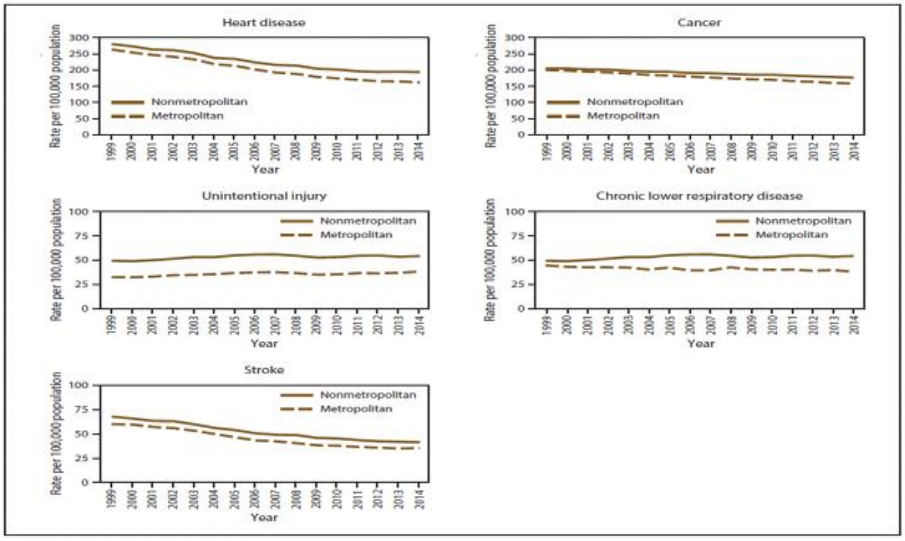
Appendix A: Some Characteristics of U.S. Rural Population, 2010–2019

Vulnerability Source	NonMetro	Metro
	Percent	
Underlying Health Problems (ages 20 to 84)	23.7	3.0
Old Adult Population Scale	15.9	4.0
Lacking Health Insurance (ages 25 to 64)	20.2	10.5
Distance to Hospital with Intensive Care Unit (ICU)	11.3	0.3

Note. Adapted from, *Rural America at a Glance 2020 Edition,* (2020), by Cromartie, J., Dubis, E., Krumel, T., McGranahan, D., & Pender, J. (2020) of the United States Department of Agriculture, https://www.ers.usda.gov/webdocs/publications/100089/eib-221.pdf?v=8268.3.

Appendix B: Age-Adjusted Death Rates Among Persons of All Ages for Five Leading Causes of Death in U.S. Nonmetropolitan and Metropolitan Areas, 1999–2014



Note. Adapted from, *Rural America at a Glance 2020 Edition,* (2020), by Cromartie, J., Dubis, E., Krumel, T., McGranahan, D., & Pender, J. of the United States Department of Agriculture, https://www.ers.usda.gov/webdocs/publications/100089/eib-221.pdf?v=8268.3. Underlying health problems are measured as the average yearly age-standardized mortality rate in 2014-18 from natural causes [excludes accidents, including overdoses; homicide, and suicide]. The old adult population scale was measured by the percent of adult population ages 60 to 74 plus double the percent ages 75 and over. Distance is measured between county geographic population centers. Both nonmetro and metro population percentages can be under 20 when vulnerability is greater in counties with relatively small populations.

Appendix C: Delmarva Demographics 1

STATE	COUNTY	ELDERLY POP.	AVG. MEDIAN HOME VALUE	AVG. RENT VALUE	AVG. W/O HEALTH INSURANCE OVER THE AGE OF 65	AVG. W/O HEALTH INSURANCE W/ DISABILITY, UNDER THE AGE OF 65
DE	Kent	17%	$220,600	$1,084	9%	8.6%
DE	Sussex	28.7%	$258,600	$1,030	10.4%	8.6%
DE	New Castle	16.1%	$260,800	$1,163	6.8%	7.8%
VA	Accomack	24.6%	$171,800	$831	15.1%	8.8%
VA	Northampton	27%	$176,800	$733	12.5%	8.8%
MD	Worcester	28.2%	$262,200	$1,035	7.4%	9.6%
MD	Wicomico	16.3%	$175,700	$1,060	8.5%	8.6%
MD	Somerset	17.3%	$139,100	$716	7.5%	10.8%
MD	Dorchester	22.1%	$183,300	$879	7.1%	12.5%
MD	Talbot	29.7%	$336,800	$1,116	8%	9%
MD	Queen Anne's	19.2%	$353,100	$1,503	5.7%	7.3%
MD	Kent	27.1%	$249,900	$1,007	8.3%	8.5%
MD	Caroline	16.7%	$202,500	$895	8.5%	10.9%
MD	Cecil	16.2%	$242,700	$1,126	5.8%	10.5%

Note. Adapted from United States Census Bureau (n.d.). *QuickFacts*. https://www.census.gov/quickfacts/fact/table/US/PST045221? QuickFacts data were extracted from: Population Estimates, American Community Survey, Census of Population and Housing, Current Population Survey, Small Area Health Insurance

Estimates, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits. Copyright by United States Census Bureau.

Appendix D: Delmarva Demographics 2

STATE	COUNTY	POPULATION	RACE	EDUCATION	INCOME & POVERTY
Delaware	Kent	162,350	65.6% white, 27% African American, 0.7% American Indian/Alaska Native, Asian 2.4%, 0.1% Hawaiian and other Pacific Islander, 3.8% Two or more races, 7.4% Hispanic or Latino, 60.4% White alone [not Hispanic of Latino]	87.4% High School Graduate or higher; 23.7% Bachelor's degree or higher	Median Household Income - $60,910; Persons in Poverty – 12.7%
Delaware	Sussex	234,225	83% White, 12.2% African American, 1.1% American Indian/Alaska Native, 1.4% Asian, 0.1% 0.2% Hawaiian and other Pacific Islander, 2.2% Two or more races, 9.3% Hispanic or Latino, 75.4%	88.1% High School Graduate or higher; 28.3% Bachelor's Degree or higher	Median Household Income - $63,162; Persons in Poverty – 12.1%

			White alone [not Hispanic of Latino]		

STATE	COUNTY	POPULATION	RACE	EDUCATION	INCOME & POVERTY
Delaware	New Castle	558,753	64.6% White, 26.4% African American, 0.5% American Indian/Alaska Native, 5.8% Asian, 0.1% 2.6% Hawaiian and other Pacific Islander, 10.4% Two or more races, 56.3% Hispanic or Latino, 75.4% White alone [not Hispanic of Latino]	91.6% High School Graduate or higher; 36.2% Bachelor's Degree or higher	Median Household Income - $73,892; Persons in Poverty – 10.4%

STATE	COUNTY	POPULATION	RACE	EDUCATION	INCOME & POVERTY
Virginia	Accomack	32,316	67.8% White, 28.8% African American, 0.7% American Indian/Alaska Native, 0.8% Asian, 0.2% Hawaiian and other Pacific Islander, 1.7% Two or more races, 9.1% Hispanic or Latino, 59.9% White alone [not Hispanic of Latino]	81.5% High School Graduate or higher; 19.5% Bachelor's Degree or higher	Median Household Income - $46,073; Persons in Poverty – 16.4%
Virginia	Northampton	11,710	62.7% White, 33.7% African American, 0.4% American Indian/Alaska Native, 1% Asian, 0.2% Hawaiian and other Pacific Islander, 1.9% Two or more races, 9.5% Hispanic or Latino, 54.3% White alone	82.5% High School Graduate or higher; 22.6% Bachelor's Degree or higher	Median Household Income - $47,227; Persons in Poverty – 18.1%

			[not Hispanic of Latino]		
STATE	**COUNTY**	**POPULATION**	**RACE**	**EDUCATION**	**INCOME & POVERTY**
Maryland	Wicomico	103,609	66.2% White, 27.3% African American, 0.4% American Indian/Alaska Native, 3% Asian, 0.1% Hawaiian and other Pacific Islander, 2.8% Two or more races, 5.5% Hispanic or Latino, 62% White alone (not Hispanic of Latino)	87.2% High School Graduate or higher; 27.2% Bachelor's Degree or higher	Median Household Income - $56,956; Persons in Poverty – 16%
Maryland	Somerset	25,616	54.2% White, 41.5% African American, 0.4% American Indian/Alaska Native, 1% Asian, 0.1% Hawaiian and other Pacific Islander, 2.7% Two or more races, 4% Hispanic or Latino, 51.4% White alone [not Hispanic of Latino]	81.3% High School Graduate or higher; 14.4% Bachelor's Degree or higher	Median Household Income - $37,803; Persons in Poverty – 23.6%

STATE	COUNTY	POPULATION	RACE	EDUCATION	INCOME & POVERTY
Maryland	Dorchester	31,929	66.7% White, 29% African American, 0.5% American Indian/Alaska Native, 1.2% Asian, 0.1% Hawaiian and other Pacific Islander, 2.4% Two or more races, 6.1% Hispanic or Latino, 62.3% White alone [not Hispanic of Latino]	87.9% High School Graduate or higher; 21.2% Bachelor's Degree or higher	Median Household Income - $52,917; Persons in Poverty – 16.4%
Maryland	Talbot	37,181	83.3% White, 12.8% African American, 0.4% American Indian/Alaska Native, 1.4% Asian, 0.2% Hawaiian and other Pacific Islander, 1.8% Two or more races, 7.2% Hispanic or Latino, 77.4% White alone [not Hispanic of Latino]	91.2% High School Graduate or higher; 40.6% Bachelor's Degree or higher	Median Household Income - $73,547; Persons in Poverty – 8.7%
Maryland	Queen Anne's	50,381	89.8% White, 6.3% African American, 0.5% American Indian/Alaska Native, 1.2% Asian, 0.1% Hawaiian and other Pacific	93.2% High School Graduate or higher; 36.5% Bachelor's Degree or higher	Median Household Income - $97,034; Persons in Poverty – 6.0%

			Islander, 2% Two or more races, 4.3% Hispanic or Latino, 86.3% White alone [not Hispanic of Latino]		
STATE	**COUNTY**	**POPULATION**	**RACE**	**EDUCATION**	**INCOME & POVERTY**
Maryland	Kent	19,422	81.3% White, 14.9% African American, 0.4% American Indian/Alaska Native, 1.4% Asian, 0.1% Hawaiian and other Pacific Islander, 2% Two or more races, 4.5% Hispanic or Latino, 77.8% White alone [not Hispanic of Latino]	88.6% High School Graduate or higher; 35.1% Bachelor's Degree or higher	Median Household Income - $58,598; Persons in Poverty – 12.4%
Maryland	Caroline	33,406	81% White, 14.1% African American, 0.9% American Indian/Alaska Native, 1.2% Asian, 0.3% Hawaiian and other Pacific Islander, 2.5% Two or more races, 7.8% Hispanic or Latino, 75.1% White alone [not Hispanic of Latino]	84.3% High School Graduate or higher; 18.4% Bachelor's Degree or higher	Median Household Income - $58,638; Persons in Poverty – 12.1%

STATE	COUNTY	POPULATION	RACE	EDUCATION	INCOME & POVERTY
Maryland	Cecil	102,855	88.3% White, 7.3% African American, 0.4% American Indian/Alaska Native, 1.4% Asian, 0.1% Hawaiian and other Pacific Islander, 2.5% Two or more races, 4.7% Hispanic or Latino, 84.6% White alone [not Hispanic of Latino]	89.5% High School Graduate or higher; 23.9% Bachelor's Degree or higher	Median Household Income - $76,887; Persons in Poverty – 10.3%

Note. Adapted from, United States Census Bureau (n.d.). *QuickFacts*. https://www.census.gov/quickfacts/fact/table/US/PST045221? QuickFacts data were extracted from: Population Estimates, American Community Survey, Census of Population and Housing, Current Population Survey, Small Area Health Insurance Estimates, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits. Copyright by United States Census Bureau.

Appendix E: Demographics for the United States and the States of the Delmarva Region

NATIONAL	RACE	EDUCATION	INCOME & POVERTY
United States	76.3% white, 13.4% African American, 1.3% American Indian/Alaska Native, Asian 5.9%, 0.2% Hawaiian and other Pacific Islander, 2.8% Two or more races, 18.5% Hispanic or Latino, 60.1% White alone [not Hispanic of Latino]	88% High School Graduate or higher; 32.1% Bachelor's Degree or higher	Median Household Income - $62,843; Persons in Poverty – 10.5%
Maryland	58.5% white, 31.1% African American, 0.6% American Indian/Alaska Native, Asian 6.7%, 0.1% Hawaiian and other Pacific Islander, 2.9% Two or more races, 10.6% Hispanic or Latino, 50% White alone [not Hispanic of Latino]	90.2% High School Graduate or higher; 40.2% Bachelor's Degree or higher	Median Household Income - $84,805; Persons in Poverty – 9.0%

NATIONAL	RACE	EDUCATION	INCOME & POVERTY
Delaware	69.2% white, 23.2% African American, 0.7% American Indian/Alaska Native, Asian 4.1%, 0.1% Hawaiian and other Pacific Islander, 2.7% Two or more races, 9.6% Hispanic or Latino, 61.7% White alone [not Hispanic of Latino]	90% High School Graduate or higher; 32% Bachelor's Degree or higher	Median Household Income - $68,287; Persons in Poverty – 11.3%
Virginia	69.4% white, 19.9% African American, 0.5% American Indian/Alaska Native, Asian 6.9%, 0.1% Hawaiian and other Pacific Islander, 3.2% Two or more races, 9.8% Hispanic or Latino, 61.2% White alone [not Hispanic of Latino]	89.7% High School Graduate or higher; 38.8% Bachelor's Degree or higher	Median Household Income - $74,222; Persons in Poverty – 9.9%

*Note***.** Source – adapted from, United States Census Bureau (n.d.). *QuickFacts*. https://www.census.gov/quickfacts/fact/table/US/PST045221? QuickFacts data were extracted from: Population Estimates, American Community Survey, Census of Population and Housing, Current Population Survey, Small Area Health Insurance

Estimates, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits. Copyright form United States Census Bureau.

Appendix F: Cause of Death Comparisons for the Nation, States, and Delmarva Region

BY COUNTY AMONG DELMARVA REGION	NUMBER OF HEART DISEASE [Male & Female] *Rate per 100,000	NUMBER OF CANCER [Male & Female] *Rate per 100,000	NUMBER OF STROKE [Male & Female] *Rate per 100,000
Kent County, DE	219.81	193.29	47.49
Sussex County, DE	197.19	178.21	42.85
New Castle County, DE	184.01	182.07	36.27
Accomack County, VA	232.19	218.13	51.33
Northampton County, VA	222.06	229.78	57.79
Worcester County, MD	206.4	184.83	37.38
Wicomico County, MD	260.11	210.23	43.82
Somerset County, MD	304.37	213.49	36.3
Dorchester County, MD	236.66	201.45	47.82
Talbot County, MD	161.1	160.55	47.07

BY COUNTY AMONG DELMARVA REGION	**NUMBER OF HEART DISEASE** [Male & Female] *Rate per 100,000	**NUMBER OF CANCER** [Male & Female] *Rate per 100,000	**NUMBER OF STROKE** [Male & Female] *Rate per 100,000
Kent County, MD	191.3	174.17	50.61
Caroline County, MD	221.02	199.84	51.36
Cecil County, MD	225.41	203.28	47.43

STATES OF THE DELMARVA REGION	**NUMBER OF HEART DISEASE** [Male & Female] *Rate per 100,000	**NUMBER OF CANCER** [Male & Female] *Rate per 100,000	**NUMBER OF STROKE** [Male & Female] *Rate per 100,000
Maryland	159.31	144.41	41.79
Delaware	154.3	151.88	45.09
Virginia	149.08	144.93	38.34

UNITED STATES	NUMBER OF HEART DISEASE [Male & Female] *Rate per 100,000	NUMBER OF CANCER [Male & Female] *Rate per 100,000	NUMBER OF STROKE [Male & Female] *Rate per 100,000
	161.52	146.15	36.96

Note. Sources – derived from: (a) United States Census Bureau (n.d.). *QuickFacts*, https://www.census.gov/quickfacts/fact/table/US/PST045221? QuickFacts data were extracted from: Population Estimates, American Community Survey, Census of Population and Housing, Current Population Survey, Small Area Health Insurance Estimates, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits. Copyright by United States Census Bureau; (b) World Life Expectancy (n.d.). *USA Health Rankings*, https://www.worldlifeexpectancy.com/usa-cause-of-death-by-age-and-gender. National and state rankings were derived from: Centers for Disease Control and Prevention: Final Deaths 2019 Release Date 12/22/20.; WHO, World Bank, UNESCO, CIA and individual country databases for global health and causes of death; & CDC, NIH and individual databases for verification and supplementation for USA data. Copyright by Centers for Disease Control and Prevention.

Appendix G: Interview Protocol

SEMI-STRUCTURED INTERVIEW GUIDE

Interview guides can be developed in detail, depending on the extent to which the interviewer is able to specify important issues in advance and the extent to which it is important to ask questions in the same order to all respondents (Patton, 2015).
*Research Method – Qualitative
*Research Design – Interpretive Description
*Type of interview – Video and/or Teleconference [one-on-one]
*Length of Interview – 45 minutes

INTRODUCTION [10 minutes – Ice Breaker]
Tell me about your years of experience providing for your community in the Delmarva area?

BEGINNING [20 minutes – Conceptual Framework]

1. Tell me how you align your vision to meet the health needs of your community in the Delmarva area? [5 minutes, Transformational Leadership – Inspirational Motivation]

2. How do you go about tending to the health needs of population groups within your community in the Delmarva area? [5 minutes, Transformational Leadership - Individualize Consideration]

3. Describe how your supportive mechanisms adhere to the health needs of your community in the Delmarva area? [5 minutes, Transformational Leadership - Intellectual Stimulation]

4. As a role model, tell me about the affects you have had in your community among the Delmarva area? [5 minutes, Transformational Leadership – Idealize Influence]

MIDDLE [10 minutes – Constructs of the Study]

5. How does your leadership style influence your collaborative partnership? [5 minutes]
6. How was your collaborative partnership effective for attempts at meeting the health needs of your community in the Delmarva area? [5 minutes]

END [5 minutes, Closure: Closing Statements/Peer Debrief]

This concludes the interview. During the interview, we have explored your management and leadership styles, and how they have influenced your collaborative partnerships in

your community among the Delmarva Region. Your responses will be transcribed and will be sent to you for verification and to confirm the accuracy of your responses.
I want to thank you for taking out the time to participate with the interview. I will be following up with you to confirm the transcription of the interview. Expect to hear from me via email or phone sometime between a week or two after today. Thanks again, and I really appreciate your assistance toward helping me complete my dissertation.

CONCLUDING STATEMENTS

Is there anything else you would like to share or add with me before we finish the interview? [1 minute]

Do you have any final thoughts about the interview? [1 minute]
How did you feel about the interview process? [1 minute]
Do you have any questions for me? [1 minute]

INVITATION EMAIL

Hello [Faith Leader],

I hope this note finds you well.

As part of my research study requirement, volunteers [21 years or older] are needed for participation as potential "interviewees" for my research study. Participation in the research study will entail the completion of an Informed Consent statement [statement will be to you], brief survey, and an interview. Only those who meet the inclusion participant of the study will advance to complete surveys and interviews. All who complete the surveys may not proceed to interview. Your total engagement should not take no longer than an hour of your time [15 minutes for completing a survey, and 45 minutes for completing the interview].You can contact me by e-mail paul.s.trotter2@waldenu.edu if you have any questions.

INFORMED CONSENT

Mr./Ms./Mrs./Dr. XXXXXXXX,

You are invited to take part in a research study about rural Faith Leaders' perceptions and experiences concerning community health. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.
This study seeks at least 12 volunteers who are:

- at least 21 years old,
- five years of experience as a lead minister, deacon, or pastor of a church,
- church being a part of a collaborative healthcare partnership, and
- church demonstrating evidence of performing health outreach in their surrounding communities.

This study is being conducted by a researcher named Paul S. Trotter Jr., who is a doctoral candidate in management at Walden University.

Study Purpose:
The purpose of this study is to explore how Faith Leaders perceive and experience their roles as social change agents in healthcare partnerships that focus on community health in a rural area.

Procedures:
This study will involve you completing the following steps:

- complete a survey [no longer than 15 minutes], and
- some individuals will also be asked to participate in a video or teleconference interview that will be audio recorded [no longer than 45 minutes]
- Participate in a follow up interview to verify interview responses [no longer than 10 minutes]

Here are some sample survey and interview questions:

- Tell me about your years of experience providing support for your community in the Delmarva area?
- How do you go about tending to the health needs of population groups within your community in the Delmarva area?
- Describe how your supportive methods adhere to the health needs of your community in the Delmarva area?
- As a role model, tell me about the affects you have had in your community among the Delmarva area?

Voluntary Nature of the Study:
Research should only be done with those who freely volunteer. So, everyone involved will respect your decision to join or not.

If you decide to join the study now, you can still change your mind later. You may stop at any time. Please note that not all volunteers will be contacted to take part. The researcher will follow up with all volunteers to let them know whether they were selected to interview.

Risks and Benefits of Being in the Study:
Being in this study could involve little to no risk of minor discomforts that can be encountered in daily life. With the protections for personal identifiable information in place, this study would pose minimal risk to your wellbeing.

This study offers no direct benefits to individual volunteers. The aim of this study is to benefit society by advancing knowledge of leadership, community health practice, and health outcomes. Once the analysis is complete, the researcher will highlight the overall results by emailing participants about the results of the study.

Payment:
The researcher will send a $20 Visa gift card to participants who are interviewed.

Privacy:
The researcher is required to protect your privacy. Your identity and data will be kept confidential, within the limits of the law. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. If the researcher were to share this dataset with another researcher in the future, the dataset would contain no identifiers so this would not involve another round of obtaining informed consent. Data will be kept secure by applying password protection, data encryption, use of codes in place of personal identifiers, and storing names in desktop files of the researcher's personal computer. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:
You can ask questions of the researcher by email [redacted] If you want to talk privately about your rights as a participant or any negative parts of the study, you can call Walden University's Research Participant Advocate at [redacted]. Walden University's approval number for this study is **IRB will enter approval number here**. It expires on **IRB will enter expiration date.**

You might wish to retain this consent form for your records. You may ask the researcher or Walden University for a copy at any time using the contact info above.

Obtaining Your Consent

If you feel you understand the study and wish to volunteer, please indicate your consent by replying to this email with the words, "***I consent***".

Appendix H: Churches in the Delmarva Region

Delmarva County	State	Church Name	Website
Accomack	Virginia	Onancock Baptist Church	http://www.churchontheshore.com/
Accomack	Virginia	Onley Baptist Church	https://www.onleybaptistchurch.org/
Accomack	Virginia	First Baptist Church – Mappsville	https://www.firstbaptistmappsville.com/
Accomack	Virginia	Zion Baptist Church	https://www.zionbaptist.info/
Accomack	Virginia	Snead's Memorial United Methodist Church	http://sneadsmemorialumc.com/
Accomack	Virginia	Naomi Makemie Presbyterian Church	http://www.nmpreschurch.org/
Accomack	Virginia	First Baptist New Church	https://firstbaptistnewchurchva.org/
Accomack	Virginia	Chincoteague Church of God	https://churchbythebeach.org/
Accomack	Virginia	Grace United Methodist Church of Parksley	https://www.graceumcesva.com/
Accomack	Virginia	Island Baptist Church	https://islandbaptistchurch.net/
Caroline	Maryland	Trinity A.M.E. Church	http://www.trinityameridgely.org/

Delmarva County	State	Church Name	Website
Caroline	Maryland	Wye Mills United Methodist Church	http://www.wyemills.org/
Caroline	Maryland	Greater New Hope Church & Ministries	http://www.newhopemd.org/about-us/statement-of-wealth/
Caroline	Maryland	Bethlehem Wesleyan Church	http://bwcalive.org/
Caroline	Maryland	Hurlock United Methodist Church	http://hurlockumc.org/
Caroline	Maryland	First Baptist Church	https://firstbaptistchurchmarydelmd.weebly.com/
Caroline	Maryland	Immaculate Conception Church	https://www.iccmarydel.org/
Caroline	Maryland	Triune Grace Reformed Baptist Church	https://www.facebook.com/Triune-Grace-Church-Plant-106328231703292
Caroline	Maryland	Community Baptist Mission Church	http://community-baptist-mission-church.business.site/
Caroline	Maryland	Greensboro Baptist Church	http://www.greensborobaptist.org/
Cecil	Maryland	Crossroads Bible Church	https://cbcmd.org/
Cecil	Maryland	Elkton United Methodist Church	http://www.elktonumc.org/

Delmarva County	State	Church Name	Website
Cecil	Maryland	Chesapeake City United Methodist Charge	http://www.chesapeakecityumc.com/
Cecil	Maryland	First Presbyterian Church	http://www.chescitypresby.pbworks.com/
Cecil	Maryland	Bethel AME Church Chesapeake	http://www.ccea4u.com/churches/Bethel_AME.htm
Cecil	Maryland	Wards Hill Baptist Church	https://www.facebook.com/wardshillbaptist/
Cecil	Maryland	Grace Church of Warwick	https://www.impactchurchwarwick.com/
Cecil	Maryland	Saint Francis Xavier Church	http://www.stfrancisxaviershrine.com/
Cecil	Maryland	Saint Augustine Church	https://www.augustineparish.org/
Cecil	Maryland	Bohemia Wesleyan Church	http://www.bohemiawesleyan.org/
Dorchester	Maryland	Open Bible Church	http://www.openbibleacademy.net/contact.html
Dorchester	Maryland	Old Trinity Episcopal Church	http://oldtrinity.net/
Dorchester	Maryland	Kingdom Churches & Ministries	https://www.kingdomchurchandministries.org/

Delmarva County	State	Church Name	Website
Dorchester	Maryland	Cambridge Church of Christ	http://churchofchristsalisbury.org/areachurchofchrist.html
Dorchester	Maryland	Bethel AME Church	https://www.bethelamecambridge.org/
Dorchester	Maryland	Grace United Methodist Church	https://www.graceumccambridge.org/
Dorchester	Maryland	St. Paul's United Methodist Church	https://stpaulscambridge.com/
Dorchester	Maryland	Bay Country Church	https://www.baycountrychurch.net/
Dorchester	Maryland	St. Mary Star of the Sea	http://www.stmaryscambridge.org/
Dorchester	Maryland	Immanuel United Church of Christ	http://immanuelucc.com/
Kent	Delaware	Deep Water Church	http://deepwater.church/
Kent	Delaware	Community Baptist Mission Church	https://community-baptist-mission-church.business.site/
Kent	Delaware	Felton-Viola United Methodist Church	https://www.feltonviola.org/
Kent	Delaware	Freedom Baptist Church	https://officefbcfrederica.wixsite.com/fbcfrederica
Kent	Delaware	Solid Rock Church	https://solidrockchurchde.org/srcwpr46/

Delmarva County	State	Church Name	Website
Kent	Delaware	Bread of Life Christian Church	https://www.breadoflifechurchde.org/
Kent	Delaware	Reformation Lutheran Church	http://reformation-lutheran.net/
Kent	Delaware	Millford Church of God	http://www.milfordcog.com/
Kent	Delaware	Orchard Church	https://orchardchurchde.com/
Kent	Maryland	Janes United Methodist Church	http://www.umc.org/find-a-church/church/78940
Kent	Maryland	St. Paul's United Methodist Church	http://www.ceciltonparish.org/locations/st-pauls/
Kent	Maryland	Shrewsbury Parish Church	http://www.shrewsburyparish.org/
Kent	Maryland	Mount Olive African Methodist Episcopal Church	http://www.mtoliveamecworton.org/
Kent	Maryland	New Kent Christian Center	http://www.newkentcc.com/
Kent	Maryland	Chesapeake Church of Christ	http://www.chesapeakechurchofchrist.org/
Kent	Maryland	Hope Fellowship	http://www.ctownhope.com/
Kent	Maryland	Rock Hall Church of God	https://www.rockhallcog.org/

Delmarva County	State	Church Name	Website
Kent	Maryland	Worton United Methodist Church	http://www.umc.org/find-a-church/church/24222
Kent	Maryland	St. John United Methodist Church	http://www.sacredparish.org/
New Castle	Delaware	Church on Main	http://www.churchonmainde.com/
New Castle	Delaware	The Mission Christian Church	https://www.themissionbfc.org/
New Castle	Delaware	Crossroads Presbyterian Church	https://crossroadsde.com/
New Castle	Delaware	The Church of Jesus Christ of Latter-Day Saints	https://www.churchofjesuschrist.org/?lang=eng
New Castle	Delaware	4 The World Ministries	https://www.4tworld.org/
New Castle	Delaware	Smyrna Wesleyan Church	https://www.smyrnawesleyan.org/
New Castle	Delaware	St. Peter's Episcopal Church	https://stpeters-smyrna.org/
New Castle	Delaware	Saint Polycarp Church	https://saintpolycarp.org/
New Castle	Delaware	St. Paul's Roman Catholic Church	http://stpaulsrcchurch.org/

Delmarva County	State	Church Name	Website
New Castle	Delaware	LifeHouse Church	http://lifehousemot.com/
Northampton	Virginia	Exmore Baptist Church	https://www.exmorebaptistchurch.com/
Northampton	Virginia	Hungars Episcopal Church	https://www.hungarscure.org/
Northampton	Virginia	Trinity United Methodist Church	https://www.trinitybythebay.com/
Northampton	Virginia	Cheriton United Methodist Church	https://www.cheritonchargeumc.com/about
Northampton	Virginia	Eastville Baptist Church	https://eastvillebaptistchurch.org/
Northampton	Virginia	Capeville United Methodist Church	https://www.capevilleonthesea.com/
Northampton	Virginia	Cape Charles Baptist Church	https://capecharlesbaptist.com/
Northampton	Virginia	Holmes Presbyterian Church	https://holmespresby.org/
Northampton	Virginia	Ebenezer Baptist Church	https://ebcesva.org/
Northampton	Virginia	Church of the Lord Jesus Christ	https://tcljc.com/

Delmarva County	State	Church Name	Website
Queen Anne	Maryland	Immanuel United Methodist Church	http://iumc21638.org/
Queen Anne	Maryland	Friends of Historic Christ Church	http://friendsofhistoricchristchurch.org/
Queen Anne	Maryland	Epworth Methodist Church	https://centreville-umc.com/about-us/our-history
Queen Anne	Maryland	Safe Harbor Presbyterian Church	http://www.safeharborpca.org/
Queen Anne	Maryland	New Life Christian Outreach	http://nlcochester.org/
Queen Anne	Maryland	Island Alliance Church	https://islandalliancechurch.com/
Queen Anne	Maryland	Wye Bible Church	https://www.wyebiblechurch.com/
Queen Anne	Maryland	Old Wye Church	http://www.wyeparish.org/
Queen Anne	Maryland	Union Wesley United Methodist	http://www.newumchurch.org/
Queen Anne	Maryland	Church Hill United Methodist	http://www.umc.org/find-a-church/church/24104
Somerset	Maryland	Manokin Presbyterian Church	https://manokinchurch.wordpress.com/
Somerset	Maryland	First Baptist Church	https://faithlife.com/first-baptist-church-crisfield-md/activity
Somerset	Maryland	Rehoboth Presbyterian Church	https://oldrehobothchurch.org/

Delmarva County	State	Church Name	Website
Somerset	Maryland	Pure Word Bible Church	https://www.purewordbiblechurch.com/
Somerset	Maryland	First Baptist Church	https://www.fbcprincessanne.org/
Somerset	Maryland	Mariners United Methodist Church	https://www.umc.org/en/find-a-church/church/?id=24352
Somerset	Maryland	St. Andrew's Episcopal Church	https://www.saintandrewsomersetparish.com/
Somerset	Maryland	Living Hope Ministries	https://www.livinghopecrisfield.com/
Somerset	Maryland	Liberty Rock Church	https://myrock67.wixsite.com/libertyrock
Somerset	Maryland	Saint Michaels Church	https://idealsites.wixsite.com/st-michael
Sussex	Delaware	Anchor Church	https://anchormilford.com/
Sussex	Delaware	Bay Shore Community Church - Rehoboth Campus	https://www.bayshorecc.org/
Sussex	Delaware	Blackwater Fellowship Church	www.blackwaterfellowshipchurch.org
Sussex	Delaware	Fenwick Island Baptist Church	http://www.fenwickislandbaptist.com/
Sussex	Delaware	Lewes Presbyterian Church	https://lewespresbyterianchurch.org/
Sussex	Delaware	Calvary Wesleyan Church	http://www.calvarywesleyan.org/

Delmarva County	State	Church Name	Website
Sussex	Delaware	CC Delaware Coast	https://ccdelcoast.com/index.html
Sussex	Delaware	Long Neck United Methodist Church	https://www.longneckumc.com/
Sussex	Delaware	Peninsula Community Church	http://pccministry.org/
Sussex	Delaware	Community Lutheran Church ELCA	https://www.clc19945.org/
Talbot	Maryland	Talbot Bible Church	https://www.talbotbible.com/
Talbot	Maryland	Christ Church Easton	http://www.christchurcheaston.org/
Talbot	Maryland	Church of the King	http://www.cotkeaston.org/
Talbot	Maryland	Easton Church of God	https://www.eastoncog.org/
Talbot	Maryland	Eastpoint Church	http://epeaston.com/
Talbot	Maryland	Mid Shore Community Church	http://www.midshorecommunitychurch.com/
Talbot	Maryland	Fountain of Life	http://www.flceaston.org/
Talbot	Maryland	John Wesley Church	http://johnwesleychurch.org/
Talbot	Maryland	Hillsboro United Methodist Church	http://www.umc.org/find-a-church/church/24164

Delmarva County	State	Church Name	Website
Talbot	Maryland	Calvary Baptist Church	http://www.calvarybaptistchurchofdenton.org/
Wicomico	Maryland	Delmarva Evangelistic	https://www.decsalisbury.com/
Wicomico	Maryland	Wesleyan Church	https://www.wesleyan.org/
Wicomico	Maryland	Crossroads Church of God	https://crossroadscog.org/
Wicomico	Maryland	Rockawalkin United Methodist Church	https://rockawalkin.com/
Wicomico	Maryland	Asbury United Methodist Church	https://www.asburymountvernon.com/
Wicomico	Maryland	St. John's United Methodist Church	https://stjohnsfruitland.org/
Wicomico	Maryland	The Uprising @St. Paul's Church	https://uprising.church/
Wicomico	Maryland	Gods Missionary Church	https://godsmissionarychurch.org/
Wicomico	Maryland	St. Phillip's Episcopal Church	http://stphilipschurchquantico.org/
Wicomico	Maryland	Freedman's Methodist Church	https://www.freedmansmethodistchurch.com/
Worcester	Delaware	Community Church at Ocean Pines	http://www.ccaop.org/

Delmarva County	State	Church Name	Website
Worcester	Maryland	All Hallows Episcopal Church	https://www.allhallowssnowhill.org/
Worcester	Maryland	Berlin First Baptist Church	https://berlinfirstbaptist.com/
Worcester	Maryland	St. Mary the Virgin Episcopal Church	https://www.stmaryspocomoke.org/
Worcester	Maryland	Snow Hill Mennonite Church	https://snowhillmennonite.wordpress.com/
Worcester	Maryland	Stevenson United Methodist Church	https://www.stevensonchurch.org/
Worcester	Maryland	Buckingham Presbyterian Church	http://buckinghampcusa.org/
Worcester	Maryland	St. Paul's by-the-Sea Episcopal Church	https://stpaulsbythesea.org/
Worcester	Maryland	Collins Temple Church	https://www.ctame.org/
Worcester	Maryland	Mt. Zion Missionary Baptist Church	https://www.mtzionmbc1.org/

Note. Sources –google and yahoo search engines of the internet.

Appendix I: Interview Participant Characteristics

Participant	Gender	Interview Method	Duration of Interview	How Many Times Interviewed	Questions
1	Male	Video Teleconference	22 minutes and 25 seconds	1	Open Ended
2	Male	Video Teleconference	23 minutes and 29 seconds	1	Open Ended
3	Female	Video Teleconference	13 minutes and 25 seconds	1	Open Ended
4	Female	Video Teleconference	23 minutes and 40 seconds	1	Open Ended
5	Male	Video Teleconference	15 minutes and 15 seconds	1	Open Ended
6	Male	Email	Not Applicable	1	Open Ended
7	Male	Video Teleconference	18 minutes and 58 seconds	1	Open Ended
8	Female	Video Teleconference	45 minutes and 9 seconds	2	Open Ended
9	Male	Video Teleconference	41 minutes and 9 seconds	2	Open Ended

Note. Data derived from final interview transcription documents.

Appendix J: Source Summary [Quotes of Participants]

Participant	Word Count Length	Number of Quotes
1	16,196	247
2	11,616	147
3	13,133	55
4	15,404	203
5	10,548	113
6	11,142	104
7	13,218	183
8	10,853	143
8A	11,032	220
9	12,356	172
9A	3,048	31

Note. Derived from Quirkos Report.

Appendix K: Multifactor Leadership Questionnaire Results 1

MLQ Questions	Participant 1	Participant 2	Participant 3
I re-examine critical assumptions to question whether they are appropriate	3	2	2
I talk about my most important values and beliefs	3	3	3
I seek differing perspectives when solving problems	4	4	3
I talk optimistically about the future	1	3	3
I instill pride in others for being associated with me	2	3	4
I talk enthusiastically about what needs to be accomplished	1	3	4
I specify the importance of having a strong sense of purpose	3	3	4
I spend time teaching and coaching	3	4	4
I go beyond self-interest for the good of the group	3	3	4

MLQ Questions	Participant 1	Participant 2	Participant 3
I treat others as individuals rather than just as members of the group	3	3	4
I act in ways that build others' respect for me	3	3	4
I consider the moral and ethical consequences of decisions	4	4	4
I display a sense of power and confidence	2	3	4
I articulate a compelling vision of the future	3	2	4
I consider each individual as having different needs, abilities, and aspirations from others	2	4	3
I get others to look at problems from many different angles	3	2	3
I help others to develop their strengths	3	2	4
I suggest new ways of looking at how to complete assignments	2	3	3
I emphasize the importance of having a collective sense of mission	3	3	3

MLQ Questions	Participant 1	Participant 2	Participant 3
I express confidence that goals will be achieved	2	3	4
Builds Trust	2.5	3	4
Acts with Integrity	3.3	3.3	3.5
Encourages Others	1.8	2.8	3.8
Encourages Innovative Thinking	3	2.8	2.8
Coaches & Develops People	2.8	3.3	3.8

Note. Data derived from Mind Garden Tool [MLQ]

Appendix L: Multifactor Leadership Questionnaire Results 2

MLQ Questions	Participant 4	Participant 5	Participant 6
I re-examine critical assumptions to question whether they are appropriate	3	3	3
I talk about my most important values and beliefs	3	4	4
I seek differing perspectives when solving problems	3	3	3
I talk optimistically about the future	4	3	3
I instill pride in others for being associated with me	3	3	3
I talk enthusiastically about what needs to be accomplished	3	4	3
I specify the importance of having a strong sense of purpose	4	3	4
I spend time teaching and coaching	4	3	3
I go beyond self-interest for the good of the group	4	4	2

MLQ Questions	Participant 4	Participant 5	Participant 6
I treat others as individuals rather than just as members of the group	4	3	3
I act in ways that build others' respect for me	4	3	3
I consider the moral and ethical consequences of decisions	4	4	4
I display a sense of power and confidence	3	3	3
I articulate a compelling vision of the future	4	3	3
I consider everyone as having different needs, abilities, and aspirations from others	4	4	4
I get others to look at problems from many different angles	3	3	2
I help others to develop their strengths	4	3	3
I suggest new ways of looking at how to complete assignments	3	4	3
I emphasize the importance of having a collective sense of mission	4	4	4

MLQ Questions	Participant 4	Participant 5	Participant 6
I express confidence that goals will be achieved	4	3	3
Builds Trust	3.5	3.3	2.8
Acts with Integrity	3.8	3.8	4
Encourages Others	3.8	3.3	3
Encourages Innovative Thinking	3	3.3	2.8
Coaches & Develops People	4	3.3	3.3

Note. Data derived from Mind Garden Tool [MLQ]

Appendix M: Multifactor Leadership Questionnaire Results 3

MLQ Questions	Participant 7	Participant 8	Participant 9
I re-examine critical assumptions to question whether they are appropriate	3	3	3
I talk about my most important values and beliefs	4	2	4
I seek differing perspectives when solving problems	3	4	2
I talk optimistically about the future	4	4	4
I instill pride in others for being associated with me	3	4	3
I talk enthusiastically about what needs to be accomplished	4	4	4
I specify the importance of having a strong sense of purpose	4	3	3
I spend time teaching and coaching	4	3	4
I go beyond self-interest for the good of the group	4	4	4

MLQ Questions	Participant 7	Participant 7	Participant 9
I treat others as individuals rather than just as members of the group	4	2	4
I act in ways that build others' respect for me.	4	2	4
I consider the moral and ethical consequences of decisions.	4	4	4
I display a sense of power and confidence.	4	2	3
I articulate a compelling vision of the future.	4	3	3
I consider everyone as having different needs, abilities, and aspirations from others.	4	4	4
I get others to look at problems from many different angles.	3	3	4
I help others to develop their strengths.	4	4	4

Note. Data derived from Mind Garden Tool [MLQ]

Appendix N: Quirkos Report [Initial Emic Coding Results]

Quirk Title	*Parent Code*	*Grandparent Code*
Inspire	Motivation/Motivate	
Awareness	Leadership	
Giving My Time and Talents to Better Community	Responsibility	Leadership
Educational Disparities	Concerns	
Donation	Church Activity	
Sitting with Family	Solutions	
Nursing Home	Health Organizations	Organizations
My Church Involves Getting Churches to Work Together	Faith Leaders	Church
Health Problems	Addresses Health Issues	Focus
Working Toward Helping Unite Churches	Responsibility	Leadership
Partnered with Public Health Department		
Help By Serving as a Resource	Resources/Resourceful	
Provide Breakfast at the Church for Policeman	Church Community Activity	
Social Change	Focus	
Preston, MD	Maryland	
Entities and Stakeholders in Communities	Stakeholders	
See What's Going on in the Community	Engagement	
Don't Realize the Impact of Behavior	Challenges	
Promotor of Social Change Programs and Initiatives	Social Change	Focus
Outreach Program	Public Service Entities/Programs	Stakeholders
Make a Significant Change	Change	
Contribute to Improvement of Personal Well-Being	Faith Leaders	Church
Service serves 3 Schools that Reach 80 Kids	Ran a Food Pantry	Church Activity
Lower Shore Shelter	Community Members and Organizations	Organizations

Quirk Title	Parent Code	Grandparent Code
Reminded on the Importance of These Factors to Achieve Good Health	Having All Three Core Factors: Spirit, Mind, and Physical Health	Wholeness
Council Meetings	Meetings	
Lead to Physical Improvements for Individuals and Their Families	Wholeness	
Don't Have Access to Resources	Limitations	
Total Body Health	Wholeness	
Different Faith Leaders Who Come Together to Discuss Events	Faith Leaders	Church
Bring Shalom to Complete Peace and Well-Being	Faith Leaders	Church
Made Myself Eligible to Become a Local Pastor	Faith Leaders	Church
County Sheriff's Department	Organizations	
The Recovery Program	Public Service Entities/Programs	Stakeholders
Help People with Their Concerns	Needs	Focus
Use to Work for Shore Regional Health	Health Resources	Resources/Resourceful
I've Been Picking People Up and Taking Them to Doctor Appointments	Church Community Activity	
Diabetes Class	Church Activity	
Don't always Talk to Each Other	Challenges	
Don't Have a Structure to Organize	Limitations	
Emotional Health	Emotional	
The Seaton Center	Community Members and Organizations	Organizations
Health Conditions	Focus	
Pregnancy Crisis Centers	Community Members and Organizations	Organizations
Do More than Just Pray for Folks	Solutions	
Church in Walkable Distance for its Members	Church	
Assist With Meeting the Needs of the Community	Leaders	Leadership

Quirk Title	Parent Code	Grandparent Code
Things Come to Us, We Pick Them Up	Resources/Resourceful	
Provide Vaccinations Through the Church	Church Activity	
Freakish Storms	Weathering Issues	Issues
We Show Up When We Say We Show Up	Church	
Establishing Positive Presence in the Community	Presence	
Come to Me for Guidance	Resources/Resourceful	
Working with Underrepresented and Undeserved Populations	Focus	
Addresses Health Issues	Focus	
My Leadership Style Opens Me Up to More Opportunities	Leadership Style	Leadership
Interesting Time to Connect	Issues	
Meet Constituents Where They Are	Faith Leaders	Church
Somerset County	Maryland	
Transportation	Limitations	
Create a Heaven Like Atmosphere	Faith Leaders	Church
Eastern Shore Long Term Recovery Program	Public Service Entities/Programs	Stakeholders
Reaching Out to Others to Gather Insight on Possible Solutions	Resources/Resourceful	
Health Assessments	Offer a Range of Services	Services/Service
Delivering Communion	Church Community Activity	
Lack of Mental Health Services	Limitations	
Healthcare Providers	Addresses Health Issues	Focus
Don't Feel Like I Have Enough Social Capital	Limitations	
Caring for First Responders	Offer a Range of Services	Services/Service
Tragic Events and Emergencies	Issues	
Make People Feel and Do Better with Their Lives	Motivation/Motivate	
Mental Health is Not Easily and Readily Available	Limitations	

Quirk Title	Parent Code	Grandparent Code
Meeting the Needs of the Community is the Responsibility of the Church	Responsibility	Leadership
There's A Lot of Partnering	Partner/Partnership	
Partner/Partnership		
Establishing Daily Visibility in the Church and Community	Faith Leaders	Church
Community Welfare	Outcomes	
Provide Produce	Solutions	
Don't Make Regional or National News	Limitations	
Give Financially to Organizations that Support the Community	Support/Supportive	
Board Member		
Lent Season	Church Activity	
Promotes the Right Image and Message	Leaders	Leadership
Provide a Perception that I Care for What They Have to Say	Faith Leaders	Church
Provide a Faith-Based Voice	Faith Leaders	Church
Welfare	Focus	
Public Service Entities/Programs	Stakeholders	
Diabetes	Health Conditions	Focus
Community Entities	Community Members and Organizations	Organizations
Congregants	Congregation	Church
Provide a Sense of Presence	Presence	
Gathering People and Resources	Resources/Resourceful	
Methodist Church	Faith-Based Organizations	Organizations
Being Supportive of Community Events, Welfare, and Well-Being	Support/Supportive	
Healing People Where Their Needs Are	Needs	Focus
Vaccines/Vaccinations		
Youth	Responsibility	Leadership

Quirk Title	Parent Code	Grandparent Code
NAACP Meeting	Meetings	
Housing is an Issue	Community Issues	Issues
Due to Health Condition, I Help with Communicating His Feeling During Court	Services/Service	
We Try Not to Be Engaged in One Niche	Mechanisms Are Unique and Spontaneous	
Grocery Shopping Best Practice	Addresses Health Issues	Focus
Identify Their Needs	Needs	Focus
Establish a Routine	Solutions	
Church Used as a Setting for Group Meetings	Resources/Resourceful	
Import ant to Be Actively Involved in the Community	Leaders	Leadership
Meet with Other Leaders	Leaders	Leadership
Tend to the Soul	Focus	
Jumping In Where I can Really Act	Mechanisms Are Unique and Spontaneous	
Keep Myself Available	Resources/Resourceful	
Don't Have the Means to Meet the Health Needs of Our Community on Our Own	Limitations	
Aware of Community Happenings	Church	
Better at Partnering for Different Things	Partner/Partnership	
Sat With Her During Her SSI Interview so That She Can Acquire SSI	Services/Service	
Being Collaborative and Informal Makes People Feel Good	Collaboration/Collaborate	
I Must Always Back Up What I Say Through Action and Image	Leaders	Leadership
Services/Service		
Volunteer to Help Out Around the Church	Volunteer/Volunteering/Volunteers	
A lot of Land that Can be Used for Farming	A lot of Land	Resources/Resourceful
Try to Avoid Redundant Offering and Services	Services/Service	
Quirk Title	**Parent Code**	**Grandparent Code**
Health Arena is One of Those Areas I Like to Be Involved With	Focus	

Quirk Title	Parent Code	Grandparent Code
Networking	Communicating/Communication	
Visibility in the Community	Community Solutions	Solutions
Using Facility for COVID Vaccine Shots	Resources/Resourceful	
Organizations		
Exercise	Solutions	
Role Model	Leaders	Leadership
Chlorine and Florine in Water	Environmental Constraints	Environment
Offset Behavior	Focus	
Local Dept. of Health and Aging	Health Department	Organizations
Dealing with the Homebound and Nursing Home Patients.	Faith Leaders	Church
My Visitation Serves as a Means of Communication to Acquire What they Need	Services/Service	
When that Environment is Toxic	Limitations	
Folks Volunteer to Help Others	Volunteer/Volunteering/Volunteers	
Hosted Eastern District Sunday School convention	Church Community Activity	
Health Conditions that Were Often Influenced by Their Physical Environments, Poor, Diet, and Lack of Exercise	Influence	
Establish Relationship with Pastors of Other Denominations	Collaboration/Collaborate	
We Don't Portray the Church Like a Foreign Entity or Business	Faith Leaders	Church
Exercise	Solutions	
Wholeness		
Have Some Youth that Hang Out at the Church	Church	
Engage into the Life of the Community	Faith Leaders	Church
Maintaining the Health of Congregation	Faith Leaders	Church
Mental Health Services	Offer a Range of Services	Services/Service
Farm	A lot of Land	Resources/Resourceful
Be Able to Collaborate with Them to Get What We Needed	Collaboration/Collaborate	
Try to Acquire People Who Are Well-Versed and Educated	Gathering People and Resources	Resources/Resourceful

Quirk Title	Parent Code	Grandparent Code
Public Health Department	Health Organizations	Organizations
Helping Others in Small and Rural Communities	Resources/Resourceful	
A Person's Living Environment	Physical Environment	Environment
Being a Pastor Is More than Just Preaching	Responsibility	Leadership
My Goal is to Build and Grow My Congregation with New Insights and Knowledge	Faith Leaders	Church
Have Pastoral Experience as an Associate Pastor	Faith Leaders	Church
Have an 'Open Door' Policy	Leadership Style	Leadership
Community of Faith Can Be A part of Caring for Folks	Church Community	Community
Guest Speaker at Somerset County Prayer Breakfast	Faith Leaders	Church
Well-Being	Wholeness	
New Day Pregnancy Center	Community Members and Organizations	Organizations
Maintaining My Health and Strength is Very Important to Me	Faith Leaders	Church
Trips to Walgreen and CVS	Church Community Activity	
Interact with Community Health Organizations	Collaboration/Collaborate	
Partner with Health Agencies	Partnerships with Three Organizations	Partner/Partnership
Focal Point for Church	What is Occurring in Community	Focus
Agencies Collaborating with Each Other to Meet Community Needs	Collaboration/Collaborate	
Judy Center of Somerset County	Public Service Entities/Programs	Stakeholders
Active Listening	Leadership Style	Leadership
Community Center Member	Community Engagement and Participation	Engagement
Occurrence of Hurricane Sandy	Weathering Issues	Issues
Find Out Ways to Help and Serve	Leaders	Leadership
Relationships	Focus	
Know Ways to Help Others	Gathering People and Resources	Resources/Resourceful

Quirk Title	Parent Code	Grandparent Code
County School Board	Community Members and Organizations	Organizations
Limitations with Transportation	Limitations	
Church to Provide a Faith-Based Voice	Church	
Positive Presence	Presence	
Responsibility	Leadership	
To Witness Collaboration at Work	Collaboration/Collaborate	
Even for Those Who Have Plenty, Old and Young	Provide Services	Services/Service
Contact Somebody to Acquire Monetary Resources	Gathering People and Resources	Resources/Resourceful
Adult and Teen Challenge in Seafood	Community Members and Organizations	Organizations
Doesn't Have to Be My Way	Leadership Style	Leadership
Motivate Others to Do the Same	Motivation/Motivate	
Concerns of Human Behavior	Concerns	
Provide Accessibility Assistance to Help People Go to the Doctor	Offer a Range of Services	Services/Service
Make Sure People Have What They Need	Resources/Resourceful	
Maintaining Blood Pressure Levels	Addresses Health Issues	Focus
Health Fairs	Church Activity	
Present in the Church Throughout the Day and Week	Faith Leaders	Church
Provide Folks with Food	Food Bank	Resources/Resourceful
Food		
COVID pandemic restricted my Capacity to DO More Things		
Acquire Members from the Clergy	Gathering People and Resources	Resources/Resourceful
Serve as a Giver and Spiritual Person	Faith Leaders	Church
Elders/Elderly	Delmarva Region	
Integrated Gentrified Community	Delmarva Region	
Been Working in the Community with Bethesda Methodist Church	Community Engagement and Participation	Engagement
We Want to Meet Those Needs	Faith Leaders	Church
Mental Healthcare Providers	Collaboration/Collaborate	

Quirk Title	Parent Code	Grandparent Code
Health Concern	Physical Environment	Environment
Social Change Agent	Social Change	Focus
Work with Food Insecurity and Housing	Organizing	
Support/Supportive		
Uniquely Position	Leaders	Leadership
Collaborate With Community Partners	Collaboration/Collaborate	
Blood Drives	Health Ministry	
Environment		
Homeless	Concerns	
I Try My Best to Share	Leaders	Leadership
Flood the Areas	Tragic Events and Emergencies	Issues
I am Very Upbeat	Leadership Style	Leadership
The Connection is in My Position	Resources/Resourceful	
Being Present	Presence	
Relating to People Where They Are	Mechanisms Are Unique and Spontaneous	
Interest in Building an Education Development	Focus	
Joined as a Member of the Community Center	Community Engagement and Participation	Engagement
Only Mechanism We Have is Financial Support	Give Financially to Organizations that Support the Community	Support/Supportive
Testing Kits	Health Resources	Resources/Resourceful
I Think We Can Do More than Just Pray for Folks	Faith Leaders	Church
A lot of Land	Resources/Resourceful	
Human Behavior	Concerns	
Health Issues	Issues	
Support Organizations Through Financial Offerings and Volunteer Labor		
Doesn't Have a Home	Homeless Shelter	
Underrepresented	Working with Underrepresented and Undeserved Populations	Focus

Quirk Title	Parent Code	Grandparent Code
Church		
Queen Anne Chapter	Community Members and Organizations	Organizations
Physical	Wholeness	
Medical Devices	Health Resources	Resources/Resourceful
Making an Extra Phone Call	Resources/Resourceful	
The Church Serves, Functions, and Behaves Like a Family	Church	
Male Phone Calls to Pharmacy to Pay for Medicines	Resources/Resourceful	
Queen Anne's County	Maryland	
Lost Weight	Exercise	Solutions
Relationships are Important	Relationships	Focus
Poverty		
Needs of the Community	Needs	Focus
Provide Support to His Family with Daily Activities and Visitation	Support/Supportive	
Black People	Focus	
I am a Firm Believer in Health	Faith Leaders	Church
Leadership Style is Based on My Personality	Leadership Style	Leadership
Get What We Needed Through Connections	Partnerships with Three Organizations	Partner/Partnership
Vision		
During Times of Tragic Events and Emergencies	Community Engagement and Participation	Engagement
Health Crisis	Concerns	
We Are Connected: Mind, Body, and Spirit	Having All Three Core Factors: Spirit, Mind, and Physical Health	Wholeness
Serve as Case Managers	Faith Leaders	Church
We Portray the Church Like a Family	Church	
Attend Community Parade	Community Events/Activities	

Quirk Title	Parent Code	Grandparent Code
Provide Recommendations for Persons Who Experience Hardship	Faith Leaders	Church
Need to Revisit and Rekindle Efforts to Focus on Community	Relationships	Focus
Estate Planning Activity	Church Activity	
The Church and I are Constantly Available in Times of Need for the Community	Faith Leaders	Church
Vision is to be a Community of Hope for All People	Vision	
Constituents	Responsibility	Leadership
Providing Visitation to Those that are Homebound	Services/Service	
Offer a Range of Services	Services/Service	
Create Opportunities	Focus	
Health Needs Depend on What the Health Needs of the People Are	Needs	Focus
Bring Professional Skills for Church Activities Useful for Community	Church Community Activity	
Enhancing the Mind, Body, and Spirit	Overall Health	Wholeness
Seeing What Needs to Be Done in the Community	Needs	Focus
Looking at How Faith Community Can Be A part of Community Health	Faith Leaders	Church
Communication with Local Health Departments	Communicating/Communication	
Visitation Experience Over the Years	Faith Leaders	Church
Health Needs	Needs	Focus
Limitations		
A Lot of People Doing Good Things	Leaders	Leadership
Most Activity Consisted of Offerings for Our Local People and Congregants	Church Activity	
As a Faith-Based Leader the Best Thing that I Can Do is Provide Awareness	Faith Leaders	Church
First Aid Training	Offer a Range of Services	Services/Service
Not Enough Mental Health Services in My Area	Limitations	

Quirk Title	Parent Code	Grandparent Code
I'm Out in the Field, Hands on With It	Leadership	
I Apply an Informal Leadership Approach	Leadership Style	Leadership
Tough to Get People to Give Blood	Blood Drives	Health Ministry
Stakeholders		
Put Forth Our Best Efforts to Serve When We Can	Church	
Social Conditions	Concerns of Human Behavior	Concerns
Utilize my Environment and Identify People and Organizations that Can Help Me	Resources/Resourceful	
Church Food Bank Activity	Church Community Activity	
Immediate and Non-Immediate Environments	Physical Environment	Environment
Recognize They Need More than Just My Help	Gathering People and Resources	Resources/Resourceful
Preach About the Importance of What it Means to Be Healthy	Faith Leaders	Church
See Who Was Engaged with Grasonville Community Center	Community Engagement and Participation	Engagement
County Health Department	Public Service Entities/Programs	Stakeholders
My strength is bridge building	Bridge Building	Collaboration/Collaborate
Drug Issues in the Area		
Communicating on What Makes Them Healthy	Enable Conversations	Communicating/Communication
A County Council Meeting is a Key Place	Resources/Resourceful	
Impacted By Social Conditions	Concerns of Human Behavior	Concerns
I Knew I Didn't Want to Preach a Sermon on Sunday Morning About Jesus	Faith Leaders	Church
I Don't View My Walls as Just the Church	Faith Leaders	Church
Children Who Are Food Insecure Get Meals for the Weekend	Food Bank	Resources/Resourceful
Community Connection as a Church Member as well as Being a Key Member in the Community that Helps Others	Congregation	Church
Being There for Others	Leadership	
Help Carry Out Vision	Vision	
Chosen By Her to Be a Point of Contact	Faith Leaders	Church

Quirk Title	Parent Code	Grandparent Code
Stroke	Health Conditions	Focus
Always Offer Good Words of Encouragement	Responsibility	Leadership
Provide Services	Services/Service	
Reliable Person	Leaders	Leadership
What Works and Makes You Healthy		
They Trust that You Are Giving Good Information	Leaders	Leadership
Willing to Open Our Facility	Resources/Resourceful	
Help Facilitate the End Product	Leaders	Leadership
Homeless Populations	Working with Underrepresented and Undeserved Populations	Focus
Being Open to Other People's Opinions and Criticisms	Leadership	
Walk the Walk and Talk the Talk	Leaders	Leadership
Leaders	Leadership	
Health Ministry		
People Seek My Help without Knowing What They Really Need	Resources/Resourceful	
Provide Various Services to Help Others in the Community	Provide Services	Services/Service
Improving Health Outcomes	Focus	
Local Health Department	Health Department	Organizations
Not Just One Group but Everyone	Responsibility	Leadership
Collaboration/Collaborate		
Becoming More Active	Faith Leaders	Church
Ministry	Church	
Gun Violence	Community Issues	Issues
Identify Big-Wigs in the Community	Gathering People and Resources	Resources/Resourceful
Heart Impediments	Health Conditions	Focus
Getting Health Experts to Help	Gathering People and Resources	Resources/Resourceful
Utilizing People's Gift to Help Others	Faith Leaders	Church
Point People in Right Direction	Gathering People and Resources	Resources/Resourceful

Quirk Title	Parent Code	Grandparent Code
The Needs are Incredibly Great	Needs	Focus
Lead By Example	Leadership Style	Leadership
I'm Just Really a Facilitator	Leadership Style	Leadership
Black Church	Congregation	Church
Church Activity		
Food Disparities	Community Issues	Issues
Faith Leaders	Church	
Takes Time to Change	Change	
Provide Outreach	Church Activity	
Bring Wholeness and Healing Through Jesus Christ	Faith Leaders	Church
Church is Supportive of Community Events, Welfare, and Outcomes	Support/Supportive	
Knowing Who to Talk To	Resources/Resourceful	
Leadership Style	Leadership	
I Must Learn How to Work with Other People	Faith Leaders	Church
Meet those Who Can't Really Get Out	Services/Service	
Drug Overdoses		
Always Tried to Collaborate with Different Stakeholders in Community	Collaboration/Collaborate	
Identify Opportunistic Ways to Help and Serve Community Needs	Leaders	Leadership
Doing My Calling	Leadership	
Christianity Should Be More Than Just Talking but Should Also Be About the Physical and Mental Aspects of Health	Solutions	
Health Difficulties	Difficulties	
Blood Pressure and Chest Screening	Blood Pressure Checks	Church Activity
Healing	Addresses Health Issues	Focus
Provide Emotional and Spiritual Support	Support/Supportive	

Quirk Title	Parent Code	Grandparent Code
Continued to Take Ministerial Courses and Training	Faith Leaders	Church
Our Financial Support Helps Keep the Organizations Operating	Give Financially to Organizations that Support the Community	Support/Supportive
Informal Partnership with Lower Shore Shelter	Partner/Partnership	
Delmarva Region		
Have a Smaller Congregation	Congregation	Church
Elderly Population	Community	
Challenges		
Visited Her When She was Admitted to the Emergency Room	Services/Service	
Volunteers Take Meals to Schools	Volunteer/Volunteering/Volunteers	
Mechanisms May Not be Formal or Common Like Other Churches	Mechanisms Are Unique and Spontaneous	
Social Services	Offer a Range of Services	Services/Service
Pandemic	Tragic Events and Emergencies	Issues
Outcomes		
Chaplain	Faith Leaders	Church
Exhibit the Appropriate Image and Behavior of a Role Model	Leadership Style	Leadership
Impacts of COVID was the separation that We Had from One Another	Challenges	
Has a Fiduciary Responsibility to Lead Others	Responsibility	Leadership
Health Agencies	Organizations	
My Followers Need to See What Being Healthy Looks Like		
Serve As a Mediator with His Family	Services/Service	
Food Pantry	Public Service Entities/Programs	Stakeholders
Unhealthy Food	Addresses Health Issues	Focus
Figure Out How to Get Services to People	Services/Service	
Often Forget About Providing for Those Who Are Not Needy	Challenges	
Supporting Different Levels of Care	Support/Supportive	

Quirk Title	Parent Code	Grandparent Code
Make Contact with Other Churches and Faith Leaders	Faith Leaders	Church
Serving the Surrounding Community	Community Engagement and Participation	Engagement
Adult and Teen Challenge in Seafood	Community Members and Organizations	Organizations
Provide a Range of Services	Provide Services	Services/Service
Health Service/Product	Addresses Health Issues	Focus
Reaching Out to the Local Health Divisions or Department	Gathering People and Resources	Resources/Resourceful
Parade		
Solutions		
Have a Reputation as the Most Loving Church in Our Area	Faith Leaders	Church
Communicate to Them What's the Latest Thing Out There That Will Help Them	Support/Supportive	
Needs	Focus	
Gauge the Happenings in Community	Engagement	
Providing Health Awareness	Solutions	
Church Cares for Them Right Where They Are	Relating to People Where They Are	Mechanisms Are Unique and Spontaneous
Help Children	Solutions	
Didn't Hear Doctor/Nurses Properly	Limitations	
People Have Seen Me as a Role Model	Leadership Style	Leadership
Provide Secure Housing for People	Services/Service	
Finances We Give Goes Toward Operating Costs of the Church and Community	Resources/Resourceful	
Opportunity to Reach Out to Local Health Departments and Organization	Health Resources	Resources/Resourceful
Workshops	Church Activity	
We Had Our Eastern District Sunday School Convention and We Hosted it at Our Church	Church	
Difficulties		
Participating in Community Events	Community Solutions	Solutions

Quirk Title	Parent Code	Grandparent Code
Somerset County Health Department	Community Members and Organizations	Organizations
Translate what the Doctor's and Nurses are Saying	Resources/Resourceful	
Children	Focus	
Coordinate Blood Drives	Blood Drives	Health Ministry
Connected Through Community through Professional Relationships	Relationships	Focus
Using Church as a Setting to Have Group Meetings	Resources/Resourceful	
Community Events/Activities		
Ran By Volunteers from the Church and Community	Volunteer/Volunteering/Volunteers	
Participate with Other Organizations	Gathering People and Resources	Resources/Resourceful
School Board Meeting	Meetings	
Offer Mobile Buses	Services/Service	
Reducing Salt	Addresses Health Issues	Focus
We Must Not Only Consider the Mind and Body, But Also Need to Consider the Importance of the Spirit	Solutions	
Loves Working with Others	Leaders	Leadership
Don't Have to Be in Front of It	Leadership Style	Leadership
Have an Open Forum to Talk About Drug Issues in the Area	Church Community Activity	
Giving Them a Reliable Person that Can Help Others	Gathering People and Resources	Resources/Resourceful
Limitations with Good Healthcare Providers	Limitations	
Teaching Elementary	Faith Leaders	Church
Help With the Healing of Folks	Faith Leaders	Church
Did A Lot of Collaboration	Collaboration/Collaborate	
I'm an Extrovert	Leadership Style	Leadership
Rural	Delmarva Region	
Emotional		
Utilize a Leadership Style that Prevents Division	Leadership Style	Leadership

Quirk Title	Parent Code	Grandparent Code
Situations When People Need Help Paying Bills	Needs	Focus
I'll Call Any Kind of Change	Change	
Food Bank of Delaware	Community Members and Organizations	Organizations
Catholic Charities	Community Members and Organizations	Organizations
Physically Serve in These Places		
Local Congregation	Congregation	Church
Important To Be Energetic and Animated on a 1-on-1 Basis	Leadership Style	Leadership
Organizing and Communicating Between Partners	Communicating/Communication	
Do Initial Counseling to Get Them in the Right Direction	Offer a Range of Services	Services/Service
Red Cross	Community Members and Organizations	Organizations
Our Collaborative Partnerships Meet the Needs of the Community	Collaboration/Collaborate	
Responsibility to Educate Ourselves		
Joined With a Methodist Church Where I Lived	Faith Leaders	Church
Meetings		
Economic Empowerment Activity	Church Activity	
Homeless Shelter in Town	Homeless Shelter	
Local VFW	Entities and Stakeholders in Communities	Stakeholders
Weathering Issues	Issues	
Health Ministry Operates Annually for Folks in Need of Medical Devices	Health Ministry	
Address Food Disparities	Solutions	
Going an Extra Mile	Leadership	
Drug Abuse		
Partnership with Local Health Department	Partnerships with Three Organizations	Partner/Partnership
Faith-Based Organizations	Organizations	
Health Department	Organizations	

Quirk Title	Parent Code	Grandparent Code
Important that I Look Good, and Have a Positive Outlook and a Smile	Faith Leaders	Church
Pentanol	Community Issues	Issues
Efforts to Impact Behavior	Focus	
Don't Have a Problem Working with Different Communities	Resources/Resourceful	
Try to Be the Role Model That I Can with Helping People See that They Can Do	Leaders	Leadership
Being Welcoming	Leadership	
Substance Abuse Issues	Community Issues	Issues
Enhancing the Mind, Body, and Spirit	Having All Three Core Factors: Spirit, Mind, and Physical Health	Wholeness
They Came Out and Other Entities and Did Workshops	Community Engagement and Participation	Engagement
Provide Awareness	Community Solutions	Solutions
A Person Who Understands What Needs to be Done in Community and Doing Something About It	Leadership	
Event at Grasonville Community Center for Those who had Grief Issues	Community Events/Activities	
House Were Flooded	Tragic Events and Emergencies	Issues
Church is in a Major Central Area of the County	Church	
Health Outcomes	Outcomes	
Advocate/Advocating		
Caroline County	Maryland	
Envision What Heaven Will Look Like	Faith Leaders	Church
Need to Advocate for Change	Advocate/Advocating	
Health Resources	Resources/Resourceful	
Drugs	Community Issues	Issues
Establishing Solutions	Solutions	
Needed Help with Bereavement	Needs	Focus

Quirk Title	Parent Code	Grandparent Code
Health Focus	Addresses Health Issues	Focus
Places that Align with Ministry and Mission of Church		
Talk to Some of My Fellow Sisters and Brothers who were Clergy and Ask Them to Participate	Community Engagement and Participation	Engagement
Partnering with Judy Center	Partnerships with Three Organizations	Partner/Partnership
COVID	Health Conditions	Focus
NAACP	Organizations	
YMCA	Community Members and Organizations	Organizations
Seek Professionals Inside and Outside the Church	Gathering People and Resources	Resources/Resourceful
Donated Items that We Lend	Resources/Resourceful	
Educate Ourselves on What Works and What Doesn't	Responsibility to Educate Ourselves	
Observe and Understand What is Taking Place	Leaders	Leadership
Local Universities	Public Service Entities/Programs	Stakeholders
Church Ministry	Church Activity	
Each County Demonstrates its Own Uniqueness	Delmarva Region	
Be Proactive in Preparing for Injury and Illness	Solutions	
Been a Focal Point for the Church	Faith Leaders	Church
Quirk Title	**Parent Code**	**Grandparent Code**
Church Leader	Faith Leaders	Church
Matter of Making Connections and Talking in the Community	Collaboration/Collaborate	
People Overdosing with Opioids	Community Issues	Issues
Being Involved with the Church and Community	Faith Leaders	Church
Open Yourself Up to Other Key Elements of the Community	Faith Leaders	Church
Coordinate and Facilitate Meals for the Homeless Shelter	Church Activity	
Delivering Food When They Need it	Church Community Activity	
Disrespect of Black People's Land	Community Issues	Issues
Presence		

Quirk Title	Parent Code	Grandparent Code
Physical, Mental, Spiritual, and Emotional Health	Having All Three Core Factors: Spirit, Mind, and Physical Health	Wholeness
Violent Crimes	Community Issues	Issues
Lack of Exercise	Health Conditions	Focus
Void of Leadership in my Community	Concerns	
Say Things that Other People Can't	Faith Leaders	Church
Go into Hospitals and Other Spaces	Resources/Resourceful	
Tell Me They're Ills and Feelings	Resources/Resourceful	
Undeserved	Working with Underrepresented and Undeserved Populations	Focus
Difficult for His Wife to Take Care of Him	Difficulties	
Level of Influence	Influence	
School Play	Community Events/Activities	
Leadership		
Bridge Building	Collaboration/Collaborate	
Serve Community Outside of Sunday Morning Worship	Church	
When You Open Yourself Up to the Opportunity to Work with Others It Gives You More Resources	Resources/Resourceful	
Our Collaborations Are Informal and Voluntary	Collaboration/Collaborate	
Community Issues	Issues	
Food Insufficiency Areas	Concerns	
We Arrange Transportation	Church Community Activity	
COVID Testing and Kits	Offer a Range of Services	Services/Service
Change		
Working with Other People Really Enhances What I Do	Faith Leaders	Church
Neighboring Areas Demonstrating Food Disparities	Issues	
Smaller Community	Community	
Faith-Based Leaders Have a Unique Position	Faith Leaders	Church
Help Repair and Build New Homes	Services/Service	

Quirk Title	Parent Code	Grandparent Code
I am a Board Member	Board Member	
Group Meeting	Meetings	
Identifying Needs to Develop Solutions	Solutions	
Counseling	Ministry	Church
12 Years as a Missionary and English Teacher	Faith Leaders	Church
Serve Others	Leaders	Leadership
Funding Comes from the Generosity of Our Attenders	Resources/Resourceful	
Creating a Conducive Helping Culture	Solutions	
Housing		
You Encourage, You Inspire	Motivation/Motivate	
Visitation Nursing Home Activity	Church Activity	
One of our Supportive Mechanisms is Our Food Pantry	Support/Supportive	
Support Them in Life Struggles They Encounter	Support/Supportive	
Spirit/Spiritual/Spiritual Health	Having All Three Core Factors: Spirit, Mind, and Physical Health	Wholeness
I am a Registered Nurse	Faith Leaders	Church
Mental Health	Mental	Wholeness
Healthcare	Addresses Health Issues	Focus
Being a Leader in Community	Leaders	Leadership
Being Flexible and Resourceful for Identifying Solutions	Resources/Resourceful	
Health Disparities	Concerns	
Community Engagement and Participation	Engagement	
Figuring Out What They Need and Identifying Solutions	Solutions	
Vision Become a Reality by Accomplishing Our Mission	Vision	
Church Assist with the Health	Church	
I am Naturally Collaborative and That's the Way I Lead	Leadership Style	Leadership
Realizing How Many People Suffer from Health Conditions	Health Conditions	Focus
Create Shared Farms	Solutions	

Quirk Title	Parent Code	Grandparent Code
A Lot of People We Tend to is the Congregation	Services/Service	
New Day Pregnancy Center	Community Members and Organizations	Organizations
Issues		
Obligation to Present the Gospel of Christ	Faith Leaders	Church
Try to Work with Different Communities	Leaders	Leadership
Volunteer/Volunteering/Volunteers		
Behavior Patterns	Human Behavior	Concerns
Constituent Well-Being	Outcomes	
I Think There Needs to Be a Faith-Based Voice in the Community	Engagement	
Community Members and Organizations	Organizations	
Overall Health	Wholeness	
Community Solutions	Solutions	
Needs are the same for both the youth and elderly	Needs	Focus
Connect With Healthcare Providers	Solutions	
Gathering People	Gathering People and Resources	Resources/Resourceful
I'm Not Someone Who Feels Insecure	Faith Leaders	Church
Preventive Measures	Solutions	
Partnered with Local YMCA	Partnerships with Three Organizations	Partner/Partnership
I Believe When We Work Together, We Achieve Greater Things	Partner/Partnership	
Family/Families	Welfare	Focus
Organizing		
Church Ministries	Ministry	Church
Don't Care to Get Credit	Leadership Style	Leadership
Provide COVID Shots	Church Activity	
Health	Addresses Health Issues	Focus

Quirk Title	Parent Code	Grandparent Code
Care for People from All Walks of Life	Leaders	Leadership
Health Organizations	Organizations	
Communicating/Communication		
Church Community Activity		
Holistic Health	Concerns	
Partnerships with Three Organizations	Partner/Partnership	
Know Who to Connect With	Collaboration/Collaborate	
I Try to Be Resourceful	Resources/Resourceful	
Improving the Outcomes Means Seeing Tangible Results	Solutions	
Connect with Resources They Need	Resources/Resourceful	
Being Able to Work with Somebody Regardless of Religion or Race	Resources/Resourceful	
Parade They Have Every Year for Labor Day	Parade	
Concerns		
Ability to Embark Needed Change	Change	
Serve As a Witness for a Person that has Alzheimer's	Services/Service	
Influence		
Be the Solutions to Their Needs	Solutions	
Hosted a Car Seat Check-In	Church Community Activity	
Still Experience Health Difficulties	Limitations	
Community Center		
Dorchester County	Maryland	
Food Insecurity	Limitations	
Our Church is Looking at Food Disparities	Addresses Health Issues	Focus
Organizations Offer Opportunities to Address Health, Mental, Physical, and Education Concerns	Organizations	
Community		
Poor Diet	Health Conditions	Focus

Quirk Title	Parent Code	Grandparent Code
Food Bank	Resources/Resourceful	
Cambridge Ministries	Church Activity	
I Do Home and Hospital Visitations	Offer a Range of Services	Services/Service
Learn Who Are the Key Players are in Those Arenas	Gathering People and Resources	Resources/Resourceful
Provide Help to Those in Need	Faith Leaders	Church
Serve As Guest Speakers to the Church	Gathering People and Resources	Resources/Resourceful
Blood Pressure Checks	Church Activity	
Food Insecurities and Inefficiencies	Addresses Health Issues	Focus
Shouldn't Wait Until There's a Problem	Engagement	
Provide Food Needs for Community	Food Bank	Resources/Resourceful
Grasonville Community Center	Community Center	
Infrastructure Devastation	Tragic Events and Emergencies	Issues
Vaccines Out to People	Vaccines/Vaccinations	
Mental	Wholeness	
Backpack Feeding Program for Children	Church Activity	
What is Occurring in Community	Focus	
Provide Awareness of Health Conditions	Church Activity	
Enable Conversations	Communicating/Communication	
Outside of Sunday Morning Worship	Community Engagement and Participation	Engagement
Important to Reach the Unreachable in the Community	Working with Underrepresented and Undeserved Populations	Focus
Not Hearing What You Said	Challenges	
Impacts of Processed Food	Addresses Health Issues	Focus
Needed to See the Doctor	Needs	Focus
Maryland		
Community Health Issues	Community Issues	Issues
Mechanisms Are Unique and Spontaneous		

Quirk Title	Parent Code	Grandparent Code
Resources/Resourceful		
Meet for a Month	Meetings	
Inclusive Efforts	Community Solutions	Solutions
Engage Everybody, not Just One Group of People	Leadership	
Serving As an Advocate for Them	Faith Leaders	Church
Getting Everyone Aware of What I Say	Faith Leaders	Church
Find Common Ground and Make Sure We Serve the Community	Faith Leaders	Church
Ran a Food Pantry	Church Activity	
Engagement		
Environmental Constraints	Environment	
Motivation/Motivate		
Church Community	Community	
Love People for Who and What They Are	Faith Leaders	Church
High School Football Games	Community Events/Activities	
Community Parade	Parade	
Princess Anne, MD	Somerset County	Maryland
Physical Environment	Environment	
Church Serves as Outlet for Support	Support/Supportive	
Food Drives	Church Community Activity	
Community Outreach	Public Service Entities/Programs	Stakeholders
Realize that You Care	Faith Leaders	Church
See People Step Up and Doing Things	Collaboration/Collaborate	
Things We Do are More Aligned with Home and Personal Needs		
Eastern Shore	Delmarva Region	
Collaborating Partnerships Allow Us to Expand Our Reach and Interact with More People	Our Collaborative Partnerships Meet the Needs of the Community	Collaboration/Collaborate
Produce Results that Impact Community Health	Leadership	

Quirk Title	Parent Code	Grandparent Code
Picking Up Offering Things	Church Community Activity	
We Were Limited in the Pandemic Time Period	Limitations	
I Must Constantly Inspire Others Through My Actions and Words	Responsibility	Leadership
Always Looking at the Mind, Body, Spirit Continuum	Overall Health	Wholeness
We Must Collaborate to Maximize Impact	Collaboration/Collaborate	
Secret Sauce is Presence and Showing Up	Presence	
Community Stakeholders and Constituents	Stakeholders	
Most of Them Don't Drive	Limitations	
Drive Them to Where They Need to Go, Like to Local Stores, Doctor's Appointments, or Even to Dept. of Health	We Have Specific Persons Pick Them Up	Services/Service
We Have Specific Persons Pick Them Up	Services/Service	
Routine Health Check Ups	Church Community Activity	
With Other Local, State, and Public Service Entities and Individuals	Relationships	Focus
Physical Health	Physical	Wholeness
Homeless Shelter		
There Is a Healthcare Component to It	Wholeness	
Meet People Where They Are	Faith Leaders	Church
Need for Feeding Children and Adults	Needs	Focus
Focus		
I am Need Wherever They Are	Faith Leaders	Church
Congregation	Church	
I'm Concerned About the Total Well-Being of the Individual	Faith Leaders	Church
Witnessing Certain Activities Making a Difference	Collaboration/Collaborate	
We Continue to Help People Get Connected	Resources/Resourceful	
Try to Live a Holistic Way of Living	Faith Leaders	Church
Make Ourselves Available to Serve Where Needed	Leaders	Leadership
Hearing Their Stories of Either Illness or Health	Resources/Resourceful	

Quirk Title	Parent Code	Grandparent Code
Community Health Problem	Addresses Health Issues	Focus
Helped Residents Get Vaccinated	Vaccines/Vaccinations	
Trust	Outcomes	
Other Local Partners	Partnerships with Three Organizations	Partner/Partnership
Education Concerns	Concerns	
Support Organizations that are Dedicated to Caring for the Health of the Community	Support/Supportive	
Church Makes it Less Troublesome to Reach Residents	Church	
Pastor	Faith Leaders	Church
See Tangible Results in Community	Focus	
Set a Vision for the Church	Vision	
Transportation is Troublesome	Transportation	Limitations
My Intention is to Be Multi-dimensional in Providing Various Services and Needs	Offer a Range of Services	Services/Service
Having All Three Core Factors: Spirit, Mind, and Physical Health	Wholeness	
Health and Fitness is Something that We All Got to Focus On	Focus	
Try to Pass on Wisdom Not Just Facts and Figures	Responsibility	Leadership
Giving Credit When Credit is Due is Another Style that I Use	Leadership Style	Leadership
Listening to Hear What Others Have to Say Allows Me to Learn More About Them	Faith Leaders	Church
Making Phone Calls to the County's Local Dept. of Health and Aging	Gathering People and Resources	Resources/Resourceful
During Church Service We Provide Basic Health Information to the Community	Church	
Provide General Health Check Ups	Church Community Activity	
Health Check Ups	Church Community Activity	
Great to Be with Other Leaders to Serve the Community	Leaders	Leadership
Hospital Visitations	Offer a Range of Services	Services/Service
Taking Them to Handle Personal Needs	Church Community Activity	
Take Clean Water and Air Seriously	Addresses Health Issues	Focus

Quirk Title	Parent Code	Grandparent Code
Mostly Have Older People in the Church and Town	Delmarva Region	
The Church Also Provides Seminars and Special Meetings	Meetings	
We're Not Seeing the Value of the Intersection of the Mind, Body, and Spirit	Health Issues	Issues
Most of the Things I have Done Have Been Local in the Community	Community Engagement and Participation	Engagement
Cardio Exercise	Solutions	
People in My Congregation I'm Attending To	Welfare	Focus
Equipping Folks	Responsibility	Leadership
Can Not Change Government Systems	Limitations	
Do My Part to Influence People	Influence	
Grief Services	Offer a Range of Services	Services/Service
See Pastors at Events other than Sunday Morning Worship	Establish Relationship with Pastors of Other Denominations	Collaboration/Collaborate
TOTAL NUMBER OF CODES	**1497**	
TOTAL NUMBER OF QUIRKS	***703***	

Note. Data derived from Quirkos Report

Appendix O: Reflective Journaling of Participant Interviews

Participant	Journal response
1	Lack of Leadership in Rural Community Social change involves having an awareness of community needs and undergoing action to address them by communication to key entities that could produce a necessary change. Faith Leaders have a unique capacity to address community health issues by utilizing internal and external organizational resources within their communities. Faith Leaders are becoming more aware of the need to address total well-being of health. Health outcomes must produce tangible results that are visible in communities Church is known as a reliable resource for emergency and disaster support. Efforts to improve health outcomes should be tailored toward all groups and needs in communities. Faith Leaders should focus their efforts to be visible in community for both common and non-common events and activities to extend their reach to impact all populations. In effort for Faith Leaders to gain trust from constituents in their communities, Faith Leaders must be actively engaged in community affairs, events, and activities. Faith Leaders who are often engaged in community affairs and events could establish opportunities to understand culture, as well as identify key stakeholders in the community. Communities could acquire perspectives from Faith Leaders that could contribute to community solutions Faith Leaders who are a part of community organizations will position themselves to network and participate in community activities that could benefit solutions for community health concerns. Faith Leader involvement could contribute to positive emotional health of constituents. Changing human behavior is the basis to change community health. Pastor focus attention on addressing negative human behavior of constituents in the church community. Culture impacts human behavior of a community. Changing patterns of negative behavior in a community to improve community, leaders must tend to the culture of the community and its impact on human behavior. In response to various community ills, the church has been working with other community entities [universities and county health departments] to provide services to combat the effects and influence of COVID.

Participant	Journal response
	Pastor has a goal to establish an educational center in the community to combat educational disparities that effects minority children.
	Pastor emphasized that most community leaders and organizations may not realize the impact of human behavior on communities in rural areas. Pastor also mentioned that environmental constraints facilitate negative behavior and drives community health problems.
	Pastor highlights that overall health includes other aspects that just physical health, but also external factors such as a person's living environment.
	Church demonstrates health awareness by providing health information about various health conditions which could impact community health.
	Church activities and traditions has impacted the health behavior of individuals.
	Lack of adequate public water drinking systems and clean air in rural areas contributes to health disparities, due to its impact on health.
	Minority landowners are experiencing various hardships by having their land taken away from them.
	Pastor can be involved in other capacities that relate to community health, such as serving as an advocate for social justice concerns that impacts the well-being and livelihood of constituents.
	Pastor highlighted the importance of participating in arrangements to address community health issues outside the normal business model contexts.
	Pastor indicates the positive result of collaboration with community entities to address community health issues.
2	Pastor believes that health is more than just spiritual. Pastor aspires to be a holistic pastor.
	Pastor has a unique position to receive personal testimonies from others, as well as being able to extend self to areas for which other leaders may not be able to do the same. Pastor expressed that housing is a factor with a person's health.
	Pastor serves as advocate for persons or families experiencing health issues or problems among the health system. Pastors' utility extends beyond than the church.
	Church demonstrates abilities to partner with other community organizations to provide health services.
	Lack of communicating best practices among leaders in rural communities serves as a limitation to collaborate more effectively.
	Lack of social capital effects Faith Leaders in rural areas to contribute to social change efforts
	Faith Leaders who have opportunities to listen to others enables them to have an awareness of health issues in the community.

Participant	Journal response
	Limitation with transportation and good healthcare are still apparent in rural areas. Church focuses on working with others that have similar goals, ideas, and perspectives to carry out their mis mission of the church.
	Pastors seek opportunities to work with other organizations or leaders that have similar interest or ideals
	Pastors demonstrates partnerships to address food insecurity and homeless issues in the community.
	Faith Leaders who engage in partnerships reach more constituents
	Faith Leaders who utilize their church for community outreach can contribute to community health by providing health related outreach activities.
	Partnering with other community organizations provides opportunities to allocate resources to benefit both involved partners.
	The core of social change is to advocate change through community activities.
	Transportation could serve as a barrier to provide health services during a tragic or emergency events.
	Churches in rural areas are often conveniently located and accessible for community residents.
	Faith Leaders are often apart of organizations to expand organizational boundaries to impact their communities.
	Weather events often impact community infrastructures that impose hardships on constituents.
	Lack of adequate housing could contribute to other health related problems.
	Faith Leader is an advocate for increasing awareness of the effects of weather in rural areas.
	Holistic health is a major focus area for Faith Leader.
	Smaller communities often demonstrate value in having organizations relationships.
	Followers of Faith Leaders must be able to trust Faith Leaders for Faith Leaders to lead followers and build relationships.
	Faith Leaders are in strategic positions to engage in community culture in which other leaders may not be able to do so.
	For Faith Leaders to be effective, they must be willing to educate themselves, and increase their awareness of best practices that enables them to navigate health systems to promote social change to improve community health.
	Leadership style of faith leader is humble and demonstrates action that is results-driven.
3	Church demonstrates partnership activity and providing health services in the community.

Participant	Journal response
	Focus of the church is serving underserved and underrepresented populations through community outreach to better livelihoods and well-being constituents.
	Collaborating with community partners increase access to social and health resources to for individuals and families to improve well-being.
	Total well-being is the vision of most Faith Leaders.
	Church engages with health agencies to provide essential health services during COVID pandemic.
	Community outreach is one of many ways for Faith Leaders and churches to serve communities.
	Internal programs of churches increase capacity to provide health services for elderly population.
	Churches and local health departments utilize resources to provide needed health services an opportunity for constituents to maintain and sustain their personal health.
	Churches entail staff and congregants who are in health professionals that could be utilized to assist with various church activities related to health.
	Churches seek to be effective and efficient for providing health services by avoiding replication of offerings to guide people to the right services they need.
	Faith Leader displays a servant leader leadership style by offering his spare time.
	Faith Leader establishes a vision for the church by having others help to carry out the vision.
	Faith Leader leadership style is leading by example and serving others, as well as utilizing the skills and talents of others assist with various church activities.
	Having people engaged in health activities offer opportunities to network and connect with others.
4	Faith Leader takes out time to assist with transportation to the doctor to receive SSI benefit. The engagement also assisted with communication between the person and health POC.
	Faith Leader was assigned as a leader without even knowing it, do to service providing behavior.
	Faith Leader is active at addressing community issues that impact health, such as homelessness and food insecurities.
	Previous health experience and background of Faith Leader enables Faith Leader to recognize and provide needed services for others, as well as assisting with acquiring specific health services through networking and recommendations.
	Church programs assist with providing meals to families in community.

Participant	Journal response
	Faith Leader participates in health system by serving as a professional that provides emotional and spiritual support during hospital visitations.
	The vision of Faith Leader is to treat the community as one church in effort to provide service and help for others in the community.
	Faith Leaders strives to support all various levels of care in the community. Multidimensional.
	The population requires attention from Faith Leaders, due to their inability to leave their habitats for access to healthcare and services.
	Church also supports community organizations and professionals that keep the community safe.
	The community is a part of the church and provides an inherent responsibility to provide for the community.
	Lack of mental health services and professionals in the community.
	Health needs should not be general, but specific and tailored for everyone. Non-health related issues can also impact health, due to its influence on stress.
	Volunteers are a valuable entity with providing health services, as well as contributing to efforts to develop solutions.
	It's essential to network, communicate and engage with others in the community to understand what onsets problems in the community, as well as gathering ideas for solutions for those problems.
	People need guidance to fully understand what service and help they need.
	Congregants are just as important as Faith Leaders, due to their insight on community issues.
	Common church activities are food services and outreach.
	Faith Leaders seek to be unbiased toward helping certain groups of people.
	Faith Leaders uses the skills sets and strengths of others to assist with meeting people needs.
	Opportunity to include Faith Community in the health of a community.
	Health intervention should include efforts that intersect the mind, body, and spirit.
5	COVID Pandemic forced Faith Leaders to provide for their local community.
	Offering was more tailored toward congregants and local constituents.
	COVID Pandemic impacted capacities for church to provide services and meet needs.
	Faith Leader made personal sacrifices to provide transportation services.
	Faith Leader was most active for tending to personal needs of others.
	Arrange transportation to health services among congregants who need it.
	Faith Leader made personal efforts to meet needs of others by utilizing communication to health organization to acquire resources to meet needs.

Participant	Journal response
	Evidence of internal church entities collaborating with external community entities to provide church activities beneficial to meeting needs.
	Faith Leader demonstrated resourcefulness.
	Church behaves and portrays itself like the characteristics of a family.
	Faith Leaders interact with one another to provide activities for community.
	Lead By Example.
	Lack of mental health services and professionals in the community.
	Faith Leader acts a facilitator.
	Faith Leader is unbiased and non-prejudice in working with others.
	Faith Leader understands the importance to work with others from different backgrounds and denominations.
	Working with others creates other opportunities.
	Networking and making connections expand organizational capacity to provide and meet community needs.
	COVID Pandemic forced Faith Leaders to provide for their local community.
	Offering was more tailored toward congregants and local constituents.
	COVID Pandemic impacted capacities for church to provide services and meet needs.
	Faith Leader made personal sacrifices to provide transportation services.
6	Leadership void in rural community. Being a leader is about results and doing more than status quo to achieve desired results.
	Faith Leader is concerned about total well-being. Faith Leader reveals the need to focus more attention on addressing issues that impact total well-being. Faith Leader mentioned the need to address food disparities through community collaboration utilizing farms.
	Faith Leader highlighted the utilization of using the church as a setting for community activities. Faith Leader expressing the importance to meet the needs of all groups in community.
	Faith Leader expresses the need to meet both those who are in need and those who still need continual services and needs.
	Faith Leader conveys the importance of being visible in the community by attending events, activities that are not church related. Faith Leader also expressed the importance of being engaged in community organizations for acquiring insight on community issues and problems.
	Faith Leader motivates others to get engage in community activities. Opportunities for community organizations to acquire a faith-based perspective for assessing community issues and problems. Faith Leader conveyed that the faith community needs to do more than just pray for others.

Participant	Journal response
	Faith Leader demonstrates the effectiveness of collaboration in getting things done.
	Community activities and events influences leaders in the community to become engaged through various interactions.
	Faith Leaders provide health awareness of various topics that impact community health.
	Sharing health awareness with others increases better health practices and behavior. Faith Leader believes that the faith community can make an impact with health behaviors and practices alongside the health industry.
	Leadership void in rural community. Being a leader is about results and doing more than status quo to achieve desired results.
	Faith Leader is concerned about total well-being. Faith Leader reveals the need to focus more attention on addressing issues that impact total well-being. Faith Leader mentioned the need to address food disparities through community collaboration utilizing farms.
	Faith Leader highlighted the utilization of using the church as a setting for community activities. Faith Leader expressing the importance to meet the needs of all groups in community.
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	Faith Leader motivates others to get engage in community activities. Opportunities for community organizations to acquire a faith-based perspective for assessing community issues and problems. Faith Leader conveyed that the faith community needs to do more than just pray for others.
	Faith Leader demonstrates the effectiveness of collaboration in getting things done.
	Community activities and events influences leaders in the community to become engaged through various interactions.
	Faith Leaders provide health awareness of various topics that impact community health.
	Sharing health awareness with others increases better health practices and behavior. Faith Leader believes that the faith community can make an impact with health behaviors and practices alongside the health industry.
	Leadership void in rural community. Being a leader is about results and doing more than status quo to achieve desired results.

Participant	Journal response
7	Leadership void in rural community. Being a leader is about results and doing more than status quo to achieve desired results.
	Faith Leader is concerned about total well-being. Faith Leader reveals the need to focus more attention on addressing issues that impact total well-being. Faith Leader mentioned the need to address food disparities through community collaboration utilizing farms.
	Faith Leader highlighted the utilization of using the church as a setting for community activities. Faith Leader expressing the importance to meet the needs of all groups in community.
	Faith Leader expresses the need to meet both those who are in need and those who still need continual services and needs.
	Faith Leader conveys the importance of being visible in the community by attending events, activities that are not church related. Faith Leader also expressed the importance of being engaged in community organizations for acquiring insight on community issues and problems.
	Faith Leader motivates others to get engage in community activities. Opportunities for community organizations to acquire a faith-based perspective for assessing community issues and problems. Faith Leader conveyed that the faith community needs to do more than just pray for others.
	Faith Leader demonstrates the effectiveness of collaboration in getting things done.
	Community activities and events influences leaders in the community to become engaged through various interactions.
	Faith Leaders provide health awareness of various topics that impact community health.
	Sharing health awareness with others increases better health practices and behavior. Faith Leader believes that the faith community can make an impact with health behaviors and practices alongside the health industry.
8	Vision is to meet the needs of the community, by providing financial resources to community organizations that support community needs.
	Church makes themselves available to help community organizations through funding key community activities.
	The church strength is providing funding.
	Funding from the church supports the sustainability of community programs and activities.
	Goal is to acquire an organizational identity in the community that is known for helping other community organizations in being successful. Church aspires in being an organizational leader in the community.
	Faith Leader is a believer of collaborating and working with others to impact community.

Participant	Journal response
	Collaborating enables Faith Leaders to reach more people, and to acquire more capacity to meet more needs of the community.
9	Past Experiences of Pastor contributed to his journey in becoming a Faith Leader.
	Faith Leader understands the importance of health.
	Faith Leader understands how the ecosystem impacts health of others.
	Faith Leader discusses the importance of looking at health through the mind, body, and spirit.
	To be an effective preacher, providing awareness and content about what it means to be healthy is just as importance as talking about faith and the gospel.
	Impacting the individual health leads to improvements with community health.
	Faith Leader believes that the needs are the same among all age groups, and being involved in the community also serves great value in achieving total health wholeness.
	Faith Leader understands the importance of image and how it gives a positive perception for constituents in the community that the church can meet needs.

Note. Journal responses were assembled from the Quirkos report.

Appendix P: Emic Codes

List of Initial Codes [Parent Codes]
A Lot of Land; Address Health Issues; Advocate/Advocating; Blood Drives; Blood Pressure Checks; Board Member; Bridge Building; Challenges, Change; Church; Church Activity, Church Community; Church Community Activity; Collaboration/Collaborate; Communication/Communicate, Community; Community Center; Community Engagement and Participation; Community Events/Activities; Community Issues; Community Members and Organizations; Community Solutions; Concerns; Concerns of Human Behavior; Congregation; Delmarva Region; Difficulties; Emotional; Enable Conversations; Engagement; Entities and Stakeholders in Communities; Environment; Environmental Constraints; Establish Relationship with Pastors of Other Denominations; Exercise; Faith Leaders; Focus; Food Bank; Gathering People and Resources; Give Financially to Organizations that Support the Community; Having All Three Core Factors: Spirit, Mind, and Physical Health; Health Conditions; Health Department; Health Issues; Health Ministries; Health Organizations; Health Resources; Homeless Shelter; Health Behavior; Influence; Issues; Leaders; Leadership Style; Limitations; Maryland Mechanisms are Unique and Spontaneous; Meetings; Mental; Ministry; Motivation/Motivate; Needs; Offer a Range of Services; Organizations; Organizing; Our Collaborative Partnerships Meet the Needs of the Community; Outcomes; Overall Health; Parade; Partner/Partnership; Partnership with Three Organizations; Physical; Physical Environment; Presence; Provide Services; Public Service Entities/Programs; Ran a Food Pantry; Relating to People Where They Are; Relationships; Resources/Resourcefulness; Responsibility; Responsibility to Educate Ourselves; Services/Service; Social Change; Solutions; Somerset County; Stakeholders; Support/Supportive; Tragic Events and Emergencies; Transportation; Vaccines/Vaccinations; Vision; Volunteer/Volunteering/Volunteers; We Have Specific Persons Pick Them Up; Weathering Issues; Welfare; What is Occurring in the Community; Wholeness; Working with Underrepresented and Undeserved Populations

Note – Derived from Quirkos Report

Appendix Q: Grandfather and Parent Codes

Grandfather Codes	Parent Codes
Church	Faith Leaders; Congregation; Ministry
Church Activity	Blood Pressure Checks; Ran a Food Pantry
Collaboration/Collaborate	Establish Relationship with Pastors of Other Denominations; Our Collaborative Partnerships Meet the Needs of the Community; Bridge Building
Community	Church Community
Communicating/Communication	Enable Conversations
Concerns	Concerns of Human Behavior, Human Behavior
Engagement	Community Engagement and Participation
Environment	Physical Environment; Environmental Constraints
Focus	Health Conditions; Working with Underrepresented and Undeserved Populations; Addresses Health Issues; Welfare; Relationships; Needs; What is Occurring in Community; Welfare
Health Ministry	Blood Drives
Issues	Tragic Events and Emergencies; Health Issues; Weathering Issues; Community Issues
Leadership	Responsibility; Leaders; Leadership Style

Grandfather Codes	Parent Codes
Limitations	Transportation
Maryland	Somerset County
Mechanisms Are Unique and Spontaneous	Relating to People Where They Are
Organizations	Faith-Based Organizations; Health Department; Community Members and Organizations; Health Organizations; Health Department
Partner/Partnership	Partnership with Three Organizations
Resources/Resourceful	Gathering People and Resources; A lot of Land; Health Resources; Food Bank
Services/Service	Offer a Range of Services; Provide Services; We Have Specific Persons Pick Them Up
Solutions	Exercise; Community Solutions;
Stakeholders	Entities and Stakeholders in Communities; Public Service Entities/Programs;
Support/Supportive	Give Financially to Organizations that Support the Community
Wholeness	Physical; Overall Health; Mental; Having All Three Core Factors: Spirit, Mind, and Physical Health

Note. Table developed from content of Quirkos Report

Appendix R: Keywords, Codes, Categories, and Themes

Grandfather Codes [Inductive]	Parent Codes [Inductive]	In-Vivo Quotes [Inductive]	Categories [Deductive]	Themes [Deductive]
Church	Faith Leaders	My Church Involves Getting Churches to Work Together; Contribute to Improvement of Personal Well-Being; Different Faith Leaders Who Come Together to Discuss Events; Bring Shalom to Complete Peace and Well-Being; Made Myself Eligible to Become a Local Pastor; Meet Constituents Where They Are; Create a Heaven Like Atmosphere; Establishing Daily Visibility in the Church and Community; Provide a Perception that I Care for What They Have to Say; Provide a Faith-Based Voice; Dealing with the Homebound and Nursing Home Patients; We Don't Portray the Church Like a Foreign Entity or Business; Engage into the Life of the Community; Maintaining the Health of Congregation; My Goal is to Build and Grow My Congregation with New Insights and Knowledge; Have Pastoral Experience as an Associate Pastor; Guest Speaker at	FL and FBO Actions	Agent for Social Change

	Somerset County Prayer Breakfast; Maintaining My Health and Strength is Very Important to Me; Present in the Church Throughout the Day and Week; Serve as a Giver and Spiritual Person; We Want to Meet Those Needs; I Think We Can Do More than Just Pray for Folks; I am a Firm Believer in Health; Serve as Case Managers; Provide Recommendations for Persons Who Experience Hardship; Myself and the Church are Constantly Available in Times of Need for the Community; Looking at How Faith Community Can Be A part of Community Health; Visitation Experience Over the Years; As a Faith-Based Leader the Best Thing that I Can Do is Provide Awareness; Preach About the Importance of What it Means to Be Healthy; I Knew I Didn't Want to Preach a Sermon on Sunday Morning About Jesus; I Don't View My Walls as Just the Church; Chosen By Her to Be a Point of Contact; Becoming More Active; Utilizing People's Gift to Help Others;

	Bring Wholeness and Healing Through Jesus Christ; I Must Learn How to Work With Other People; Continued to Take Ministerial Courses and Training; Chaplain; Make Contact with Other Churches and Faith Leaders; Have a Reputation as the Most Loving Church in Our Area; Teaching Elementary; Help With the Healing of Folks; Joined With a Methodist Church Where I Lived; Important that I Look Good, and Have a Positive Outlook and a Smile; Envision What Heaven Will Look Like; Been a Focal Point for the Church; Church Leader; Being Involved with the Church and Community; Open Yourself Up to Other Key Elements of the Community; Say Things that Other People Can't; Working with Other People Really Enhances What I Do; Faith-Based Leaders Have a Unique Position; 12 Years as a Missionary and English Teacher; I am a Registered Nurse; Obligation to Present the Gospel of Christ; I'm Not Someone Who Feels Insecure; Provide

		Help to Those in Need; Serving As an Advocate for Them; Getting Everyone Aware of What I Say; Find Common Ground and Make Sure We Serve the Community; Love People for Who and What They Are; Realize that You Care; Meet People Where They Are; I am Need Wherever They Are; I'm Concerned About the Total Well-Being of the Individual; Try to Live a Holistic Way of Living; Pastor; Listening to Hear What Others Have to Say Allows Me to Learn More About Them		
Church	Congregation	Congregants; Community Connection as a Church Member as well as Being a Key Member in the Community that Helps Others; Black Church, Have a Smaller Congregation	Various FL and FBO Interventions	Agent for Social Change
Church	Ministries	Counseling, Church Ministries	Various FL and FBO Interventions	Agent for Social Change
Collaboration /Collaborate	Bridge Building	My strength is Bridge Building	Community Organizing	Community Healthcare Partnership

Grandfather Codes [Inductive]	Parent Codes [Inductive]	In-Vivo Quotes [Inductive]	Categories [Deductive]	Themes [Deductive]
Collaboration/ Collaborate	Establishing Relationship with Pastors of Other Denominations	See Pastors at Events other than Sunday Morning Worship	Community Organizing	Community Healthcare Partnership
Collaboration/ Collaborate	Our Collaborative Partnership Meet the Needs of the Community	Collaborating Partnerships Allow Us to Expand Our Reach and Interact with More People	Community Organizing	Community Healthcare Partnership
Communicating/ Communication	Enable Conversations	Communicating on What Makes Them Healthy	FL and FBO Actions	Community Health in Rural Areas
Community	Church Community	Community of Faith Can Be a Part of Caring for Folks	Strategic Interventions	Community Health in Rural Areas
Concerns	Concerns of Human Behavior	Social Conditions; Impacted by Social Conditions	Problematic Situations	Community Health in Rural Areas
Concerns	Human Behavior	Behavior Patterns	Problematic Situations	Community Health in Rural Areas
Engagement	Community Engagement and Participation	Community Center Member; Been Working in the Community with Bethesda Methodist Church; Joined as a Member of the Community Center; During Times of Tragic Events and Emergencies; See Who Was Engaged with Grasonville Community Center; Serving the Surrounding Community; They Came Out and Other Entities and Did Workshops; Talk to Some of My Fellow Sisters and Brothers who were Clergy and Ask Them to	FL and FBO Actions	Agent for Social Change

		Participate; Outside of Sunday Morning Worship; Most of the Things I have Done Have Been Local in the Community		
Grandfather Codes [Inductive]	**Parent Codes [Inductive]**	**In-Vivo Quotes [Inductive]**	**Categories [Deductive]**	**Themes [Deductive]**
Environment	Environmental Constraints	Chlorine and Fluorine in the Water	Barriers within SEM	Community Health in Rural Areas
Environment	Physical Environment	Immediate and Non-Immediate Environments; A Person's Living Environment	Barriers within SEM	Community Health in Rural Areas
Focus	Address Health Issues	Health Service/Product; Healthcare Providers; Health Focus; Healing; Unhealthy Food; Reducing Salt; Health Problems; Maintaining Blood Pressure Levels; Healthcare; Health; Grocery Shopping Best Practices; Our Church is Looking at Food Disparities; Food Insecurities and Insufficiencies; Impacts of Process Foods; Community Health problems; Take Clean Water and Air Seriously	Barriers within SEM	Community Health in Rural Areas
Focus	Health Conditions	Heart Impediments; COVID; Lack of Exercise; Realizing How Many People Suffer from Health Conditions; Stroke; Poor Diet; Diabetes	Areas of Concerns	Community Health in Rural Areas

Grandfather Codes [Inductive]	Parent Codes [Inductive]	In-Vivo Quotes [Inductive]	Categories [Deductive]	Themes [Deductive]
Focus	Needs	Help People with Their Concerns; Needed Help with Bereavement; Healing People Where There Needs Are; Health Needs Depend on What the Health Needs of the People Are; Seeing What Needs to Be Done in the Community; Health Needs; Situations When People Need Help Paying Bills; The Needs are Incredibly Great; Needs are the same for both the youth and elderly; Needs of the Community; Identify Their Needs; Needed to See the Doctor; Need for Feeding Children and Adults	Community Health Requirements	Community Health in Rural Areas
Focus	Relationships	Need to Revisit and Rekindle Efforts to Focus on Community; Relationships are Important; Connected Through Community through Professional Relationships; With Other Local, State, and Public Service Entities and Individuals	Community Organizing	Collaborative Healthcare Partnerships
Focus	Social Change	Social Change Agent; Promotor of Social Change Programs and Initiatives	Leadership Capacities	Agent for Social Change

Grandfather Codes [Inductive]	Parent Codes [Inductive]	In-Vivo Quotes [Inductive]	Categories [Deductive]	Themes [Deductive]
Focus	Welfare	Family/Families; People in My Congregation I'm Attending To	Areas of Concerns	Community Health in Rural Areas
Focus	What's Occurring in Community	Focal Point for Church	Strategic Interventions	Community Health in Rural Areas
Focus	Working with Underrepresented and Underserved Populations	Underrepresented; Homeless Populations; Underserved; Important to Reach the Unreachable in the Community	Various FL and FBO Interventions	Agent for Social Change
Health Ministries	Blood Drives	Tough to Get People to Give Blood; Coordinate Blood Drives	FL and FBO Actions	Community Health in Rural Areas
Issues	Community Issues	Housing is an Issue; Gun Violence; Food Disparities Pentanol; Substance Abuse Issues; Drugs; People Overdosing with Opioids; Disrespect of Black People's Land; Violent Crimes; Community Health Issues	Barrier within SEM	Community Health in Rural Areas
Issues	Health Issues	We're Not Seeing the Value of the Intersection of the Mind, Body, and Spirit	Areas of Concern	Community Health in Rural Areas
Issues	Tragic Events and Emergencies	Flood the Areas; Pandemic; Houses were Flooded; Infrastructure Devastation	Problematic Situations	Community Health in Rural Areas
Issues	Weathering Issues	Occurrence of Hurricane Sandy; Freakish Storms	Problematic Situations	Community Health in Rural Areas

Leadership	Leaders	Assist With Meeting the Needs of the Community; Promotes the Right Image and Message; Import ant to Be Actively Involved in the Community; Meet with Other Leaders; I Must Always Back Up What I Say Through Action and Image; Role Model; Find Out Ways to Help and Serve; Uniquely Position; I Try My Best to Share; A Lot of People Doing Good Things; Reliable Person; They Trust that You Are Giving Good Information; Help Facilitate the End Product; Walk the Walk and Talk the Talk; Identify Opportunistic Ways to Help and Serve Community Needs; Loves Working With Others; Try to Be the Role Model That I Can with Helping People See that They Can Do; Observe and Understand What is Taking Place; Serve Others; Being a Leader in Community; Try to Work with Different Communities; Care for People from All Walks of Life; Make Ourselves Available to Serve Where Needed; Great to Be with Other Leaders to Serve the Community	Transformational Leadership	Agent for Social Change

Grandfather Codes [Inductive]	Parent Codes [Inductive]	In-Vivo Quotes [Inductive]	Categories [Deductive]	Themes [Deductive]
Leadership	Leadership Style	My Leadership Style Opens Me Up to More Opportunities; Have an 'Open Door' Policy; Active Listening; Doesn't Have to Be My Way; I am Very Upbeat; Leadership Style is Based on My Personality; I Apply an Informal Leadership Approach; Lead By Example; I'm Just Really a Facilitator; Exhibit the Appropriate Image and Behavior of a Role Model; People Have Seen Me as a Role Model; Don't Have to Be in Front of It; I'm an Extrovert; Utilize a Leadership Style that Prevents Division; Important To Be Energetic and Animated on a 1-on-1 Basis; I am Naturally Collaborative and That's the Way I Lead; Don't Care to Get Credit; Giving Credit When Credit is Due is Another Style that I Use	Transformational Leadership	

Grandfather Codes [Inductive]	Parent Codes [Inductive]	In-Vivo Quotes [Inductive]	Categories [Deductive]	Themes [Deductive]
Leadership	Responsibility	Giving My Time and Talents to Better Community; Working Toward Helping Unite Churches; Meeting the Needs of the Community is the Responsibility of the Church; Youth; Being a Pastor Is More than Just Preaching; Constituents; Always Offer Good Words of Encouragement; Not Just One Group But Everyone; Has a Fiduciary Responsibility to Lead Others; I Must Constantly Inspire Others Through My Actions and Words; Try to Pass on Wisdom Not Just Facts and Figures; Equipping Folks	Transformational Leadership	Agent for Social Change
Limitations	Transportation	Transportation is Troublesome	Barriers with SEM	Community Health in Rural Areas
Maryland	Somerset County	Princess Anne, MD	Areas of Concern	Community Health in Rural Areas
Mechanisms Are Unique and Spontaneous	Relating to People Where They Are	Church Cares for Them Right Where They Are	FL and FBO Actions	Agents for Social Change
Organizations	Community Members and Organizations	Lower Shore Shelter; The Seaton Center; Pregnancy Crisis Centers; Community	Types of Organizations	Community Healthcare Partnership

		Entities; New Day Pregnancy Center; County School Board; Adult and Teen Challenge in Seafood Queen Anne Chapter; Adult and Teen Challenge in Seafood; Somerset County Health Department; Food Bank of Delaware; Catholic Charities; Red Cross; YMCA; New Day Pregnancy Center		
Grandfather Codes [Inductive]	**Parent Codes [Inductive]**	**In-Vivo Quotes [Inductive]**	**Categories [Deductive]**	**Themes [Deductive]**
Organizations	Faith-Based Organizations	Methodist Church	Types of Organizations	Community Healthcare Partnership
Organizations	Health Department	Local Dept. of Health and Aging	Types of Organizations	Community Healthcare Partnership
Organizations	Health Organizations	Nursing Home; Public Health Department	Types of Organizations	Community Healthcare Partnership
Organizations	Faith-Based Organizations	Methodist Church	Types of Organizations	Community Healthcare Partnership
Partner/ Partnership	Partnership with Three Organizations	Partner with Health Agencies; Partnered with Local YMCA; Partnering with Judy Center; Partnership with Local Health Department; Other Local Partners; Get What We Needed Through Connections	Partnering Organizations	Community Healthcare Partnership
Resources/ Resourceful	A Lot of Land	A Lot of Land Can Be Used for Farming; Farm	Strategic Interventions	Agent for Social Change

Grandfather Codes [Inductive]	Parent Codes [Inductive]	In-Vivo Quotes [Inductive]	Categories [Deductive]	Themes [Deductive]
Resources/ Resourceful	Food Bank	Provide Folks with Food; Children Who Are Food Insecure Get Meals for the Weekend; Provide Food Needs for Community	Community Organizing	Collaborative Healthcare Partnerships
Resources/ Resourceful	Gathering People and Resources	Acquire Members from the Clergy; Know Ways to Help Others; Contact Somebody to Acquire Monetary Resources; Recognize They Need More than Just My Help; Reaching Out to the Local Health Divisions or Department; Identify Big-Wigs in the Community; Getting Health Experts to Help; Point People in Right Direction; Participate with Other Organizations; Try to Acquire People Who Are Well-Versed and Educated; Gathering People; Seek Professionals Inside and Outside the Church; Giving Them a Reliable Person that Can Help Others; Learn Who Are the Key Players are in Those Arenas; Serve As Guest Speakers to the	FL and FBO Actions	Agent for Social Change

		Church; Making Phone Calls to the County's Local Dept. of Health and Aging; Provide Folks with Food; Children Who Are Food Insecure Get Meals for the Weekend; Provide Food Needs for Community		
Grandfather Codes [Inductive]	**Parent Codes [Inductive]**	**In-Vivo Quotes [Inductive]**	**Categories [Deductive]**	**Themes [Deductive]**
Resources/ Resourceful	Health Resources	Use to Work for Shore Regional Health; Medical Devices; Testing Kits; Opportunity to Reach Out to Local Health Departments and Organization	Community Organizing	Collaborative Healthcare Partnerships
Services/ Service	Offer a Range of Services	First Aid Training; Caring for First Responders; Mental Health Services; Social Services; Provide Accessibility Assistance to Help People Go to the Doctor; Do Initial Counseling to Get Them in the Right Direction; COVID Testing and Kits; I Do Home and Hospital Visitations; My Intention is to Be Multi-dimensional in Providing Various Services and Needs; Hospital Visitations; Grief Services	FL and FBO Actions	Agent for Social Change
Services/ Service	Provide Services	Even for Those Who Have Penty, Old and Young; Provide Various Services to Help	FL and FBO Actions	Agent for Social Change

		Others in the Community		

Grandfather Codes [Inductive]	Parent Codes [Inductive]	In-Vivo Quotes [Inductive]	Categories [Deductive]	Themes [Deductive]
Services/ Service	We Have Specific Persons Pick Them Up	Drive Them to Where They Need to Go, Like to Local Stores, Doctor's Appointments; or Even to Dept. of Health	FL and FBO Interventions	Agent for Social Change
Solutions	Community Solutions	Participating in Community Events; Provide Awareness; Visibility in Community; Inclusive Efforts	Strategic Interventions	Agent for Social Change
Solutions	Exercise	Lost Weight	Strategic Interventions	Agent for Social Change
Stakeholders	Public Service Entities/Programs	Outreach Program; The Recovery Program; Eastern Shore Long Term Recovery Program; Judy Center of Somerset County; County Health Department; Food Pantry; Local Universities; Community Outreach	Types of Organizations	Collaborative Healthcare Partnership
Stakeholders	Entities and Stakeholders in the Community	Local VWF	Types of Organizations	Collaborative Healthcare Partnership
Support/ Supportive	Give Financially to Organizations that Support the Community	Only Mechanism We Have is Financial Support; Our Financial Support Helps Keep the Organizations Operating	FL and FBO Interventions	Agent for Social Change

Wholeness	Having All Three Core Factors: Spirit, Mind, and Physical Health	Reminded on the Importance of These Factors to Achieve Good Health; We Are Connected: Mind, Body, and Spirit; Enhancing the Mind, Body, and Spirit; Physical, Mental, Spiritual, and Emotional Health; Spirit/Spiritual/Spiritual Health	Areas of Concern	Community Health in Rural Areas

Grandfather Codes [Inductive]	**Parent Codes [Inductive]**	**In-Vivo Quotes [Inductive]**	**Categories [Deductive]**	**Themes [Deductive]**
Wholeness	Mental	Mental Health	Areas of Concern	Community Health in Rural Areas
Wholeness	Overall Health	Enhancing the Mind, Body, and Spirit	Areas of Concern	Community Health in Rural Areas
Wholeness	Physical	Physical Health	Areas of Concern	Community Health in Rural Areas
No Grandfather Code	Board Member	I am a Board Member	Useful Experience	Faith Leader Experience and Perceptions
No Grandfather Code	Challenges	Don't always Talk to Each Other	Barrier within SEM	Community Health in Rural Areas
No Grandfather Code	Challenges	Don't Realize the Impact of Behavior	Areas of Concern	Community Health in Rural Areas
No Grandfather Code	Challenges	Impacts of COVID was the separation that We Had from One Another	Areas of Concern	Community Health in Rural Areas
No Grandfather Code	Challenges	Not Hearing What You Said	Areas of Concern	Faith Leader Experience and Perceptions

Grandfather Codes [Inductive]	Parent Codes [Inductive]	In-Vivo Quotes [Inductive]	Categories [Deductive]	Themes [Deductive]
No Grandfather Code	Challenges	Often Forget About Providing for Those Who Are Not Needy	Areas of Concern	Community Health in Rural Areas
No Grandfather Code	Change	Make a Significant Change; Takes Time to Change; I'll Call Any Kind of Change; Ability to Embark Needed Change	Leadership Capacities	Agent for Social Change
No Grandfather Code	Church	Church in Walkable Distance for its Members; Church Cares About their Welfare; We Show Up When We Say We Show Up; Aware of Community Happenings; Have Some Youth that Hang Out at the Church; Church to Provide a Faith-Based Voice; The Church Serves, Functions, and Behaves Like a Family; We Portray the Church Like a Family; Put Forth Our Best Efforts to Serve When We Can; Ministry; Faith Leaders; We Had Our Eastern District Sunday School Convention and We Hosted it at Our Church; Church is in a Major Central Area of the County; Serve Community Outside of Sunday Morning Worship;	Leadership Capacity	Community Health in Rural Areas

		Church Assist with the Health; Congregation; Church Makes it Less Troublesome to Reach Residents; During Church Service We Provide Basic Health Information to the Community		
Grandfather Codes [Inductive]	**Parent Codes [Inductive]**	**In-Vivo Quotes [Inductive]**	**Categories [Deductive]**	**Themes [Deductive]**
No Grandfather Code	Church Activities	Donations; Health Activities; Most Activity Consisted of Offerings for Our Local People and Congregants; Workshops; Coordinate and Facilitate Meals for the Homeless Shelter; Diabetes Class; Provide Vaccinations Through the Church; Lent Season; Provide Outreach; Estate Planning Activity; Economic Empowerment Activity; Provide Health Affairs and Health Checks; Church Ministry; Provide COVID Shots; Visiting Nursing Home Activity; Cambridge Ministries; Blood Pressure Checks; Ran A Food Pantry	Various FL and FBO Interventions	Agent for Social Change
No Grandfather Code	Church Common Activity	Trips to Walgreen and CVS; Providing Health Fairs Through the Church; Delivering Food When They Need it; I've Been Picking People Up and Taking Them to Doctor	Various FL and FBO Interventions	Agent for Social Change

		Appointments; Delivering Communion; Bring Professional Skills for Church Activities Useful for Community; Church Food Bank Activity; Provide Breakfast at the Church for Policeman; We Arrange Transportation; Hosted a Car Seat Check-In; Have an Open Forum to Talk About Drug Issues in the Area; Hosted Eastern District Sunday School Convention; Food Drives; Picking Up Offerings Things; Routine Health Check Ups; Providing General Health Check Ups; Health Check Ups; Taking Them to Handle Personal Needs		
Grandfather Codes [Inductive]	**Parent Codes [Inductive]**	**In-Vivo Quotes [Inductive]**	**Categories [Deductive]**	**Themes [Deductive]**
No Grandfather Code	Collaboration/ Collaborate	Establish Relationship with Pastors of Other Denominations; Our Collaborative Partnerships Meet the Needs of the Community; Bridge Building; I am Naturally Collaborative and That's the Way I Lead; Being Collaborative and Informal Makes People Feel Good; Collaborating Partnerships Allow Us to Expand Our Reach and Interact	Community Organizing	Collaborative Health Partnership

		with More People; We Must Collaborate to Maximize Impact; Agencies Collaborating with Each Other to Meet Community Needs; Mental Healthcare Providers; Collaborate with Community Partners; Always Tried to Collaborate with Different Stakeholders in Community; Be Able to Collaborate with Them to Get What We Needed; To Witness Collaboration at Work; Did A Lot of Collaboration; Interact with Community Health Organizations; Our Collaborations Are Informal and Voluntary; Know Who to Connect With; Matter of Making Connections and Talking in the Community; Witnessing Certain Activities Making a Difference		
Grandfather Codes [Inductive]	**Parent Codes [Inductive]**	**In-Vivo Quotes [Inductive]**	**Categories [Deductive]**	**Themes [Deductive]**
No Grandfather Code	Delmarva Region	Elders/Elderly; Integrated Gentrified Community; Rural; Each County Demonstrates its Own Uniqueness; Eastern Shore; Mostly Have Older People in the Church and Town	Areas of Concern	Community Health in Rural Areas

No Grandfather Code	Difficulties	Health Difficulties; Difficult for His Wife to Take Care of Him	Problematic Situations	Community Health in Rural Areas
No Grandfather Code	Influence	Health Conditions that Were Often Influenced by Their Physical Environments, Poor, Diet, and Lack of Exercise; Level of Influence; Do My Part to Influence People	Barriers of SEM	Community Health in Rural Areas
Grandfather Codes [Inductive]	**Parent Codes [Inductive]**	**In-Vivo Quotes [Inductive]**	**Categories [Deductive]**	**Themes [Deductive]**
No Grandfather Code	Limitations	When that Environment is Toxic; Don't Have the Means to Meet the Health Needs of Our Community on Our Own; Transportation; Don't Have a Structure to Organize; Not Enough Mental Health Services in My Area; Didn't Hear Doctor/Nurses Properly; Don't Have Access to Resources; Lack of Mental Health Services; Limitations with Transportation; Limitations with Good Healthcare Providers; Mental Health is Not Easily and Readily Available; Still Experience Health Difficulties; Don't Make Regional or National News; Food Insecurity; We Were Limited in the Pandemic Time Period; Can Not Change	Barriers of SEM	Community Health in Rural Areas

		Government Systems; Most of Them Don't Drive; Don't Feel Like They Have Enough Social Capital		

Grandfather Codes [Inductive]	**Parent Codes [Inductive]**	**In-Vivo Quotes [Inductive]**	**Categories [Deductive]**	**Themes [Deductive]**
No Grandfather Code	Meetings	Council Meetings; NAACP Meetings; School Board Meetings; Group Meetings; Meet for a Month; The Church Also Provides Seminars and Special Meetings	FL and FBO Actions	Agent for Social Change
No Grandfather Code	Motivation/ Motivate	Inspire; Make People Feel and Do Better with their Lives; Motivate Others to Do the Same; You Encourage, You Inspire	Transformational Leadership	Agent for Social Change
No Grandfather Code	Organizations	NAACP; YMCA; Community Members and Organizations; Faith-Based Organizations; Health Department; County Sheriff's Department; Health Organizations; Work with Food Insecurity and Housing; Organizations Offer Opportunities to Address Health, Mental, Physical, and Education Concerns;	Types of Organizations	Agent for Social Change

Grandfather Codes [Inductive]	Parent Codes [Inductive]	In-Vivo Quotes [Inductive]	Categories [Deductive]	Themes [Deductive]
No Grandfather Code	Parade	Parade They Have Every Year for Labor Day; Community Parade	Useful Experience	Faith Leader Experience and Perceptions
No Grandfather Code	Partner/Partnership	I Believe When We Work Together, We Achieve Greater Things; Informal Partnership with Lower Shore Shelter; Better at Partnering for Different Things; There's A Lot of Partnering; Partnerships with Three Organizations;	Community Organizing	Collaborative Healthcare Partnership
No Grandfather Code	Pastor Experience	Third church that I've been a part of on the Eastern Shore, I have been in Dorchester County, Caroline County, and now I'm in Queen Anne's County; Also have previous pastoral experience as an Associate Pastor at Trinity United Methodist Church in Salisbury Maryland for 18 years; I then joined with a local Methodist Church near where I lived. I would volunteer to help around the church and was then asked if I would like to take classes to help with	Useful Experiences	Faith Leader Experience and Perceptions

	the service. They were encouraging. Over time I took more courses and eventually made myself eligible to become a local pastor. Since then, I have continued to take other ministerial courses and training; I am also becoming more active with publicity of the weathering issue for which not too many people knew about; For example, this isn't quite a health concern, but we hosted a car seat in our parking lot, a car seat check-in. So, they gave out car seats and they also made sure that we put them in properly. So, it's kind of car seat safety check. And that was through partnering with the Judy Center; I can go into hospitals of Robinson A.M.E. Church in Grasonville, MD; My visitation experiences over the years have taught me the important skills of dealing with the home bound and nursing home patients that I visit on a regular basis; I guess like the example that the one that we could use for collaboration was the Somerset County Public Health Department

	and coming in and using our facility for COVID vaccine shots; By traveling and experiencing the world via church ministry and military, maintaining my health and strength is extremely important to me in order to live the life I want to live and help the people I want to help; I end up sometimes being an advocate for families and patients in the hospital system just trying to translate what the doctors and nurses are saying, or if I am sitting with the family and I'm like they didn't hear the doctors or nurses properly, you know, kind of let them know you're going to have to talk to this family again or they're not hearing what you said or just some clarification; Not only do I serve the role of a pastor, but also serve as a giver and as a spiritual person; You know, there has been some first aid training for mental health that I did make sure that I participated to keep myself fresh and keep myself available as far as the medical part;14 years of being an ordained pastor.

No Grandfather Code	Presence	Establishing Positive Presence in the Community; Provide a Sense of Presence; Positive Presence; Being Present; Secret Sauce is Presence and Showing Up	Transformational Leadership	Agent for Social Change

Grandfather Codes [Inductive]	**Parent Codes [Inductive]**	**In-Vivo Quotes [Inductive]**	**Categories [Deductive]**	**Themes [Deductive]**
No Grandfather Code	Prior Occupational Experience	I am also a registered nurse; A board member of the Eastern Shore Long Term Recovery program; I was in the military for 15 years; Worked with a lot of various officials; Been working in the community with Bethesda Methodist Church of Preston, MD serving the surrounding community and church; 12 years as a missionary and English teacher; Used to teach elementary school; I've lived in five countries and traveled to 25 countries with some of those places being considered as 'Third World' countries; Used to work within the administrative area for Shore Regional Health	Useful Experience	Faith Leader Experience and Perceptions
No Grandfather Code	Specific Church/Pastor Experiences	We also on occasion provide breakfast at the	Useful Experience	Faith Leader Experience

	church for policemen in the community; Primarily as a pastor, I seek to make a significant change in others and in the surrounding community of the church; We provide blood pressure checks on a regular basis throughout the year; Today we had a food pantry. We had 34 people that were served which enabled them to provide for their families. It was a very interesting and fulfilling morning because that was more than what we usually get; I have been working with the county health department, and local universities to identify ways to provide services through our church; Picking people up, taking them to the doctors for appointments, and other personal obligations taking them to handle personal needs, such as trips to Walgreens and CVS, things of that sort; One of the things that I'm involved with right now is court related, in which I serve as a witness at hand for a person that has Alzheimer's. I provide support to his family with daily activities and	and Perceptions

	visitation. Due to the person's Alzheimer's condition, I help with communicating his feelings during court. I also serve as a mediator with his family as they continue to go through this unfortunate experience; Community outreach is just one of the different ways we help with the healing of folks, regardless of wherever they are; I have been engaged in Greensboro, MD with other church leaders to onset the development of an educational center; I am also becoming more active with publicity of the weathering issue for which not too many people knew about; I have been advocating for these folks and it's said for them to still experience the master/slave behavior in the community pertaining to this issue. I've approached some of the elective officials in my area; Being open in having the church assist with the health department, along with participating with the relief program with housing initiatives, I have been involved with

	making connections with funding among other churches and nonprofit organizations; Health fairs that we've have held for getting the health experts to help. Maintaining the health of my congregation, as well as their friends and families is another way to reach the health needs of the community; Cambridge ministry of my church involves getting churches to work together; We also provide outreach that enables us to coordinate and facilitate meals for the homeless shelter and other related services; I do home and hospital visitations to provide emotional and spiritual support; Collaborate with community partners like social services and other local partners that offer mobile buses that provide a range of services that also contribute to improvements of personal well-being; My church provides economic empowerment activity, specifically for younger congregants of the church. And for the elderly congregants of the church, estate planning

	activities are provided; Work with different communities, partner with health agencies to offer a range of services, like COVID testing and kits; For instance, with us being able to get COVID tests while we were out, just virtually coming together, it was an opportunity to reach out to local health departments and organizations, but we had to know people, we had to go there and be able to collaborate with them to get what we needed; Working together with the Grasonville Community Center and the NAACP create other opportunities to collectively solve some of our challenges; We have one lady who generally keeps an abreast of those things that are going on in the community and she'll bring in pamphlets for making sure that you test yourself for a different thing that might be coming up or visit your doctors or she'll bring in pamphlets; I have another homebound lady that is quite talker. She is different than the other lady that demonstrated more severe

	limitations. But I think uh, with her it's just the opposite. My visitation with her is more of just listening. However, I think just by being present by active listening does her a lot of good. Another homebound lady I go see is more in a secluded environment, in which you need permission to get in and out of the facility where she is located. It's kind of a lockdown situation; When I visit her, sometimes there are group activities taking place [e.g., games] and others come around me as well. She is just so appreciative; Previously, I engaged with a homeless woman that feared going to the doctor, due to her disability. She needed to see a doctor to receive SSI. So, I took her to the doctor and sat with her during her SSI interview so that she can acquire SSI; As an example, again during the whole COVID thing, it was very important for us to be in partnership with the local health department to make sure people were getting correct information about vaccines to be vaccinated; We

	have specific persons to pick them up and drive them to where they need to go, like to local stores, doctor's appointments, or even to Dept. of Health for frequent and/or routine health checkups; There are occasions when I provide recommendations for persons who experience hardship with their health, to go and see the doctor; In one instance, we had a gentleman who was ill. And his wife was elderly. It was difficult for his wife to take care of him. Me and my wife assisted by making phone calls to the county's local Dept. of Health and Aging to enable needed services; Having a health ministry to interact with community health organizations like Red Cross to coordinate blood drives and things of that sort; Church provides awareness about various health conditions, such as diabetes, heart impediments, and stroke, along with the value of exercise; Regarding the visitation nursing home activity, we have several people in the

		nursing home right now. One has a very, uh, you know terrible disease. She can't talk and can't respond. I'm in close contact with her, with her husband. And he says other than his wife not being able to talk/respond or move, she can listen and hear. He said that just my presence and voice while visiting, is important; I was honored to be the guest speaker at Somerset County prayer breakfast; Making sure that children who are food insecure get meals for the weekend is one of our essential services. This service serves three schools that effectively reach 80 kids. And its ran by volunteers from the church and community. Volunteers take meals to the school, and the school; I was previous in a call for a NAACP meeting, Queen Anne County chapter; Have a specific health ministry that operates annually for folks in need of medical devices such as walkers, canes, wheelchairs, elevated stools for toilets, bed rails, and things of that nature. Regarding

	the elderly population, we have a lot of donated items that we lend. We often either release those donated items to people really need them, or we provide those items through a lease; Have an open forum to talk about the drug issues in the area; There's been times where if there's a health crisis my folks will come, and they will talk to me and ask me questions. But in general, when I see someone encountering health difficulties, I often conduct my own general health assessment of their health condition and situation; My collaboration with the local VFW provides a yearly donation of $1,200 to address the needs of the local church and the Grasonville community; Equipping folks and identifying those in the congregation that have the skills, talents, and gifts, to support the coordination of gathering these folks; I have engaged myself to focus on these specific health concerning areas in my community [effects of COVID, crime, and drug abuse, but

		particularly drug abuse]; We also had, for a long time ran a food pantry. We now moved it to a different location, but we had a food pantry to provide the food needs of the community; Part of my ministry is to provide visitation to the homebound on a regular basis to bring communion to them and just to be a friend and support them in life struggles that they encounter; My visitation experiences over the years have taught me the important skills of dealing with the home bound and nursing home patients that I visit on a regular basis; Recently I had a couple that came in and sat with me because they weren't sure if they should consider hospice or not. And so, we had a really great conversation about that; I also visited her when she was admitted to the emergency room and thereafter, I was chosen by her to be her person of contact, for which I didn't even know that she had did that. I didn't know that was going to happen, but when I reached out to the hospital to find out how she was one

		of the hospital members that shared that with me. So that experience made me aware of my value.		
Grandfather Codes [Inductive]	**Parent Codes [Inductive]**	**In-Vivo Quotes [Inductive]**	**Categories [Deductive]**	**Themes [Deductive]**
No Grandfather Code	Vaccines/ Vaccinations	Vaccines Out to People; Helped Residence Get Vaccinated	FL and FBO Action	Community Health in Rural Areas
No Grandfather Code	Vision	Vision is to Be a Community of Hope for All People; Help Carry Out Vision; Vision Become a Reality by Accomplishing Our Mission; Set a Vision for the Church	Transformational Leadership	Agent for Social Change
No Grandfather Code	Volunteer/ Volunteering	Volunteer to Help Out Around the Church; Folks Volunteer to Help Others; Volunteers Takes Meals to School; Ran by Volunteer from the Church and Community	FL and FBO Action	

Appendix S: Inclusion and Exclusion Criteria for Participants of the Study

Inclusion Criteria	Exclusion Criteria
Faith Leaders at least 21 years of age or older	Faith Leaders under 21 years of age
Faith Leaders having five years or more experience as a lead minister, deacon, rector, or pastor of a church	Faith Leaders who do not have five years or more experience as a lead minister, deacon, rector, or pastor of a church
Faith Leaders and/or their church being a part of a collaborative healthcare partnership	Faith Leaders and/or their church are not a part of a collaborative healthcare partnership
Faith Leaders demonstrating evidence of performing health outreach activity in their surrounding communities	Faith Leaders do not demonstrate evidence of performing health outreach

Note. Derived from Interview Protocol

Appendix T: Deductive Analysis [Categories and Themes]

Categories	Themes
Barriers within SEM; Problematic Situations; Community Health Requirements; Areas of Concern, SEM Conditions; Strategic Interventions	Community Health in Rural Areas
Useful Experiences	Faith Leader Experience and Perceptions
FL and FBO Actions; Various FL and FBO Interventions; Transformational Leadership; Leadership Capacities	Agent for Social Change
Community Organizing, Partnering Organizations	Collaborative Healthcare Partnerships

Note. From results of inductive analysis.

Appendix U: Mind Garden Inc. Permission Letter

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Sample Items:

As a leader ….
I talk optimistically about the future.
I spend time teaching and coaching.
I avoid making decisions.
The person I am rating….
Talks optimistically about the future.
Spends time teaching and coaching.
Avoids making decisions

Sincerely,

Robert Most

Robert Most
Mind Garden, Inc.
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