

FAITH COMMUNITY NURSING
PROGRAM DEVELOPMENT PROJECT

A Major Paper Presented

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Abstract

Faith community nursing is a model of nursing care that focuses on health promotion and disease prevention and the intentional care of the spirit within the context of a faith community's values, beliefs, and practices. The purpose of this program development project was to develop and identify an implementation plan for a faith community nursing program at the Church of The Apostles in Coventry, Rhode Island. A needs assessment was completed in order to determine the health status and risk factors of the congregants, identify diversity in needs within the congregation and to identify perceived needs and perceived barriers in meeting those needs. The needs assessment was an essential first step in assisting the church and the faith-based nurse. The approach used to complete the needs assessment included a demographic and health questionnaire and focus group. The nursing theoretical framework used to guide this project was a grand nursing theory based on human needs, *The Neuman Systems Model*. This model uses a systems approach to describe holistic health that is focused on a client's or client system's optimal well-being. The PRECEDE-PROCEED logic model was chosen as the framework to guide the construction of this long-term plan to develop a faith community nursing program. The proposed faith community nursing program will represent a Congregational model and an independent, stand-alone faith community nursing program. The health promotion program will be phased-in based on the needs of the congregation identified from the needs assessment.

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Statement of Purpose

The overall goal of this project was to identify and develop an implementation plan for a faith community nursing program at the Church of The Apostles in Coventry, Rhode Island. In doing so, this author hopes to understand how the relationship between faith community nursing/health ministries and faith members influences the physical, emotional, and spiritual aspects of members' lives. The overall outcome of this project as a nurse is to connect with faith members through community involvement and provide social support to the members, as well as serving as an educator, counselor, resource person, referral agent, advocate, and prayer partner. A key component of the nurse in this role (ministry) will be on health promotion activities that will directly impact the health and wellness of members and provide social support in order to sustain healthy lifestyle changes. The idea is to integrate the practice of nursing with the practice of faith so that church members can achieve wholeness (physical, emotional, spiritual, and social).

The church interacts with people spanning the entire socioeconomic spectrum, and across the life span, from the beginning of life to the end of life (McNamara, 2002). The church's mission traditionally has been salvation, and from a historical perspective congregations have ministered to the physically ill (Solari-Twadell & McDermott, 1999). Currently, there is an awakening of the effect of faith on health. Medical science is documenting the link between spirituality and physical health. Studies have showed that one of the strongest predictors of survival after heart surgery is the degree to which the patients draw comfort and strength from religion; likewise individuals who attend religious services usually have better health overall than those who do not (Pravecek,

2005). Several critical events are occurring parallel with this awakening, including: access to health care has become more limited and complex; rising health care costs; many are suffering from a lack of or inadequate health insurance; and an overall aging population. Many congregants recognize that health is not the absence of disease or just a physical matter, but a sense of wholism of mind, body, and spirit that must be balanced (Kotecki, 2002). Caring for God's people is a part of the church's mission and of its understanding of the Christian Gospel. Care refers to the whole person- mind, body, and spirit. The Bible often refers to the significance of the inter-relationship of body and soul. Much of what happens in churches is just the type of thing that helps people stay well. Activities such as music, worship, prayer, building of friendships, and the opportunities to serve and to be served by others abound in the church. These attributes may help create an atmosphere of gratitude and hope and in return impact a person's total health (Westberg & McNamera, 1990).

Literature Review

Key words: community assessment; faith community nursing; health; health promotion; parish nursing; program development; spirituality; spiritual care; and wholistic care.

Data base: CINAHL

Introduction

In 1979, the U.S. Public Health Service published *Healthy People: Surgeon General's Report on Health Promotion and Disease Prevention* which outlined strategies for keeping people healthy. This document brought together much of what is known about the relationship between personal behavior and health status. The document also presented a "personal responsibility" model that provided Americans with a prescription for reducing their health risks and increasing their chances for good health. The report also identified nursing professionals' obligation in providing health promotion and disease prevention services. In 1980, one year later, the U.S. Public Health Service published *Healthy People 2000: Promoting Health/Preventing Disease: Objectives for the Nation*. This would be the first of three decades of national health objectives aimed at preventing disease and promoting health. These objectives provided specific direction and goals for public health nurses to promote and protect health as well as to reduce health risks. This document includes access to 10 leading health indicators, 467 specific objectives, and 28 focus areas (Ivanoc & Blue, 2008). *Healthy People 2010* (US Public Health Service, 1980) builds on these initiatives pursued over the past two decades and can be used by many different people, professional organizations, communities, states, and others to help develop programs to improve health. The two overarching goals of

Healthy People 2010 are to increase the quality and years of healthy living of individuals and to eliminate health disparities between groups of people (US Public Health Service, 1980).

Specifically, *Healthy People 2010* defined the leading health indicators that reflect the major health concerns in the US at the beginning of the twenty-first century. These indicators include: physical activity; overweight and obesity; tobacco and substance abuse; responsible sexual behavior; mental health; injury and violence; environmental quality; immunization; and access to health care. The Institute of Medicine's (IOM) landmark report in 1988 entitled, *The Future of Public Health* initiated important changes in the US public health system (Turnock, 2009). The report challenged the public health community to "think more strategically, plan more collectively, and perform more effectively" (Turnock, 2009, p. 215).

Health, Holism, and Health Promotion

The message of *Healthy People* was so effectively spread that there are few Americans today who do not know the importance of good health behavior. Health is defined in *Healthy People 2010* as "the health of the total population and the consequences of the determinants of health- biology, behavior, social environment, physical environment, and policies and interventions that promote health" (p. 18). The World Health Organization's (WHO) definition of health reflects a holistic perspective: "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (1948, p.10). Holism is derived from the Greek meaning "whole", including the mind, body, and spirit (Westberg & McNamera, 1990).

Healthy People 2010 launched the US into the health promotion phase of public health history. The WHO defined health promotion as “the process of enabling people to increase control over, and to improve their health...and reduce differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential” (1986, p. 1). WHO (1986) further suggested that health promotion means building public policy, creating supportive physical, social, and community environments, and strengthening community action with the goal of creating healthy living conditions and lifestyles. Green and Kreuter (1999) defined health promotion as the “combination of health educational and ecological supports for actions and conditions of living conducive to health” (p. 27). Health promotion and disease prevention also suggests purposeful activities, implementation of behavior change strategies, health education, health protection measures, risk factor detection, health enhancement and health maintenance. Green and Kreuter further suggested that health education is an important component of health promotion and is one of several different interventions that can be used to promote health. Health promotion is a multidisciplinary practice that aims at improving and maintaining health, not just of individual, but of families, communities, and populations (Ivanov & Blue, 2008).

Historical Roots

Nursing has its historical roots in the link between faith and healing in the ancient traditions of most major religions (ANA and HMA, 2005; Westberg & McNamara, 1990). Faith community nursing’s focus on health and healing is rooted in Judeo-Christian traditions which reflect a Hebrew, or Old Testament, understanding of health in

which the physical and spiritual aspects of health and healing are inseparable. It is also modeled on a New Testament understanding of Jesus' ministry of teaching, preaching, and healing, and addressing the concerns of mind, body, and spirit holistically (Smucker, 2009). Diakonal ministry in the church is a fusion of care for the body and soul and this ministry continues to exist today in local congregations. Diakonia is the Greek word for "service." Service on behalf of the church community in early Christian church development recognized the need for this diakonal ministry. The theology of 'serving those in need' maintains that in serving those in need, we provide service to Christ. In the Bible (New International Version [NIV]), the book of Acts (6), refers to diakonal as a table server, an office that then allowed the other leaders of the church to engage in ministries of preaching and teaching. This Christian ministry in the early church defined and engaged in service to the poor, sick, widowed, and orphaned (Patterson, 2008). This theology, paraphrasing Saint Paul in Romans and Corinthians, also proclaims that "each and every Christian was a part of the body of Christ, with unique gifts to be used in the service of others" (Patterson, 2003, p. 26). The Bible tells us in Luke 9:2, Jesus sent out his disciples, not only to preach the kingdom of God, but also to heal the sick in order to show that God is the ultimate healer. Many Christians believe that the offices of deacon (servant ministry) were held by men and women in the early church. Paul wrote, "I commend to you our sister Phoebe, a deaconess of the church in Cenchrea (Romans 16: 1-2, NIV). These verses describe the early works of Phoebe, who is considered to be the first visiting nurse (Niles & McEwen, 2001). The holistic care of body, mind, and spirit centered on congregants was first described by

Reverend Granger Westberg during the early 1980s (Westberg & McNamera, 1990).

Rev. Dr. Granger Westberg gave deaconess nursing the name “parish nursing.” The title “parish nursing” was copyrighted by The International Parish Nurse Resource Center (IPNRC) (Westberg & McNamara).

Nursing and Holistic Health

Nursing and public health specialists define health and wellness as a holistic concept encompassing physical, psychological, social, and spiritual dimensions (Ivanov & Blue, 2008). Effective physical health refers to the body’s ability to adapt in ways that result in positive health status. Psychological health encompasses self-esteem, inner-directedness, creativity, and the ability to adapt to and cope in challenging situations. Social health means the ability to make and maintain relationships with other individuals, groups, and communities. Spiritual health is a relationship with a higher power and inner peace essential to maintaining health and wellbeing (Patterson, 2008). Neuman (Neuman & Fawcett, 2002) defined health as “a continuum; wellness and illness are at opposite ends” (p.23). The term wellness refers to the idea of health as holistic rather than merely the absence of disease or illness (Ivanov & Blue, 2008). Health is a key term in a community-oriented nursing practice. Community-oriented nursing practice recognizes the need to shift from the emphasis in health care from illness to wellness. The five dimensions of wellness include self-responsibility, nutritional awareness, physical fitness, stress management, and environmental factors (Stanhope & Lancaster, 2004).

The concept of holism is well grounded in nursing, as nursing has traditionally been concerned with health care to the whole person (McEwen & Wills, 2007). Florence

Nightingale, the founder of the nursing profession, possessed a holistic view of the client, wrote about the relationship between nursing, the client, and the environment, and published a framework of wellness nursing that integrated dimensions of the entire person: physical, mental, emotional, social, and spiritual (Swinney, Anson-Wonkka, Maki, & Corneau, 2001). Many theorists have adopted a holistic paradigm for nursing theory, research, and practice such as Neuman, Rogers, and Johnson (McEwen & Wills, 2007; Neuman & Fawcett, 2002). Nursing has traditionally practiced within a framework of promoting health and it is an accepted aim of nursing practice (Stanhope & Lancaster, 2004). Beginning with Nightingale's efforts, nursing has always taken an active role in promoting the health of populations and the total community (Stanhope & Lancaster). Nightingale promoted health through education of individuals and families, social reform, and nursing care (Swinney, et al., 2001).

Faith Community Nursing

A current nursing care framework or modality that is practicing wholistic health care is faith community nursing. Faith-based nurses, in some capacity, serving as diaconal ministers, are bringing the ministry of caring and service to the faith communities. In a given faith community the nurse may still be referred to as a parish nurse, congregational nurse, health ministry nurse, health and wellness nurse, or crescent nurse (ANA & HMA, 2005). Faith community nursing is the "specialized practice of professional nursing that focuses on the intentional care of the spirit as part of the process of health promotion, wholistic health and preventing or minimizing illness in a faith community" (Brudenell, 2003, p. 85). The scope and standards of faith community nursing (ANA & HMA, 2005)

reaffirm that spiritual care is an integral part of all nursing practice. Stanhope & Lancaster (2004) further described faith community nursing as an independent practice of professional nursing that focuses on health promotion within the context of the faith community's values, beliefs, and practices.

Within the context of a changing health care environment, faith community nursing can supply an innovative way to provide care to individuals, families, groups, the church community, and the wider local community (Wallace, Tuck, Boland, & Witucki, 2002). Today, Americans are experiencing one of the most significant health care reform movements in history. Contributing factors include access to health care and insurance coverage, disparities in health care, dissatisfaction with the disease-focused medical model (Anderson & McFarlane, 2008), the aging population and rising health care cost (Administration on Aging [AoA], 2008), an increase in chronic diseases (CDC, 2009), and the provision of many health care services moving to the community setting (Stanhope & Lancaster, 2004). In the face of this changing health care marketplace, congregations are increasingly forming partnerships with nursing for health promotion programs (Solari-Twadell & McDermott, 1999). This model has continued to develop and evolve in response to unique needs and priorities of the members of faith communities. A faith-based nurse does not duplicate community services, but instead collaborates with other service providers to enhance health care delivery services and to address unmet needs of their church community members (Weis, Schank, Coenen, & Matheus, 2002). The existing beliefs, organization, and supports provided within faith-based congregations provide reinforcements that can make health initiatives in churches

particularly effective (Chase-Ziolek, 2005). The church can serve as a powerful influence in the members' lives. The church is seen as one of the few places where it is acceptable to talk about and examine values and lifestyles and to evaluate whether they are in conflict or in harmony with each other. The church accepts its members in sickness and in health and when members become ill, they are surrounded by people who have known them in health and who will care for them (Westberg & McNamara, 1990).

Rev. Westberg had a vision on how church congregations could impact the health of their communities. He created courses about the religious aspects of illnesses, hulled the concept of "wholistic health centers", and conducted a study in wholistic health centers. His findings suggested that nurses were the catalyst in the relationship between faith and health and that nurses bridged the gap between science and faith (Westberg & McNamara).

Faith community nursing is a relatively new area of community health nursing practice. A review of the empirical literature on "parish nursing" revealed that parish nursing is a positive adjunct to conventional health care services. Parish nurses offer spiritual care, which is lacking in many health care settings. The practice of parish nursing is growing tremendously (King, 2004). By the beginning of the twenty-first century, the documented specialized practice of faith community nursing or parish nursing has expanded across all of the United States and in many regions of Canada as well as New Zealand, Russia, South Korea, and the United Kingdom. Currently, over 7,000 nurses have been prepared using the standardized curriculum developed by the

International Parish Nurse Resource Center (Hickman, 2006). Some nurses have also sought preparation from other sources (Stanhope & Lancaster, 2004).

Faith community nursing is a community-based nursing practice model that gives nurses the opportunity to address the physical, emotional, cultural, and spiritual needs of faith communities (ANA & HMA, 2005; O'Brien, 2003; Smith, 2003; Stanhope & Lancaster, 2004; Westberg & McNamara, 1999). In 1986, the International Parish Nurse Resource Center (IPNRC) began to sponsor an annual professional meeting on parish nursing, called the Westberg Symposium. The symposium is still an arena in which the latest research and practice patterns in parish nursing are presented (Patterson, 2003). Health Ministries Association (HMA) is the professional organization for nurses in this specialty (ANA & HMA, 2005).

Faith community nursing practice is governed by the Nurse Practice Act of each state in conjunction with state board of nursing policies and practices. Application of the professional skills and responsibilities are guided by the American Nurses Association's standards (Stanhope & Lancaster, 2004). In 1998, the American Nurses Association (ANA) recognized parish nursing as a specialty area of practice and published scope and standards of practice in collaboration with the Health Ministries Association (ANA & HMA, 2005). The autonomous roles of the faith community nurse require a nurse experienced in clinical nursing and community-based nursing practice (Gustafson, 2005). Current educational preparation for the faith community nurse includes completion of continuing education designated coursework in faith community nurse (parish nurse) preparation at the baccalaureate or graduate level. Educational preparation occurs in

parish nurse networks, health care institutions, colleges, and universities (Stanhope & Lancaster, 2004). Many of these programs are in partnership with the IPNRC for ongoing support and revision (Solari-Twadell & McDermott, 1999). According to the ANA & HMA (2005), the preferred minimum preparation for the specialty is the following: educational preparation at the baccalaureate or higher level with content in community nursing; experience as a registered nurse; and specialized knowledge of required spiritual skills and knowledge. The annual HMA meeting and the annual Westberg Symposium offered by the IPNRC offers comprehensive sessions and a forum for nurses to network and gain new knowledge (IPNRC). There are at least two different models of faith community nursing including a congregational-based model and an institutional-based model. In both models the nurses may be paid or volunteer (Chase-Ziolek, 2005; Patterson, 2003; Solari-Twadell & McDermott, 1999; Westberg & McNamara, 1990).

The purpose of a faith community nursing program is not to re-create what is already being provided within the health care system, but to provide services not readily available in a way that consistently integrates faith and health (Stanhope & Lancaster, 2004). According to the ANA & HMA (2005), a nurse will function within the parameters of his/her own professional background and within the scope and standards that “reflects current faith community nursing practice from a national perspective, the professional and ethical standards of the nursing profession, and the legal scope and standards of professional nursing practice” (p. 2). Seven areas of ministry or roles in which a faith community nurse may serve in are identified in the literature: integrator of faith and

health; health educator; personal health counselor; referral agent; trainer of volunteers; developer of support groups; and health advocate (ANA & HMA, 2005; Solari-Twadell & McDermott, 1999; Westberg & McNamara, 1999).

The faith community nurse serves as a health educator and teacher to promote healthy lifestyles and help members of the congregation to understand the relationships between lifestyle, health and well-being, and faith. Facilitating education of individuals and groups within the congregation will serve to assist members to gain knowledge in order to make best or better choices for maintaining health, lowering risks, preventing disease, and managing present diseases (Solari-Twadell & McDermott, 1999). Providing guidance to individuals within the congregation is a valuable part of a health ministry and a primary independent function of a faith-based nurse (Stanhope & Lancaster, 2004). Faith-based nurses see individual members in all degrees of health and illness. The goal of nurses in this role is to empower the individual to deal with his or her concern in an effective manner (O'Brien, 2003). The faith community nurse has the opportunity to discuss health risk appraisals, plan for healthier lifestyles, provide support and guidance related to numerous acute and chronic and potential health problems, and perform spiritual assessment (Chase-Ziolek & Iris, 2002).

The complexity of our health care system creates challenges that provide an opportunity for a nurse to function as a referral agent. In this role, the nurse serves as a liaison between resources in the faith community and the local community. Creating an awareness of the resources within and beyond the congregation helps link members to the appropriate services and guides members to access available resources (Westberg &

McNamara, 1999). The faith-based nurse mobilizes the church community to meet the needs of the congregation and surrounding community members. The role of the coordinator of volunteers includes recruiting, training, and directing volunteers to work with the faith community nurse program and health ministry (Solari-Twadell & McDermott, 1999). The nurse may work with other nurses and health care professionals, as well as non-professionals in the congregation. Volunteers routinely transport clients to physician offices, deliver meals, and provide other important services (Stanhope & Lancaster, 2004). In the facilitator role, the nurse connects the church with existing programs and resources to meet identified health and educational needs. In this role the nurse is not duplicating available community services but is partnering with other agencies to provide care to the church community (Stanhope & Lancaster). For example, the nurse might facilitate available health screenings, flu shots or immunizations through the local public health department.

The function of health advocacy is based on knowing the client, listening skills, supporting self-care, and being the client's voice when he or she has none (Solari-Twadell & McDermott, 1999). With a present day health care system that is growing more and more complex, people in the community are in need of advocacy. The role of advocate is woven into all of what a faith community nurse does. Solari-Twadell & McDermott (1999) suggested that there are numerous needs in the congregation and opportunities to develop support groups. The role of developer of support groups requires skills in community assessment and program evaluation. A needs assessment of the faith community might indicate the need for development of a support group.

Examples of some issues that may be addressed in support groups are bereavement, chronic disease, new mothers, and care-givers.

As an integrator of health and faith, the faith community nurse understands and integrates spirituality as the basis of his or her practice. The nurse lends support during difficult times in health and illness and in sorrow and joy. The nurse can identify spiritual strengths that assist the client in healing and help to instill hope (Stanhope & Lancaster, 2004). Depending on the needs of the church community and its members, the roles of the nurse may be implemented in a variety of ways.

Faith Communities and Health Promotion

A review of the literature by Campbell et al. (2007) suggested that church-based health promotion (CBHP) interventions can reach broad populations by providing meaningful and effective health promotion programs that have the potential for reducing health disparities and reaching millions of Americans. Capitalizing on the strengths of faith organizations in an era when other organizational and social ties may be less accessible is important. The studies reviewed by Campbell et al. (2007) on CBHP efficacy and effectiveness suggested that religious affiliation and church attendance improve physical and psychological health across multiple religions and populations in various parts of the world. The literature also demonstrated significant effects of CBHP on a number of health-promoting behaviors, including nutrition, physical activity, smoking cessation, and screening. The importance of health promotion for individuals across the life span as well as highlighting various outcomes of health promoting activities is clearly evident (McKenzie & Smeltzer, 1997; O'Brien, 2003; Stanhope &

Lancaster; 2004; US Public Health Service, 1979). Buijis and Olson (2001) suggested that faith communities are ideal settings for health promotion because of the relationship between health and healing. The goal of health promotion activities is to enhance positive health and prevent illness through health education, prevention, and health protection (Butler, 2001). Several of the faith-based nurse functions, such as health educator, personal health counselor, integrator of faith and health, and advocate are aimed at health promotion.

Community Partnerships

Under President Bush's administration, a White House office on faith-based and community initiatives was established that moved faith-based initiatives into the public spotlight (Kotecki, 2002). Though controversy exists over the governments' role in faith-based communities, nursing has the opportunity to bring health promotion education to faith communities.

Faith-based initiatives are inherently different from faith community nursing or parish nursing. Faith-based initiatives potentially bring together local congregations, community members, and government funding (Pattilo, Chelsey, Castles, & Sutter, 2002). Persons of different faith may come together to plan, implement, and participate in the programs. Faith community nursing is more inclusive and generally the nurses within the same congregation provide care for their members and share a similar belief system. Though the focus of this project is on faith community nursing, either program, faith community nursing or faith-based initiatives, allows for opportunities to bring health promotion education into a unique community setting and partner with segments of the

wider health community. *Healthy People in Healthy Communities* (a community planning guide using Healthy People 2010) suggested that a healthy community enables people to maintain a high quality of life and productivity. However, it also recognized that this can't be accomplished unless individuals and communities work together (US DHHS, 2001).

Community partnerships between health care organizations and faith-based organizations are an effective way to reach people with health promotion strategies in the comfort of their member group (Niles & McEwen, 2001). Collaboration between faith community nurses and public health agencies (Zahner & Corrado, 2004), home health agencies, and nursing educational programs (Pattillo et al., 2002) are described in the literature. Community-as-client, based on Neuman System Model, suggests that the community and the nurse must form a partnership to achieve mutual goals (Neuman & Fawcett, 2002). In community partnerships, the members (congregants) and the nurse (professional) need to actively participate in collaborative decision making in order to ensure the success of the program.

Rifkin (1986) described three approaches to community participation in health programs. The third approach, community development, suggests that the people are involved in the decision-making process to improve health. He described this as a grass-root approach, in which members within the community determine what health care services should be provided. Through empowerment, community health nurses can enable people to make decisions and respond to issues and concerns they believe are essential to their health and well-being. Freire (1997) proposed that community

partnerships develop through a process of empowerment. He described four characteristics of an empowered community: faith in people; trust established through dialogue; hope in positive transformation benefiting the community as a whole; and discussions grounded in critical thinking without fear of repercussion by those in power. Freire suggested that communication between people is the key to empowerment. Anderson and McFarlane (2008) suggested that community participation is a social process involving people who share common values in identifying their need and implied that the role of the nurse in community empowerment is to build effective partnerships through community participation. The PRECEDE-PROCEED model chosen for this program development project reflects the concepts of community participation, empowerment, and collaboration.

Spiritual Care

Spirituality is that life principle that pervades the entire being. It gives meaning to life and death and integrates and transcends all other dimensions of life. It offers love and relatedness and includes hope, trust, and faith. It embraces the need for forgiveness. It involves a belief in a supernatural or higher power (Solari-Twadell & McDermott, 1999).

The role of spirituality has been recognized as a contributing factor to an individual's overall state of wellness (Chase-Ziolek, 2005; O'Brien, 2003; Westberg & McNamara, 1990). Spirit, derived from the Latin meaning "breath," is a concept of the force which gives us life. It is believed by Christians that mind, body, and spirit are deeply intertwined aspects that make up who we are (Swinney et al., 2001).

Jesus charged the early church to preach, teach, and heal. These three themes exemplified Christ's ministry. Healing was an important part of this ministry. Many accounts in the Gospels speak to Jesus healing the sick (Westberg & McNamara, 1999). Jesus went about healing every disease and sickness" (Matthew 4:23). In Paul's letter to the Corinthians he describes healing as one of the gifts of the Holy Spirit (I Corinthians 12:9). Jesus understood that the health of a person is affected by the various conditions and influences that are part of life. From the earliest days, the church understood Jesus' call to care for one another and to care for the total well-being of those they came in contact with. Early Christians provided food for the poor, prayed with the sick, and cared for the widows (Clark & Olson, 2000). Good physical health is only part of what being healthy and whole is all about. There are many who have been blessed with good physical health and yet suffer emotionally and spiritually. On the other hand, there are those who are mature spiritually and emotionally yet suffer physically (Westberg & McNamara, 1999).

The fundamental focus of the faith community nursing is the intentional care of the spirit. This concept is what differentiates this specialty practice of nursing from the general practice of nursing. The Circle Model of Spiritual Nursing Care was developed to help nurses provide spiritual care by offering spiritual interventions. This model uses the nursing process to address the spiritual dimension and also encompasses settings for spiritual care, the recipient of spiritual nursing care, the provider of spiritual nursing care, and uses the nursing process to address the spiritual dimension (Solari-Twadell & McDermott, 1999). Any nurse who has an interest, knowledge, skills, and the

commitment necessary to care for the whole person can provide spiritual nursing care. There are six concepts included in providing spiritual nursing care: caring, intuition, respect of religious beliefs and practices, caution, listening, and emotional support (CIRCLE) (Solari-Twadell & McDermott, 1999). Understanding these concepts will help the nurse to provide spiritual care to the members of the congregation. Bergquist and King (1994) suggested that through prayer, spiritual assessment, and hope and faith, a faith community nurse can facilitate important client outcomes for spiritual health and well-being, including self-esteem, self-actualization, hope, trust, and peace.

O'Brien (2003) developed the Spiritual Assessment Scale, a tool for parish nurses to measure spiritual well-being. The purpose of her research study entitled "An Experiment in Parish Nursing: The Gift of Faith in Chronic Illness" was to test the effectiveness of a model of parish nursing on spiritual well-being and quality of life among ill persons. Her intention was to explore the relationship between spiritual well-being and quality of life using this measure. The sample consisted of 45 chronically ill adults, whose health conditions interfered with the usual or desired practice of their faith. The study was conducted over the course of one year. Following baseline data assessment of spiritual well-being and quality of life using the Spiritual Assessment Scale, a plan of pastoral care intervention was designed and carried out for all participants. Most study participants received five or more visits, phone calls, and notes from parish nurses. The results of this study suggested that the interventions provided by parish nurses resulted in positive increases in the components of spiritual well-being, including the concepts of personal faith, hope, life satisfaction, religious practice, and spiritual contentment. Implications of

this study suggested that parish nurses have the opportunity to engage in other identified parish nurse role behaviors such as integrator of faith and health (spiritual companion), health advocate, health educator, health consultant (referral agent), and health counselor while helping those who are chronically ill embrace the fullness of their faith in innovative and creative ways (O'Brien).

The North American Nursing Diagnosis Association (NANDA) provides three accepted diagnoses for nursing intervention related to spiritual care: spiritual distress, risk for spiritual distress, and readiness for spiritual well-being (NANDA, 1994). The form that spiritual care takes will depend upon the beliefs and practices of the faith community, the needs of the faith community, the skill of the nurse or member of the health and wellness ministry, and the collaboration of other staff members and volunteers (Solari-Twedell & McDermott, 1999). In order to respond to spiritual needs effectively and in a holistic manner, a faith community nurse needs to use his/her professional skills to integrate nursing care and spiritual care and draw on resources both within and outside of the faith community (O'Brien, 2003).

Faith community nursing focuses on the faith community and recognizes the relationship between spirituality and health (Berquist & King, 1994; Brudenell, 2003; McDermott & Burke, 1993). Clark and Olson (2000) described faith and health seeking as "parallel processes" and believed that faith communities provide a unique setting for health promotion. They suggested that many developmental and situational life transitions occur within or are related to a faith community context, opening up a window of opportunity to respond to the congregants in their times of need. Nurses have

historically observed that when illness or brokenness occurs, clients (individually or within their families) may turn to their source of spiritual strength for healing, support, and reassurance. The ANA reaffirmed that spiritual care is part of all nursing practice. The primary focus of faith community nursing is the intentional care of the spirit with each faith-based nurse demonstrating competency on a continuum from novice to expert (ANA & HMA, 2005).

Social support and spiritual beliefs are consistently reported as positive facilitators, both empowering and enabling adults (older adults in particular) to incorporate health-promoting activities as part of their lifestyle (Boland, 1998). Integral to the role of the faith-based nurse is the promotion of these health-related activities leading to the improved health of the individual and the community (Fawcett & Noble, 2004). Boland (1998) suggested that the presence of social support and spiritual beliefs are vital to the success of improving health promotion behaviors (HPBs). Spiritual relationships, along with interaction, foster hope and a sense of life's meaning and have been identified as essential elements in older adults' experiences of feeling healthy. Boland contended that the need for social support and spirituality has remained constant and forms a basis for practice within a caring philosophy that includes health promotion activities. Other researchers have also reported this relationship between social support and spiritual beliefs (O'Brien, 2003; Solari-Twadell & McDermott, 1999).

Conclusion

Faith community nursing may be on the cutting edge in the promotion of healthy lifestyles choices, health counseling, and education and illness prevention. Churches are

responding to the needs of their congregations and communities by supporting faith community nursing programs and the nurses that serve in them. Faith-based nurses and health and wellness ministries' goals are to provide wholistic care and preventive health-related education and services to their congregations, and help members access the health care system. Although faith community nursing shares many qualities with other areas of nursing, the congregational context for care creates a distinctive set of experiences that impact both the client (congregant) and the nurse (Smucker, 2009). As innovative means are sought to address individual's health care needs, congregations may be an effective environment to integrate faith and health. Health promotion and faith communities can complement each other. Health promotion can serve to remind faith communities of their health and healing missions, whereas faith communities can remind health promotion of the importance of including the spiritual component, resulting in a wholistic health practice.

Within the congregational setting, community faith nurses are in a unique position to promote the goals of *Healthy People*, including increasing the quality of life and eliminating health disparities among groups (US DHHS, 2001). Chase-Ziolek and Gruca (2000) suggested that nurses in the congregation do not replace other health care services, but that the services within the congregation enhance the use of traditional care through advocacy and increased accessibility, consistent with the goals and objectives of *Healthy People 2010*. Public health functions involve identifying health problems and their causative factors, developing strategies to address these problems and seeing that these strategies are implemented in a way that achieves the desired goals (Ivanoc & Blue,

2008). As an advanced practice nurse (APN) in public health and community leadership, there is an opportunity to apply these principles in the faith community setting. Changes in patient needs and expectations, a shift in the delivery of care to community settings, and changing attitudes about the role of the nurse have fostered opportunities for the development of new APN roles (Joel, 2004). *Faith Community Nursing: Scope and Standards of Practice* “reflects current faith community practice from a national perspective, the professional and ethical standards of the nursing profession, and the legal scope and standards of professional nursing practice” (ANA & HMA, 2005 vii). This specialty practice of faith community nursing provides registered nurses and advanced practice nurses with an opportunity to use their knowledge and skills to minister within this unique community setting.

Theoretical Framework

The Neuman Systems Model

The nursing theoretical framework chosen for this project is a grand nursing theory based on human needs, *The Neuman Systems Model* (Appendix A). This model uses a systems approach to describe wholistic health that is focused on a client system's optimal well-being. Neuman adheres to a nursing metaparadigm that links the client, environment, health, and nursing (McEwen & Wilkes, 2007). The client is described as a composite of several variables and his/her interaction (physical, psychological, developmental, socio-cultural, and spiritual), all of which make up the whole of the client. The environment is described as the internal and external forces and influences that surround the client and impact the client's quality of life. In this model health is defined as a continuum, with illness and wellness at opposite ends and a reflection of the optimal system stability of a client. The nursing component in this model is represented by the nursing process. A three-step nursing process is delineated: nursing diagnosis, nursing goals, and nursing outcomes (Neuman & Fawcett, 2002). The major focus of this process is to maintain client system stability by accurately assessing stressors and needs and assisting the client with adjustment and maintaining optimal well-being (McEwen & Wilkins, 2007). The intent of the Neuman Systems Model is to illustrate a structure that shows the parts and subparts of the client in relationship to one another and the environment (Neuman & Fawcett, 2002).

The major goal of nursing in the Neuman Systems Model is to keep the client system stable through accurate assessment of actual and potential stressors, followed by

implementing appropriate interventions. Three intervention strategies, primary, secondary, and tertiary prevention are suggested (Neuman & Fawcett, 2002). Primary interventions are implemented to strengthen the lines of defense by reducing risk factors and preventing stress. Primary prevention can be used to identify community risk factors and to plan for health education programs. Secondary prevention begins after the occurrence of symptoms to strengthen lines of resistance by establishing relevant goals and interventions to reduce the reaction. At the secondary prevention level, the nurse can help the community identify the stressors and begin interventions to correct the problem. Tertiary prevention can be initiated at any point after treatment when some degree of the system stability has occurred. Tertiary prevention is aimed at dealing with chronic health problems that have developed over time, for example the upward trend in chronic diseases such as diabetes. The three prevention strategies lead back toward primary prevention in a circular fashion (Neuman & Fawcett). Health promotion and its emphasis on primary prevention within the Neuman Systems Model becomes a specific goal for nursing action and makes the model useful in meeting the objectives of *Healthy People 2010*. Nursing's goal is to maintain client system stability by assessing and planning actions to assist individuals, families, and groups attain, retain, and maintain optimal client health (Neuman & Fawcett).

Consistent with the Neuman Systems Model, these beliefs direct the faith community nurse in planning nursing care. Health is defined not only as wellness, but also as wholeness of mind, body, and spirit. Solari-Twadell and McDermott (1999) and Westberg & McNamara (1990) described the philosophical basis of parish nursing as

encompassing the following five key elements: (1) The spiritual dimension is central to the practice; (2) The role balances nursing science and technology with service and spiritual care; (3) The nurse's client are members of the faith community defined by the church and its public service philosophy; (4) Parish nursing services are built upon principles of self-care and capacity building with a focus on understanding the connection between health and the individual's relationship with God, faith, traditions, nursing, and the broader society; and (5) The parish nurse understands that holistic health is a dynamic process that requires a connection between the person's spiritual, psychological, physical, and social dimensions.

Aligned with the Neuman Model, health promotion will be a specific goal of the proposed faith community nursing program, with interventions being implemented at the three levels of prevention as the program develops over time. Within the systems perspective, all strategies lead back toward primary prevention in a circular fashion. An aim of the faith community nursing program will be to initiate health promotion strategies to reduce stressors (present and future) and to strengthen the church members' (who make up the community) lines of defense. The health promotion efforts will also support secondary and tertiary goals to promote optimal well-being across the life span. Common to all three models of intervention are advocacy for the client, coordinating health resources, and providing information to maintain or regain system stability or balance (Neuman & Fawcett, 2002). These roles also reflect the role of the faith community nurse outlined by the ANA. Faith community nurses, as public health and community nurses, are appropriate individuals to lead these activities.

Neuman's model has also been used to guide nursing practice for community-as-client (Stanhope & Lancaster, 2004). Community-as-client often emphasizes health promotion and health maintenance. When the community is the focus of the services, the nurse and community form a partnership to achieve mutual goals. In this partnership, the professionals and the members actively participate in collaborative decision-making because they have vested interest in the success of the programs (Neuman & Fawcett, 2002). Assessment, diagnosis, planning, intervention, and evaluation at the Church of The Apostles will focus on the entire community or aggregates within it. It will be important to remember that the process is interactive and collaborative between the nurse and the community. In structures of the community, the core structures include physiological, psychological, socio-cultural, spiritual, and developmental (Neuman & Fawcett). For Christians, the spiritual component is at the center of one's faith journey. Neuman's support for wholeness and the recognition that spirituality is an important variable provides a framework that a faith community nurse can apply to practice. Understanding that the variables are interactive and interdependent supports the idea of community wholeness as the Neuman Systems Model proposes.

Program Development

PRECEDE-PROCEED Model Overview

The PRECEDE-PROCEED logic model (Green & Kreuter, 1999) was chosen as the framework to guide the construction of a long-term plan to develop a faith community nursing program (Appendix B). This model provides a comprehensive structure for assessing, health and quality-of-life needs, and for designing, implementing, and evaluating health promotion programs to meet those needs. PRECEDE (Predisposing, Reinforcing, and Enabling Constructs in Educational Diagnosis and Evaluation) outlines the diagnostic planning process to assist in the development of targeted and focused public health programs. PROCEED (Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development) guides the implementation and evaluation of the programs designed using PRECEDE. PRECEDE-PROCEED has nine phases. The first five are diagnostic, addressing both educational and environmental issues. These include: (1) social assessment; (2) epidemiological assessment; (3) behavioral and environmental assessment; (4) educational and ecological assessment; (5) administrative and policy assessment. The last four comprise implementation and evaluation of health promotion intervention and include: (6) implementation; (7) process evaluation; (8) impact evaluation; (9) outcome evaluation (Green & Kreuter).

PRECEDE consist of five groundwork phases. The first two phases of PRECEDE drive the needs assessment and are critical to the development of the goals and objectives. The last three phases examine factors such as health determinants, behavior and environment, and organizational issues that will help determine the desired outcome

for the community and decide on the interventions. Phase One involves determining the quality of life and social problems or needs of a given population, essentially defining the ultimate outcome. Phase Two consists of identifying the health determinants of these problems and needs. Phase Three involves analyzing the behavioral and environmental determinants of the health problems. In Phase Four, the factors that predispose to, reinforce, and enable the behaviors and lifestyles are identified. Phase Five involves ascertaining which health promotion, health education and/or policy-related interventions would best be suited to encouraging the desired changes in behaviors or environments. It also includes the factors that support those behaviors and environments. The comprehensive nature of PRECEDE allows for application in a variety of settings, particularly public and community health (Green & Kreuter).

PROCEED has four phases that give direction to and cover the actual implementation of the intervention and the evaluation of it. In Phase Six, the interventions identified in Phase Five are implemented. Phase Seven involves process evaluation of those interventions. Phase Eight entails evaluating the impact of the interventions on the factors supporting behavior, and on behavior itself. The Ninth and last phase comprises outcome evaluation, which involves determining the ultimate effects of the interventions on the health and quality of life of the population. The two parts of the model work in tandem to provide a continuous series of steps in planning, implementing, and evaluating the health promotion process of a community (Green & Kreuter). Green and Kreuter suggested that this model is unique in that it begins with active engagement of the target population in defining the desired final outcome and works backward, asking what

factors must precede that. The overriding principle in this approach to health education is that health behavior must be voluntary behavior.

Needs Assessment

A needs assessment in the traditional sense is a means by which to determine the gaps, needs, and wants relative to a defined population and to define a specific health problem (Issel, 2009). The initial question that needed to be answered was, "Is there need and/or interest to implement a faith community nursing program at the Church of The Apostles in Coventry, Rhode Island?" The purpose of assessing the faith community was to describe the attributes of the membership, learn its gifts and strengths, identify its health and spiritual needs, identify its health risk factors, and identify its needs and interests in health-related services and programs. The hope was to determine what specific interventions were needed, where, and with which target audience within the congregation. The needs assessment looked at some data in the wider community, but, the focus of the needs assessment was on the community members at the Church of The Apostles. The Rhode Island College IRB approved the proposal for the development of a faith community nursing program and the methodology to be used (Appendix C).

The Church of The Apostles in Coventry, Rhode Island is a suburban community that borders the town of West Warwick. West Warwick is the youngest town in the state of Rhode Island, incorporated in 1913. It is located in Kent County and is situated on the western bank of the Pawtuxet River. At one time West Warwick was an industrial center; however, after the collapse of the state's textile industry, it has fallen on hard times (Town of West Warwick). According to the United States Census Bureau (2006-2008),

the census designated place (CDP) has a total area of 8.1 square miles (0.2 is water). West Warwick consists of ten villages (Artic, Centerville, Clyde, Crompton, Jericho, Lippitt, Natick, Phenix, River Point, and Westcott) (Town of West Warwick). Coventry is the largest town in land area in Rhode Island, being surpassed in total area only by South Kingstown. The town of Coventry is bordered by Foster, Scituate, and Cranston to the north, by West Warwick to the east, by West Greenwich and East Greenwich to the south, and Sterling, Connecticut to the west. Coventry was incorporated in 1740. It is a rural town that has seen a significant population growth in the 20th century. Currently, there is a movement in the town to limit new homes in order to keep the rural flavor of the western part of the town, referred to as Western Coventry. Coventry consists of eight villages (Anthony, Greene, Harris, Hopkins Hollow, Quidnick, Rice City, Summit, and Washington) (Town of Coventry).

Prior to the initiation of this project, a pre-assessment was conducted. An informal telephone survey of 20 churches in Kent County and three large mainline churches in the greater Providence area was completed to determine if any other faith-based or parish nursing programs existed within the Christian culture of Rhode Island. This author identified herself as a graduate nursing student at Rhode Island College and described how she was interested in faith community nursing. Each of the parish administrators or church secretaries who answered the phone was asked if their church had a parish nurse program or a health ministry. Follow-up questions would have explored the range of services offered and who provided these services. The results from this survey indicated

that there was a lack of faith-based programs in the surrounding local community and, perhaps, in the State of Rhode Island.

In addition to the telephone survey, an informal, self-reported questionnaire was completed within the congregation in the fall of 2008 and prior to the start of this program development project. This preliminary survey was used to assess the communities' ideas for health-related services and health-related education, as well as to generate a sense of interest in the concept of a faith community nursing program. In this brief survey, the themes identified suggested an interest in education and services around the issues of nutrition, weight loss, exercise, chronic diseases (in particular, diabetes and arthritis), and support groups (caregivers, chronic disease, and nutrition and weight).

Consistent with the PRECEDE model the needs assessment is driven by the first five phases, but especially phases one and two. The five phases include: (1) social assessment, (2) epidemiological assessment, (3) behavioral and environmental assessment, (4) educational and ecological assessment, (5) administrative and policy assessment. Based on the assessment and diagnosis of Phase One and Phase Two, the goals and objectives were written and interventions developed.

Spradley and Allendar (1996) defined an assessment of a faith community as the "process of determining real or perceived needs and assets of the faith community" (pg. 86). They described four types of community assessments commonly used in faith communities: comprehensive assessment; familiarization; problem-oriented assessment; and community subsystem assessment. The comprehensive assessment seeks to discover pertinent information related to health including demographics of the faith community

and past surveys that were completed. Familiarization involves a review of data that is already available. This may include a "windshield survey", becoming familiar with community resources, reviewing budget documents of the congregation, and learning the responsibilities of current staff members of the congregation. The problem-oriented assessment is the most common type of assessment done by parish nurses. The most common method of assessment is a paper-and-pencil checklist. The fourth type of assessment is a subsystem assessment of assets and needs that focuses on a single constituency of the faith community such as the elderly (Spradley & Allendar).

Throughout the five phases of PRECEDE, representing the needs assessment, three of the above mentioned assessments will be completed. It is envisioned the community subsystem assessments will be completed in the near future.

Phase I: social assessment. The premise of the PRECEDE-PROCEED model suggests that *community member participation* is very important. Subjective assessment is the "yeast" for health promotion planning and offers a view through the eyes of the community members themselves (Green & Kreuter, 1999). Member's subjective assessment of quality of life shares with planners what matters to them and shows where health lies in the context of their lives. Health promotion seeks to promote healthful conditions that improve quality of life, as seen through the eyes of those affected, which in this assessment that represents the members at the Church of The Apostles. The first phase of the PRECEDE-PROCEED model focuses on what this community wants and needs, essentially defining the ultimate outcome. The ultimate value of this project will lie in its contribution to quality of life. The goal of this phase is to gain an understanding

of the social problems that affect the quality of life of the members and link them to specific health problems which will then become the focus of health promotion.

A key step in the beginning phase of the needs assessment was to define the community or population to be assessed, followed by making decisions about which data to collect. The “who” for this needs assessment was defined geographically, delineating the population of interest by site, the Church of The Apostles in Coventry, Rhode Island. The target population, or all potential participants, was the entire membership and visitors of the congregation.

This faith community is an organization of individuals, families, and groups who share common values, beliefs, and religious doctrines, and faith practices that guide their lives. Hickman (2006) suggested that the whole of the faith community is composed of the sum of the persons, environment, structures, values, and practices. This faith community is an Evangelical Anglican community. Evangelicals are committed to preaching and sharing the Gospel. They are Christians who worship in the Anglican tradition and their mission is “to obey, follow, and bear witness to Jesus Christ” (Church of The Apostles Constitution and Bylaws, 2010).

The social assessment phase started with the collection of demographic data about the members of the congregation. The current number of congregants at the Church of the Apostles is 261. The average weekly attendance from the three services is 200. The majority of the congregants attend the 9:30am Sunday service. There are 112 male and 149 female members of the congregation. A profile of the community showed that members ranged from 7 months to 97 years of age. Twenty percent of the congregation

represent individuals under the age of 18, 50% are between the ages of 19 and 64, and 32% are over the age of 65 (Church of The Apostles Annual Report, 2009). Rhode Island is one of eight states where persons 65 and older constitute 14% of the total population (Administration on Aging [AOA], 2009). This growing number of elderly will pose unique challenges to this nation, Rhode Island, communities, and congregations.

The process to determine what the members of the Church of The Apostles needed was carried out in partnership with the church community. Two data collection methods were used to discern subjective health needs and concerns, a health questionnaire (Appendix D) at the individual level and a focus group at the community level. Data collected included gathering basic demographic data; information to determine the health status or current health issues congregants were dealing with; and what type of health-related classes, programs, and/or services they were interested in. The needs assessment portion of the project was originally intended to be limited to qualitative data that sought to obtain attitudes and opinions from the members of the congregation related to health-related needs and health-related services through a focus group and community forum. This author believed that a health questionnaire would provide valuable information and some limited quantitative data; therefore, it was added as a strategy for gathering data and the original plan to hold a community forum was eliminated.

Next, data from the *health questionnaire* will be presented and as relevant in Phase 2 (epidemiological assessment). The health questionnaire asked the respondent to rate their current health status, indicate what health issues, past and current, and indicated what health-related programs and services that they would be interested in seeing offered at the

church. The questionnaire was adapted from Solari-Twadell & McDermott (1999) *Parish Health Ministry Survey*. The questionnaire reflects a wholistic perspective on health, including physical, emotional, social, and spiritual aspects. Questions number 6 (regarding exercise) and 14 (name) were eliminated from the original questionnaire. This problem-oriented assessment was a paper-and-pencil checklist. The problem-oriented assessment is the most common type used by faith community nurses (Spradley & Allendar, 1996). It was recognized that the use of this method typically yields a low rate of return. If the return rate is too low, a minority poll could dictate the results, and these may not determine the real needs of the whole (Solari-Twadell & McDermott, 1999). The Health and Wellness Ministry members reviewed and approved the questionnaire to be sure it reflected the information that was being sought. Questionnaires were made available at all services over the course of three weekends. Congregants were informed and encouraged to participate from the pulpit, during announcements, through the weekly church bulletin, and through *Church Notes*, a monthly publication. Participation was voluntary and the questionnaire didn't request any identifiable information. Anonymity and confidentiality were maintained.

Sixty seven individuals responded to the questionnaire, representing 33% of the average weekly attendance (200 congregants) including men, women, and children. A profile of the community showed participants ranged from under 20 to over 80 years of age. Of the members who responded, 72 % were female and 28% were male, 54% were married, 30% were single, and less than 2% were either widowed or divorced. Forty-two percent of the members were employed (either full or part time), 24% were retired, 27 %

were students, and less than 1% percent was planning retirement in the next five years and/or was homemakers. The first five questions on the 14-item questionnaire requested demographic information such as age, gender, marital status, employment status, and number of children and ages. The sixth question was a self-rating of health (excellent, good, fair, or poor). Of the members who responded, 31% (n=21) perceived themselves in excellent health, 46% (n=31) in good health, and 21% (n=14) in fair health, and one respondent believed themselves to be in poor health.

Question 9 addressed health promotion classes that members believe might enhance their emotional, physical, and spiritual health. Figure 1 shows how the participants responded. Participants may have indicated one or more areas of interest. Additional areas of interest included: men's health issues; breaking a habit; adolescent health issues; pre-retirement planning; and sexuality issues in the elderly, young adults, and middle age populations. Findings from the health questionnaire demonstrate that among the 67 members who responded, a significant number stated they needed health promotion activities that address health concerns using a wholistic perspective (physical, emotional, social, and spiritual). Results from the health questionnaire are posted on the Health and Wellness Ministry's bulletin board in the parish hall for members to view and will be printed in the Church's publication, *Church Notes* in May 2010.

Question 11 offered the opportunity to write in major health concerns that members were dealing with in the physical, emotional, or spiritual dimensions of health. The following are a list of these concerns: hereditary diseases; depression; stress; stress eating; ostomy care; Lyme disease; financial stress; employment stress; weight and

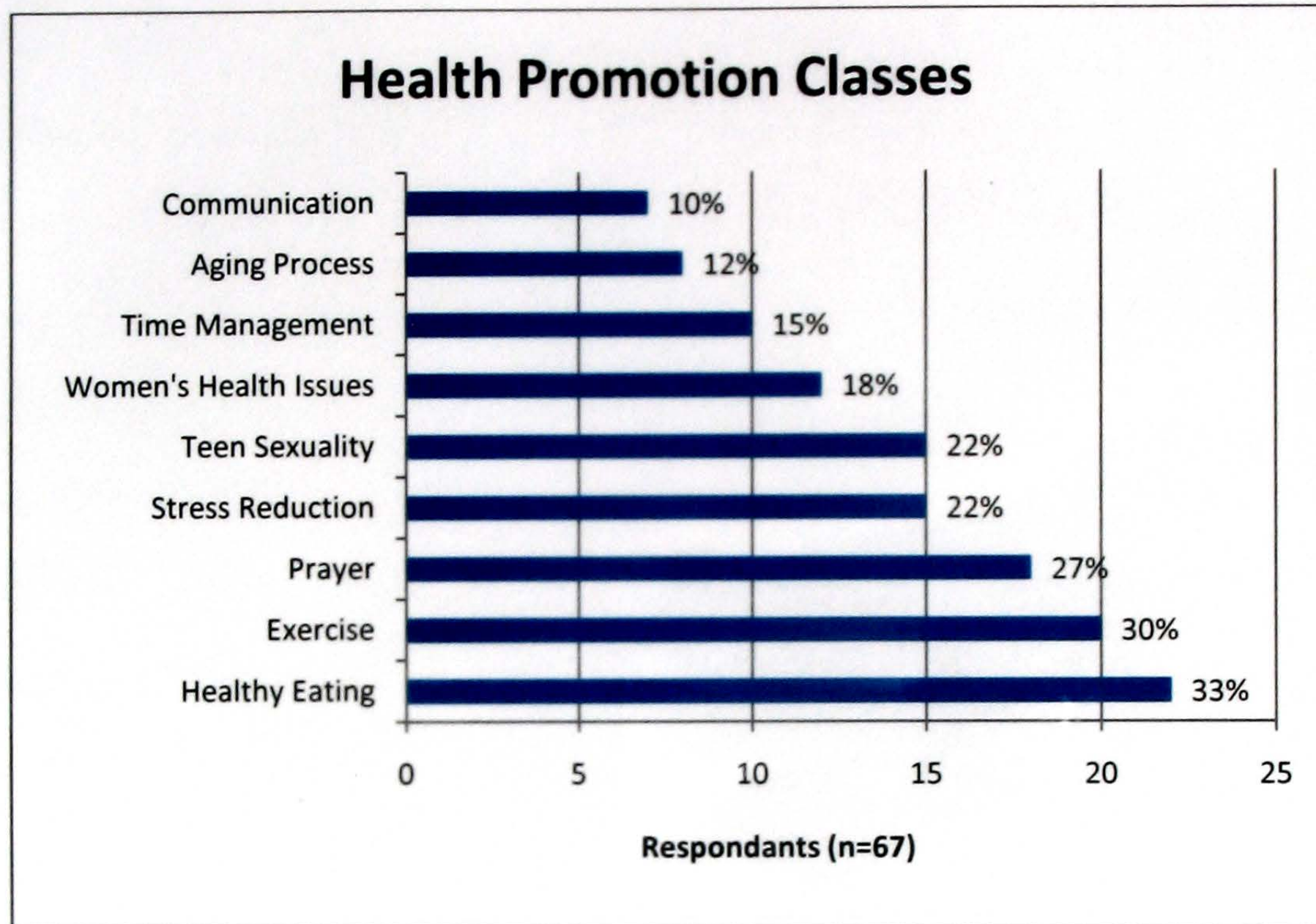


Figure 1. Reported interest in health promotion education and activities.

image; weight and mobility; macular degeneration; pulmonary and heart issues; irritable bowel; chronic pain; anxiety; celiac disease; spiritual (dedication to faith); and physical exercise/activity. Many of these areas of needs and concerns are consistent with the leading health indicators from *HealthyPeople 2010* including physical exercise, overweight and obesity, blood pressure, arthritis, mental health, tobacco and substance use, and responsible sexual behavior (US DOH). Rhode Island's (RI) plan of action entitled *Healthy Rhode Island 2010* adopted the Federal government's ten Leading Health Indicators and established targets for 27 objectives. This document encourages best practices and collaboration and was designed to help individuals and organizations

use the information to develop and implement interventions to improve the quality-of-life and eliminate health disparities for all Rhode Islanders (RI DOH).

A focus group methodology was used in order to better understand the members' attitudes, perceived needs, and barriers in meeting those needs regarding health-related issues and to confirm the data obtained from the health questionnaire. Focus groups are a way to listen to the voice of the client, in this case congregants.

The goal was to have members participate who were between the ages of 18-65 and 65 and older and represented subsets of members that included: parents with young children; parents with adolescents; young adults; single adults; middle-aged individuals; the "sandwich generation"; boomers; widows; the elderly; individuals with chronic disease; males and females; and health care professionals. Excluding minors, participants were selected by the chief pastor of the Church of The Apostles to reflect a representative sample of the congregation. The chief pastor presented names to this investigator that he believed were an accurate sample of the demographics of the congregation. The sample that was selected represented members from the three services offered at the church: Saturday 5pm; Sunday 8am; Sunday 9:30am.

Participation in the focus group was voluntary and by invitation. Twenty two invitations were sent out. Potential participants were mailed an Institutional Review Board (IRB) approved letter of invitation (Appendix E). At the time of invitation, the participants received general information about the session, what they would be asked to do, and that their responses would remain confidential. Potential participants were not given any specifics in order to ensure that responses would be on target, yet spontaneous.

The focus group was facilitated by this author, who is also a member of the congregation. See Appendix F for a script that the facilitator followed in the focus group session. The script questions were selected from a research study completed by the Amherst School of Nursing for a large church in Massachusetts on community assessment (Swinney et al., 2001). The questions to guide group discussion were refined by this author and reviewed by the Health & Wellness Ministry. The nature of the data that was collected included answers to open-ended questions. Since the discussions of the focus group were open-ended, the order of the questions varied. The focus group consisted of 10 members representing a sample makeup of the congregation. Due to the small sample size and the setting used for the focus group, the facilitator of the focus group opted to have two members of the Health and Wellness Ministry serve as recorders during the session; therefore, the session was not audio-taped. Both recorders were asked to take notes on all responses by participants. The records of the focus group were kept private and in a locked file, and access is limited to the facilitator of the focus group. Any publications of this project will not include information that will make it possible to identify participants. The transcripts do not have any identifiable information. The focus group allowed for qualitative data to be obtained in an interactive environment and members talked freely with others group members. All participants engaged in the discussion and due to the dynamics of this group, no one individual monopolized the conversation. Discussion brought insights and understanding in ways that the health questionnaire was not able to do.

The results of the focus group were analyzed by this author. The data derived from the two recorders were categorized by themes. The themes reflect a wholistic perspective: physical, emotional, spiritual, and social. The themes are displayed in Table 1. The results were shared with the Health and Wellness Ministry at its monthly meeting. The two recorders are current members of the Health and Wellness Ministry and were present at this meeting. The original notes taken by the two recorders both reflected similar response data for each of the questions asked. The members of this ministry were given a copy of the responses from the focus group and a copy of the themes organized in the table. The dialogue at that meeting clarified and confirmed the findings. The major disadvantage of a focus group approach (particularly if only one session is conducted as in this case) is that there is little generalizability that emerges from the session. The focus group results are posted on the Health and Wellness bulletin board in the parish hall for members to view and will be printed in the Church's publication, *Church Notes* in May 2010.

During group discussions participants of the focus group seemed eager to support the idea of wholistic care and spirituality in health care, and wanted to see how a nurse and a Health and Wellness Ministry would facilitate participation in improving the health of their faith community. During the session one member suggested that the church is an ideal setting to integrate faith and health. Another participant suggested that we "need to understand that these areas or issues (mind, body, and spirit) are all interrelated and can't be separated." "Supporting the spiritual component will be the key to this ministry," suggested one participant. A participant who is a social worker suggested that "we are

Table 1

Themes Generated in the Focus Group (n=10).

Physical	Emotional
Lifestyle change education and support	Support services for the elderly
Better understanding of chronic disease and prevention	Support services for adolescents and young adults
Exercise	Support for caregivers
Weight issues	Stress and stress management
Healthy eating	Education and support for depression
Health counseling and education	Sexuality across the life span
Spiritual	Social
Spiritual education and support	Feeling of connectedness and support/caring for one another
Connection between faith and prayer	Address the needs of the elderly in the congregation
Relationship between prayer and healing	Advocacy
Relationship between faith and health	Referrals
Healing versus cure	Support group for caregivers
Health and worship	Health resource library

a microcosm of the world or the society and that all of these issues (spousal or child abuse, excess alcohol use, abortion, etc) must be here, but we don't always know." One senior suggested that there is really no one to ask when they have "simple" questions regarding their health problems and/or medications. One member shared her experience related to being diagnosed with breast cancer. She expressed how she initially felt that no one else could understand what she was experiencing; however, she discovered that once she shared her story to another church member that she was then surrounded by support that gave her strength and peace. A member of the Health and Wellness Ministry felt that "the church needs to do its part promoting and maintain health of the faith community."

The social assessment was concluded with a *social diagnosis*. The comments of participants and the identified themes in the focus group affirmed the questionnaire results regarding health concerns and desired health-related education, programs, and services that are needed or that they would like to see provided. The identified health needs of this faith community are similar to the goals of *HealthyPeople 2010*. These goals include improving quality-of-life and access to preventive care and health promotion, and decreasing health disparities among citizens (US DHHS, 2000).

Based on the health questionnaire and focus group data, members of this faith community perceive themselves to be in good physical health. There is consensus that health and wellness need to be approached from a wholistic perspective, by integrating faith and health. Consistent with the questionnaire results, most focus group participants perceived themselves to be in good health. Participants affirmed that areas that are needed to help make and sustain healthy lifestyle changes are more likely to occur if all

components of wholistic health are addressed including physical, emotional, social, and spiritual. During discussion, focus group participants indicated that the presence of a faith community nurse and a Health and Wellness Ministry would help facilitate improved health and well-being of the faith community by creating a supportive environment.

Phase 2: epidemiological assessment. This phase of the needs assessment looked at member's health status. The primary task in this phase is to determine which health problems are most important for which group within the church community and pose the greatest threat to health and quality of life (Green & Kreuter, 2005).

A portion of the epidemiological assessment will present data from the health questionnaire relevant to this phase. The health questionnaire asked congregants to indicate their health status by marking a "P" for past or a "C" for current. Only one respondent used the suggested coding. Subsequently, the responses can not be separated into past or current health status and puts the responses in question. The impact of this is not significant as the responses reflect the health conditions that the congregants have dealt with in the past and/or what they are currently dealing with. The results suggested that the predominate conditions, past and/or present, included high blood pressure, heart disease, arthritis, depression, and cancer. The responses about existing health conditions revealed much diversity in responses. Predominate health conditions, past and/or current, are represented in Figure 2. Additional health conditions included muscular dystrophy, cerebral palsy, Lyme disease, anxiety, celiac, back problems, kidney disease,

neurofibromatosis, bladder problems, attention deficit hyperactivity disorder, and epilepsy.

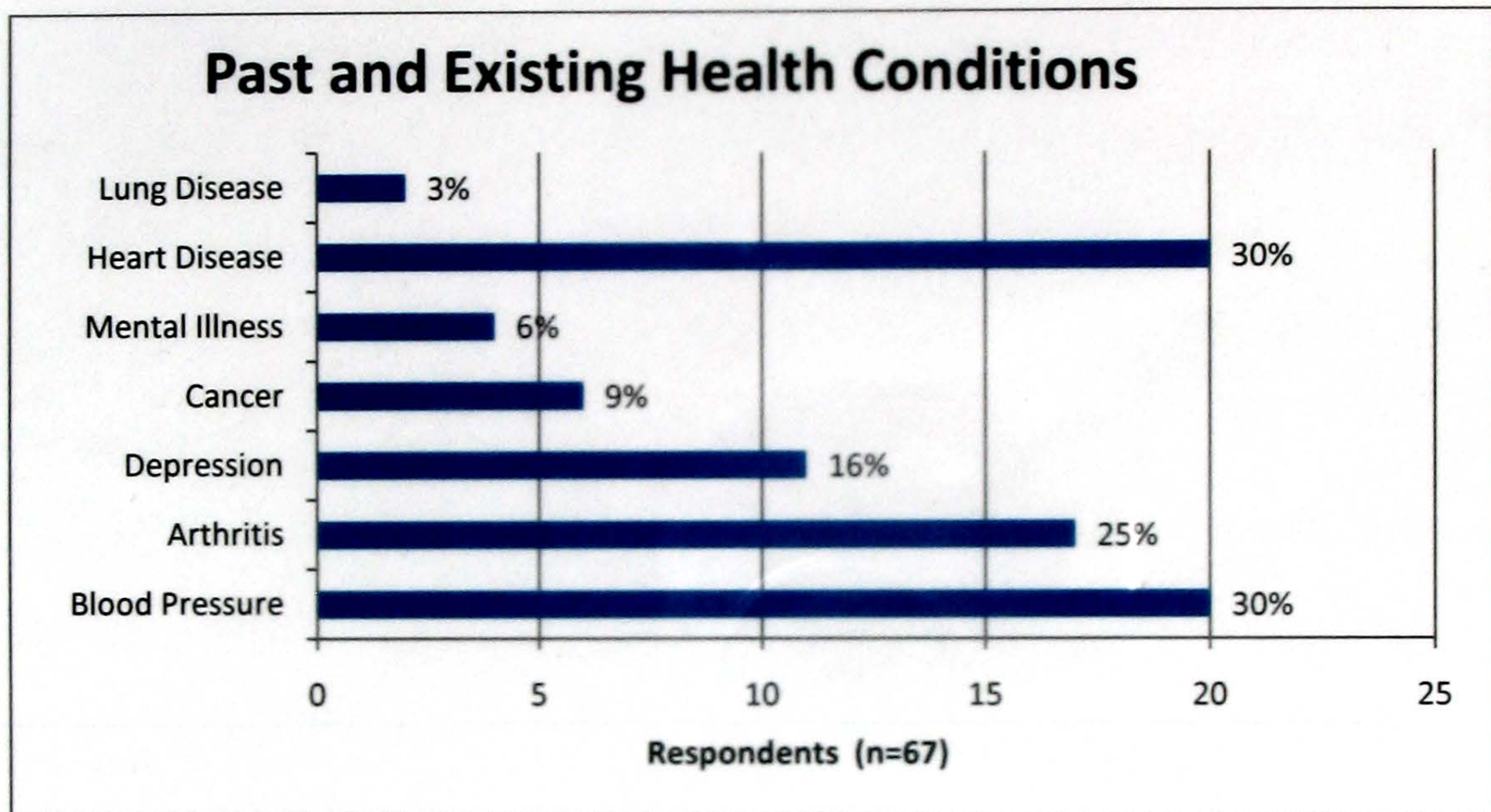


Figure 2. Past and/or current health conditions.

Six out of ten Americans (37 million) will be managing more than one chronic condition by the year 2030 (CDC). It is projected that almost half of the baby boomers will live with arthritis, 14 million will be living with diabetes, and more than one out of three will be obese. There occurrence are a substantial burden on the health and economic status of individuals, their families, and the nation as a whole (AOA, 2008). According to the CDC (2006), the burden of chronic disease such as heart disease and stroke, cancer, arthritis, and diabetes in Rhode Island are among the most prevalent, costly, and preventable of all health problems. In Rhode Island, 15.8% of individuals 50

years of age and older were indicated as having a lifetime diagnosis of depression. These chronic conditions affect the quality of life and contribute to disability and decline in independent living (CDC).

The greatest interest for potential support groups was for caregivers of aged relatives. Figure 3 represents respondents' interest areas in support groups. Areas identified for support groups are consistent with current health care issues and needs prominent in society. These interests span across the lifespan and reflect a need for a wholistic approach in providing faith community nursing services.

An epidemiological diagnosis suggests that while not all chronic diseases are life threatening, their occurrence present a substantial burden on the health and economic status of individuals, their families, and the nation as a whole. Quality of life is affected by changes in physical and psychological health, social relationships, level of independence, the environment, and personal beliefs (AOA, 2009). The faith community nurse is in a unique position of enabling members to become stewards of their own health at all levels.

Phase 3: behavioral and environmental assessment

This phase focuses on the systematic identification of health practices and other factors which seem to be linked to health problems. Most factors influencing the issues or outcomes can be classified as behavioral, lifestyle, or environmental (Green & Krueter, 1999). Because this program development project is not targeting a specific behavior, the assessment identified behavioral risk factors and conditions that will be

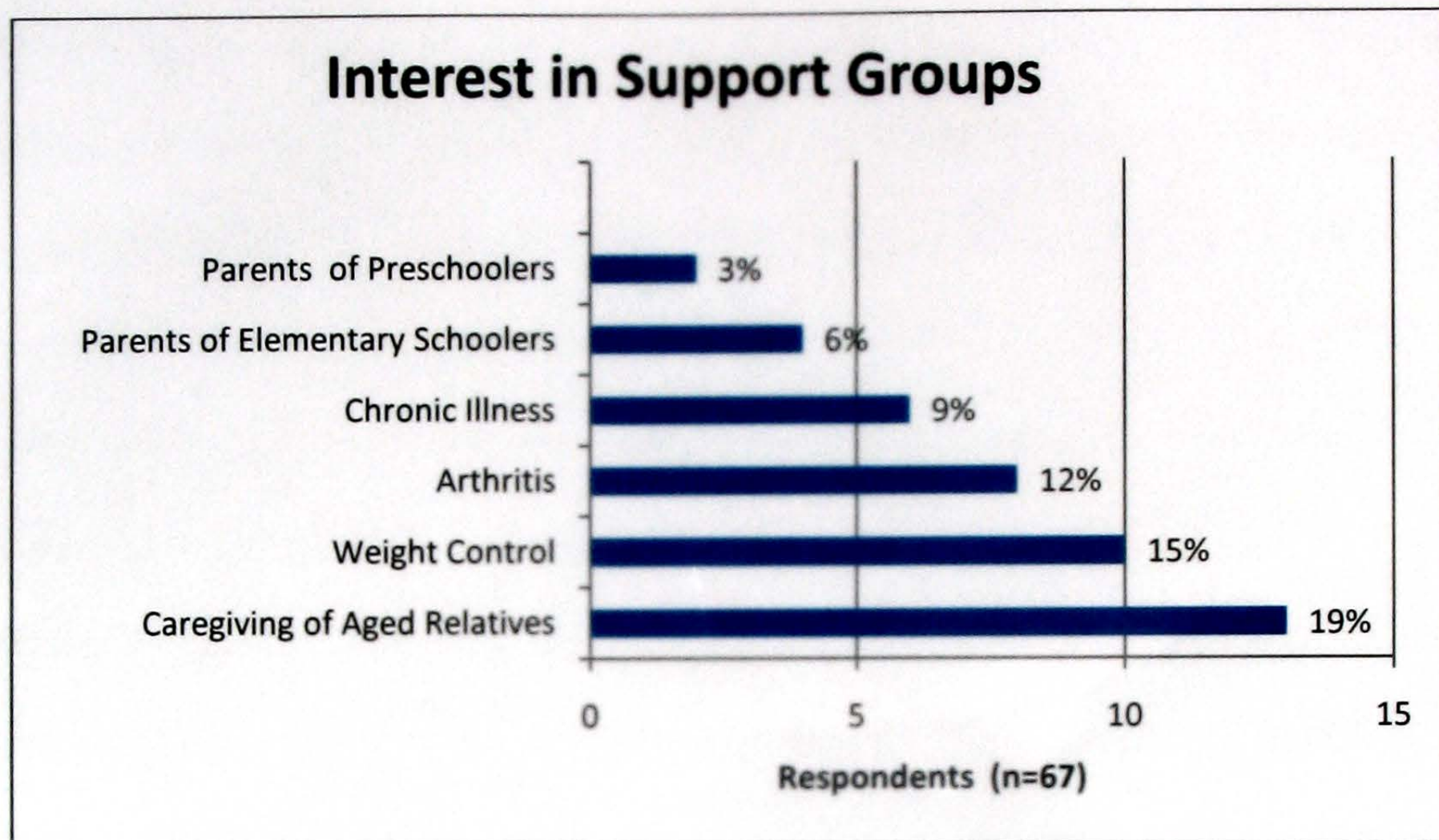


Figure 3. Interest in particular support groups.

targeted for potential health promotion programs. This information was derived from the results of the health questionnaire and focus group discussion and included an interest in management of high blood pressure, diet, overweight and obesity, chronic disease, lack of exercise, stress, prayer, depression, and sexual practices. Environment in regard to a particular issue or problem can refer to the physical, social, political, and economic environment. Social environment suggests influence of family and peers, community attitudes, values, and beliefs. The social environment at the Church of The Apostles represents membership ties, social support, and church culture. These determinants will have the greatest impact on influencing behavioral and lifestyle changes with the members of the congregation.

A behavioral and environmental diagnosis of the Church of The Apostles community would suggest that it provides a social network for its members, possesses a strong desire to engage in health and wellness activities, and creates an environment that assist members to strive for balance and wholism in their lives.

Phase 4: educational and ecological assessment (organizational). This phase examines the factors that influence behavior, lifestyle, and responses to environment and helps identify the factors that will create the behavior and environmental changes (Green & Kreuter, 2005). Green and Kreuter described three broad categories of factors that influence health behavior: predisposing, enabling, and reinforcing factors. Predisposing are pre-existing factors that “provide the rational or motivation for the behavior” (p. 39). Enabling factors are those pre-existing conditions that allow the behavior to occur. Reinforcing factors are those factors that follow a behavior that provide the “continuing reward or incentive for the persistence or repetition of the behavior” (p. 40).

Predisposing factors include intellectual and emotional factors such as knowledge, attitudes, beliefs, values, perceived needs and abilities, and confidence that tend to make individuals more or less likely to adopt healthful or risky behaviors and lifestyles. These factors also influence whether an individual or groups will approve of or accept particular environmental conditions (Green & Kreuter). Specific predisposing factors were not assessed in this needs assessment process; however, socio-demographic factors such as age, gender, and family size, general knowledge, attitudes, values, and beliefs about health related needs and concerns, and interests were gathered via the questionnaire and

focus group. The information obtained will serve as the rationale and motivation to provide interventions.

Enabling factors are the internal and external conditions directly related to the issues that help individuals, families, or groups adopt and maintain healthy or unhealthy behaviors or lifestyles. Among them are availability of resources, accessibility of resources, and community commitment to the issue (Green & Kreuter). Community and member services were the enabling factors identified in this needs assessment. An abbreviated "windshield survey" was completed in West Warwick, Coventry, and Kent County to assess extra-community services. The intra-community assessments looked at services within the church community.

Extra-community services are located outside the church community. Extra-community health facilities include a branch of the Rhode Island Department of Health and Human Services, two senior centers, three nursing homes, one adult day care, three home health agencies, one primary care health care center (Thunder Mist), two urgent care clinics, a school-based clinic located at West Warwick High School, one Career and Technical School, and a full selection of general medical and specialty care. Extra-community social services include public housing for the elderly and disabled (five facilities and a total of 445 units), two church-based soup kitchens, and one shelter. The Artic Mission serves as a link between faith communities and community residents in need of social services. One caregiver support group was identified within Coventry, located at the senior center. Additional health facilities in Kent County include Kent County Hospital and Kent County Mental Health. A full selection of general medical and

specialty care is available in Kent County, as well as additional services including pharmacies, laboratories, and a special facility to serve the physically or mentally disabled (Trudeau Center). In addition, social services include a full selection of counseling and support services, as well as groups and organizations that provide shelter, food, and basic welfare services. The recreation facilities within West Warwick and Coventry are sufficient. There is a bicycle/jogging trail that runs through portions of Coventry and West Warwick. This fitness path is currently undergoing expansion. There are six fitness centers, including one family fitness center within these two communities. Additional recreational facilities in Kent County abound. Two large city parks include a beach, ball fields, and picnic areas but are over five miles away. The major source of private transportation is the automobile and the major source of public transportation within Coventry and West Warwick and surrounding communities is the Rhode Island Public Transportation Authority (RIPTA).

Intra-community factors are services located inside the church community. The church offers three services, five o'clock on Saturday, eight and nine thirty on Sunday morning. This faith community has a plethora of ministries and activities to engage and serve individuals, families, and groups within the congregation and others that provide outreach within and outside of the church community. Most services provided are voluntary. Worship volunteers include lay readers, chalice bearer, acolytes, altar and flower guild. Congregants are greeted at the door by those who serve as ushers. Bible studies offered include Sunday Christian education for adults, Sunday evening worship and bible study, Precepts Bible study, basic Christianity Bible study, Joshua's men Bible

study, women's Bible study, Joyful women's Bible study, and the *Truth Project*, Children's Christian education classes are offered on Sunday mornings and include children's chapel and a nursery program. Other ministries offered for young members are youth group and a play group. Music ministries that lead the congregation in worship include the organist and instrumental group, hand bell choir, praise band, men's choir, and Sunday evening instrumentalists. Other ministries include intercessions prayer group, Angle Wings, CD ministry, Vacation Bible School, lay visitation, SOS ministry, Milk & Honey, Sheppard's Table, blood bank drive, food bank drive, Sunday brunch ministry, kitchen ministry, men's breakfast, Strengthening Marriages, knitters, building and grounds, office volunteers, and an outreach committee. The breadth of these offerings reflects church leadership and a church community that believes in supporting many ministries within and outside of the local church community. These ministries and services will be the force that enables a faith community nursing/Health and Wellness Ministry to be implemented and sustained within the church community.

Reinforcing factors are the people and community attitudes that support or make it difficult to adopt healthy behaviors or foster healthy environmental conditions (Green & Kreuter). This assessment examined the people and attitudes that foster a healthy environment, provide social support, and provide advice and feedback. The Church Council is the legal governing body of the Church of The Apostles and oversees both the temporal and pastoral work of the congregation. The Church Council consists of a chief pastor (overseer), elders, and deacons. This ministry is responsible for "guarding the unity, doctrine, discipline and worship of the congregation; setting administrative

policies; establishing and approving the annual budget; giving opportunities for all members and visitors; overseeing the outreach program; maintaining the Congregation's buildings and grounds; and developing and coordinating various ministries with the priesthood of believers within the Church of The Apostles" (Constitution and Bylaws of Church of The Apostles, 2010). According to Chief Pastor Galloway (personal communication, November 10, 2009), "just as Jesus called his followers to preach, teach, and heal, this governing body believes that the Church needs to play a leadership role in reclaiming Christ's ministry of healing in the world and to reclaim His voice and vision for healing of body, mind, spirit, and community." Galloway also believes that a faith community nurse and a Health and Wellness Ministry will compliment and help grow existing ministries, as well as offering the key connection between health and wholeness (mind, body, and spirit). Integrating spirituality and health has been the mission of faith communities for millennia, and it is important that the church find new ways to make that possible to all generations within changing societies.

The educational and organizational assessment was concluded with an *educational and organizational diagnosis*. The Church of The Apostles demonstrated availability of resources, accessibility of resources, and community commitment. There is a plethora of community and member services that will serve as enabling factors in the pursuit of healthy life styles and improving the quality of the congregant's lives. Social reinforcement is the strength of this congregation, and the leadership is committed to the success of the faith community nursing program under the umbrella of the Health & Wellness Ministry. There is a need to increase knowledge, help with the acquisition of

skills, and provide reinforcement of healthy lifestyles. This can be accomplished through education, promoting self-efficacy, empowering individuals, building self-confidence, influencing beliefs, values, and attitudes, providing motivation, and by sustaining a supportive environment.

Phase 5: administrative and policy assessment. This phase focuses on the administrative and organizational concerns and issues that might have an impact on one's actual intervention and which must be addressed prior to program implementation. These include assessment of resources, development of an implementation timetable, budget development and allocation, organization of personnel within programs, and coordination of the program with other ministries.

An *administrative assessment* was conducted. Currently, the Church of The Apostles employs one full-time pastor (Superintendent), a Christian Education Director, a Communications Officer, a Parish Administrator, an Organist and Music Director, a Pastoral Assistant (MSW, LICSW), a Maintenance Technician, and a Sexton. Additional leadership includes three Elders and four of Servants (deacons). Church staff (non-stipend) includes a Youth Pastor, a Sacristy Minister, a Health and Wellness Minister, a Treasurer, and a Clerk. This author has received administrative support from the church Communication Officer and the Parish Administrator in accessing the membership data base. Community involvement in the development and implementation of this program has been in a volunteer capacity. The Health and Wellness Ministry is currently represented by a variety of health care workers and a non-professional who have the knowledge, skills, willingness to implement health promotion programs and activities.

A timeline was developed and represents the sequence of events that were involved in planning and initiating this project (Appendix G). The timeline has served as a graphic representation of the activities necessary and their target dates in order to stay on schedule. When creating a budget, it was important to remember that it was for a ministry of the church, not for the funding of a faith community nurse. It is a church's ministry, not the ministry of an individual, so the church needed to decide how much it wanted to invest in this particular ministry. Appendix H represents a potential start-up budget for the faith community nursing program. The IPNRC's guide for creating and developing faith community nursing programs was used in the development of the budget (2009). Financial support, program structure, budget line items, financial responsibilities, funding sources, and budget maintenance was discussed with the chief pastor and the budget template was accepted. The Church of The Apostles has experienced a budget growth of 11% over the past year. The faith community program will be financed by a grant from the outreach ministry for the year 2010 and it is anticipated that the Church council, who has committed to supporting this ministry, will make it a line item on the 2011 budget.

A mini "walk-about" assessment of the Church of The Apostles, similar to a community windshield assessment, but on a smaller scale, was completed to collect data about the setting and structure of the congregational meeting place. The church is located on three acres and has plenty of open space for outside activities. The property is well maintained, the neighborhoods surrounding the church are clean and safe. The church is accessible by well-maintained side walks. The closest bus route is within one mile of the

church. The parking lot was recently resealed, and currently there are adequate parking spaces available to meet the needs of the congregation. There are seven handicap parking spots and the church is handicap accessible from both entrances, including a handicap ramp. There is one handicap accessible bathroom. The church structure can hold a capacity of 260 in the sanctuary and 175 in the parish hall. There are five classrooms and the capacity to create three additional rooms in the parish hall with petition dividers. The kitchen facilities are adequate and include a large, two oven and eight burner/griddle gas stove and three sink areas. There are four offices that are used by the staff, the pastor, head of Christian education, parish administrator and communication's officer, and the elders and deacons. Computers and printers, phones, and fax machines are available in the various offices. However, a lap-top computer will be requested to provide portability and assured confidentiality of data. Multiple bulletin boards exist that display information regarding various ministries and announcements. Several tables in the narthex provide information on upcoming events and current ministries, resources, and sign-up sheets for upcoming activities.

As with many organizations, space is a commodity. Due to the expanding nature of the ministries at the Church of The Apostles, space to accommodate an expanding faith community ministry may be a barrier. Currently the faith community nursing ministry has been given space for the storage of supplies and a locked file cabinet for maintaining confidential records, as well as access to a phone and a computer. The use of a beeper will be discussed with the church council in the near future. A private room for personal and/or health counseling is shared by many ministries.

An *administrative diagnosis* would suggest that there is adequate administrative support in quantity and quality at the Church of The Apostles to carry out a faith community nursing program. As evidenced in the "walk around" assessment, adequate space exists for most programs that would be implemented at the church. The faith community nursing program is being phased in to allow for a manageable and sustainable ministry. Incorporating a faith community nursing program into the ministries of the church community is financially feasible due to the volunteer nature of the ministry.

A *policy assessment* was conducted and at this time the Church of the Apostles has a very small ethnic population. Diversity is reflected in the distribution of age across church members. The church is experiencing a growth in the population of families with young children and the aging population. The congregation essentially reflects blue collar working class, and there are members on both ends of the socioeconomic spectrum. Many of the congregants live outside of the local geographic community. The faith community nursing program will compliment, overlap, and collaborate with the already existing ministries at the church. Currently, there is a paid social worker on staff and an Elder whose primary ministry is prayer. The addition of a nurse will bring a focus to the physical component of wholistic health and assist to integrate mind, body, and spirit.

Ethical issues for faith based nurses are outlined by the American Nurses Associations Code for Nurses along with the ethical principles that guide nursing behavior (ANA, 1998). Nursing interventions are also guided by statements of faith, polity, and doctrines of the Church of The Apostles. As a Christian, the nurse will also be guided by virtue ethics, such as caring, compassion, and forgiveness. The nurse and members of the

Health and Wellness Ministry will protect the rights to confidentiality regarding health-related information of members. Although the nurse may need to share information with the state agency and church leadership in certain circumstances, the nurse may only share confidential information with church leaders, church staff, or prayer groups with the member's permission. Awareness of professional accountability will be essential to the integrity of the faith community nursing ministry. Communication, responsible behavior, respect, and appropriate documentation and reporting will all be essential if ongoing support for this ministry is to develop. Accountability of the nurse will be to church leadership and demonstrated to the congregation through the Health and Wellness Ministry. The faith community nurse's activities will be included in the church's annual reports. As a licensed professional, this author is accountable to a licensing body to conduct behavior in a manner consistent with the standards of the profession. Insurance is another dimension of accountability. The nurse will carry malpractice insurance; however, the church's insurance will need to be informed of the planned health ministry activities to ensure coverage in the church's policy. Liability issues around lawsuits may arise. It has been important that the leadership understand that the role of the nurse or qualified lay person is to bridge the gap between systems of care and the congregational members rather than to provide invasive procedures.

Potential barriers may surface around the use of language and the role of the faith-based nurse. It is important that the leadership understand the concept of faith community nursing, the model chosen to develop the program, and the role of the nurse, as well as the Health and Wellness Ministry. There can be some negative effects from a

nurse practicing in his/her own congregation. Sometimes the line between acting as the nurse or as a member may become blurred. It will be important for the nurse to recognize this and develop healthy boundaries. At present, there has been no discussion regarding a job description for the nurse. Conflicts may surface if there is no job description.

Sample job descriptions will be brought to the leadership for review with the suggestion that a job description will serve to clarify the role and eliminate assumptions by members of the congregation and staff as to what the nurse will or will not do. It may also serve as a tool for evaluation to determine the success of the program and the effectiveness of the nurse functioning in that role.

A *policy diagnosis* would suggest that the faith community nursing program fits within the church organization and can be positioned for success and sustainability within the church community. The mission statement of the Health and Wellness Ministry is in alignment with the mission of the Church of The Apostles and will compliment existing ministries. For all players, the partnership (leadership and members), funding, communication, and accountability are imperative for the overall success of the faith community nursing program.

Vision, Values, Mission Statement, and Philosophy Statements

Strategic program planning for a faith community nursing program has given direction to the development of a vision statement, values, a mission statement, philosophy statements, and goals and objectives. This process has led to the setting of realistic and attainable, yet challenging goals, to help ensure goal achievement. The vision statement reflects what this author envisions the faith community nursing program will represent or

reflect in the future. The mission statement was influenced by the adopted philosophy. The vision for the Church of The Apostles is to provide wholistic care to the members within the congregation by promoting wellness and healthy lifestyles through community health education programs and services; providing quality faith community nursing ministry to all members of the congregation and selected members of the wider community; creating an environment that integrates faith and health; developing creative solutions to challenging health issues facing members of the congregation; and working in partnership with other leading health care organizations. It is hoped that the accomplishment of these will then enhance the quality of life of the members of the congregation.

The Health & Wellness Ministry's guiding values include care, compassion, dignity, respect, quality, integrity, healing, prayer, forgiveness, faith, innovation, and teaching. The mission statement of the Health and Wellness Ministry at the Church of The Apostles is "to promote positive lifestyles by supporting members of the congregation in caring for their spiritual, physical, emotional, and social needs."

A philosophy is a particular set of beliefs about the nature of something, in this case, faith community nursing. This philosophy describes what faith community nursing is and identifies meaning, important elements, and development of this concept (Solari-Twadell & McDermott, 1999). The International Parish Nurse Resource Center (IPNRC) (2009) has developed a philosophy statement about faith community nursing that has been adopted by the faith community nurse and the Health & Wellness Ministry at the Church of The Apostles. This ministry will initially use these identified beliefs which are

reflected in the following statements but plans to develop their own philosophy as the ministry evolves:

The faith community role reclaims the historical roots of health and healing found in many religious traditions. Faith community nurses live out the early work of deacons and deaconesses, church nurses, monks and nuns, traditional healers, and the nursing profession itself. The spiritual dimension is central to faith community nursing practice. Personal spiritual formation is essential for the faith community nurse. The practice holds that all persons are sacred and must be treated with respect and dignity. Compelled by these beliefs the faith community nurse serves and advocates with compassion, mercy, and justice. The faith community nurse assists and support individuals, families, and communities in becoming more active partners in the stewardship of personal and communal health resources. The faith community nurse understands health to be a dynamic process which embodies the spiritual, psychological, physical, and social dimension of the person. Spiritual health is central to well-being and influences a person's entire being. A sense of well-being can exist in the presence of disease, and healing can exist in the absence of cure. The focus of practice is faith community and its ministry, and the faith community nurse, in collaboration with the pastoral staff and congregational members, participates in ongoing transformation of the faith community into a source of health and healing. Through partnerships with other community health resources, parish nursing fosters new and creative responses to health concerns (p.3-4).

Goals and Objectives

After the completion of the needs assessment and analysis of the data, the Neuman Systems Theory delineates a three-step process model that includes making a diagnosis, setting goals (appropriate prevention and intervention strategies), and evaluation of nursing outcomes and reformulation of nursing goals if necessary. It is at this stage in program development that the faith community nurse links the client, environment, health, and nursing.

The overall goal of this project was to develop and identify an implementation plan for a faith community nursing program. In doing so, this author hoped to understand how the relationship between faith community nursing/health ministries and faith members influences the physical, emotional, and spiritual aspects of members' lives. The overall outcome of this project is to connect with faith members through community involvement and provide social support to the members, as well as serve as an educator, counselor, resource person, referral agent, advocate, and prayer partner.

The goals reflect components of the mission statement and will address the expressed needs of the congregation at Church of The Apostles. The objectives and interventions, as Neuman suggests, address the three levels of interventions and reflect the actions for achieving the mission statement, philosophy, and goals. From phase I (social assessment) and phase II (epidemiological assessment), program goals, objectives, and intervention activities were created (Table 2).

Due to the nature of this program development project, the goals and objectives focus on the activities of the staff implementing and sustaining the health program, rather than

Table 2 Goals, Objectives, and Intervention Activities

Component	Goal	Objective	Intervention Activities
Physical	Encourage healthy lifestyles and encourages preventive practices	Provide physical health and wellness activities	Congregational-wide wellness initiative Healthy Eating Workshop Walking Program Monthly health promotion and education on health-related topics
Emotional and Social	Empower individuals within the congregation; build a responsive church community that recognizes and addresses the need of others; build healthy relationships	Support emotional and social health and well-being	Health counseling by faith community nurse through established office hours Develop and implement a caregivers support group
Spiritual	Interweave the spiritual component of wholistic health with physical and emotional aspects of health	Stress the importance of spirituality	Spiritual wellness “weekend” Provide a series on spiritual wellness <i>(Giving God 1st Place)</i>

on the benefits of the program for the participants. The two overarching goals of the faith community nursing/ Health and Wellness Ministry include: to help individuals of all ages live a healthy life and improve their quality of life; and to help individuals, families, and groups to see health from a wholistic perspective (physical, spiritual, emotional/mental, and social). As Neuman suggested (Neuman & Fawcett, 2002), the client (members) are a composite of variables (physiological, psychological, socio-cultural, development, and spiritual), each of which is a subpart of all parts and forms the whole of the client. Thus, the goals and objectives were written from a wholistic perspective to reflect the interrelatedness of the variables and to emphasize the need for dynamic balance that the faith community nurse can provide through problem identification and goals setting. The importance to members, changeability, necessity, feasibility, and the ability to make an impact on the member's health and wellbeing were considered in the development of the goals, objectives, and intervention activities.

Plan for Implementation

Brudenell (2003) suggested that faith communities form nursing programs or health ministries in a developmental process. She described four phases of the process as preliminary thinking about faith community nursing, knowing the faith community, being accepted as part of the congregations' ministry, and becoming an ongoing ministry. The Church members of the Apostles have thought about how a faith community nursing program would fit into the congregation's mission and have decided to support this program as reflected in the needs assessment. The chief pastor and the leadership of the church are committed to the implementation of this health promotion ministry. The goal

is to complete the last two phases suggested by Brudenell (2003) by gaining acceptance as an essential ministry within the congregation and by becoming an effective conduit for community connections and advocacy.

The proposed faith community nursing program will represent a congregational model. It will be an independent, stand-alone faith community nursing program. The nurse will be autonomous and considered a staff member at the church in a non-stipendiary position. The development of the program will arise from the Church of The Apostles and the nurse will be accountable to the congregation and its governing body. However, there will be no contractual relationship with the church.

Health and Wellness Ministry. The faith community nursing program at the Church of the Apostles will develop through the expansion of a Health and Wellness Ministry. The Health and Wellness Ministry will serve as an umbrella group, which promotes the healing ministry in the church. It will have a comprehensive view of what is already going on in terms of health such as visiting the sick, educating, socializing during the coffee hour and brunch, helping families work through periods of great stress, and worshipping on Sunday morning. The faith community nurse will form a Health and Wellness committee and this ministry will consist of eight to twelve individuals from within the congregation who have an interest in health promotion and who recognize the relationship between faith and health, and who understand that the Christian perspective of health includes mind, body, and spirit. If possible, the Health and Wellness Ministry will include several nurses, a social worker, school teachers, a doctor, and other and interested individuals. The nurse will chair the committee and the chief pastor at Church

of The Apostles will be an important ex-officio member of the health and wellness ministry and will be present at the meetings. It is envisioned that the Health and Wellness Ministry will serve as the catalyst in encouraging individual members and groups to be involved and in making them aware of the importance of healing. The Health and Wellness Ministry will provide leadership in bringing about change and setting up programs. However, it is envisioned that their responsibility will not be to carry off the entire ministry, but to enable it throughout the church community. The Health and Wellness Ministry will act as a source of influence in the life of the church community to ensure that the stewardship of health is expressed in worship, education, and networks of support and recreation. Through the Ministry's influence promotion of healthy behavior and provision of strong support to individuals who are not well can be actualized. The Health and Wellness Ministry will play an important role in bridging the gap between the segments of individual's lives by focusing on totality and caring for the whole person. Envisioned responsibilities of the faith community nurse and/or the Health and Wellness Ministry (as outlined in the goals and objectives) may include the following: assessing the needs in the congregation on an on-going basis; educating the congregational membership about the concept of holistic health care and health promotion; communicating with the congregation regarding health promotion and health education activities, as well as reporting to the church leadership; leading health promotion, health education/training within their expertise: disease prevention and case-management for the senior population; bring in crisis intervention, lay pastoral care, social events, social justice issues, health and worship, and resources. The Ministry

could potentially play a role in developing opportunities that include inviting neighborhood churches to participate in programs and activities; and assisting with health fairs and seminars.

The implementation strategy that will be used for the faith community nursing program is referred to as "phased- in" (McKenzie & Smelter, 1997, p. 209). Phasing in the program will protect the nurse and Health and Wellness Ministry (planners and facilitators) from getting in over their heads and it will allow for more control over the program. The program will be phased in, targeting needs within the congregation identified from the needs assessment. Promoting visibility of the faith community nursing program began, in part, with the needs assessment process. A health questionnaire and a focus group were part of this process. A second way that has been used initially, to create visibility, is the providing of weekly blood pressure screening during coffee hour following the main service (Sunday 9:30am) and monthly following additional services (Saturday 5pm and Sunday 8 am). Additional strategies used to promote the concept of a faith community nurse have included articles in the church's monthly publication (*Church Notes*), inserts in the weekly Sunday bulletin (topics such as H1N1), availability of health-related literature, a workshop on the aging process (lead by this author), and providing a seminar on wholistic health and finding balance in life (physical aspect led by this author).

Kick-off Event. The Health and Wellness Ministry has been vital in planning the kick-off event for project called, "*Get My People Going: An Invitation to Wholeness.*" This event is an eight week congregational-wide initiative that invites members of the

congregation to take a healthy lifestyle challenge with others. The invitations encourages members to identify small changes in their lifestyle which would help them be healthier and choose three areas that they would like to work on, set three personal goals, and find a partner to journey with. The program is based on the Exodus story and invites everyone in the congregation to seek wholeness in all areas of their lives. It is designed for all ages and for people of every health condition. Two weeks prior to the kick-off event an introduction letter will be sent out in the monthly *Church Notes* announcing and briefly explaining the event. Also, two weeks prior to the sign-up date, a brief note will be written in the announcement section of the bulletin and a member of the Health and Wellness Ministry made an announcement at each of the three services explaining the program and generating excitement. A large bulletin board will be created to display the weekly themes for the event in the parish hall.

For each of the eight weeks of the journey an event will be planned that corresponded with the theme of the week. The eight themes included: healthier lifestyles; good nutrition; exercise; water; prayer; relationships/friendships; prayer/spirituality; and rest and sleep. Individuals were asked to provide their e-mail address at the time of sign-ups in order to receive a weekly message of encouragement. A weekly insert will be placed in the church bulletin with information on the theme for the week to help encourage participants on their journey. Handouts with additional information will be made available on the Health and Wellness Ministry table in the Narthex each week. At the end of the first and second month a newsletter article will be published in the *Church*

Notes that provides information about the themes and further resources that could be accessed on-line.

Program Evaluation

Process evaluation suggests finding out if the program has all its parts, if the parts are functional and operating as they are supposed to be operating. It also can be referred to as implementation evaluation (Issel, 2009). Process evaluation is used to help create infrastructure that supports the process functions (McKenzie & Smeltzer, 1997). The goal of evaluation was to determine the program's effectiveness and to improve it. For the purpose of this project, the process evaluation focused on the administrative objectives and timeline. Due to the retrospective nature of this evaluation "implementation evaluation" is a better descriptor of the type of evaluation actually completed and will continue to be ongoing throughout the implementation phase of the program. Possible measures of process evaluation during implementation may include attendance, participation and feedback, observation, appropriateness of intervention activities (Issel, 2009), and feedback from the church leadership.

One of the first steps in initiating a faith community nursing program within the congregation was engaging in discussion with the chief pastor. The pastor endorsed the program and took part in the initial planning stages. He agreed that a demographic and health questionnaire and focus group would be effective tools for a needs assessment and concurred that a community forum was probably not necessary given the data obtained from the other two forms of assessment. This congregation actively seeks out opportunities within the church community and to the wider community, as evidenced by

the significant amount of ministries offered, in order to improve the health of individuals. They have embraced the faith community nursing program as a ministry that will help fulfill their mission.

In February of 2010, the Church Council unanimously endorsed the selection by the chief pastor of this author to be the Health and Wellness Minister of the Church of The Apostles. This ministry is currently being funded by a grant from the outreach ministry and it is anticipated that the ministry will be a line item on the annual budget February of 2011. Administrative and clerical support from the Communication Officer and the Parish Administrator has been given throughout the process. Storage space of supplies and a locked file cabinet for maintaining confidential records has been provided. Now that the church has chosen to support the faith community nursing program, a method of collecting data reflecting the work of the staff will be investigated in order to support the longevity of the program, the budget, nursing outcomes, and the achievement of the vision and mission statements. The key players must continue to be educated on the potential breadth of the program and the benefits to the church and wider community.

The Health and Wellness Ministry's first meeting was on September 30, 2009 and has continued to meet on a monthly basis since that time. The Health and Wellness Ministry has been invaluable in the development of this program and will be an essential component to maintaining and sustaining a quality faith community nursing program. Attendance at the monthly meeting has been excellent and the process has been invigorating through teamwork, brainstorming, and collaboration.

In order to determine the needs of the congregation on an ongoing basis, future problem-oriented and community subsystem assessments will be done by the faith community nurse. The results from the health questionnaire and the focus group will be shared with the members of the congregation. Results have been displayed on the Health and Wellness Ministry's bulletin board in the parish hall. Sharing the results with the faith community may encourage better participation in future surveys if the members understand that their input is important. As a member of the congregation, this author already had established relationships within the congregation, a key component of a faith community nursing ministry, as it is a ministry accomplished through relationships.

As of January 1st, 74 individuals had signed up for the program, *Get My People Going*. At the conclusion of the eight weeks, each participant was asked to complete a final survey that will help members of the Health and Wellness Ministry determine if the program was helpful and in what ways (Appendix I). Results from this survey are still being collected at this time. Participant's feedback suggested that they were encouraged by the weekly emails. A follow-up letter was sent out to participants at the end of the program reviewing the themes and providing information on how to continue on this journey. It is anticipated for future health promotion activities and programs that a process measure will be completed by participants to determine their effectiveness and worth.

Impact evaluation assesses the overall effectiveness of a program in producing favorable attitudes, knowledge, skills, and/or health status. It also indicates immediate effects, such as a change in behavior or an increase in knowledge (McKenzie & Smeltzer,

1997). Impact evaluations for the faith community nursing program will be done at the conclusion of each health promotion or educational activity offered at the church, as well as a process measure that seeks feedback from participants. This tool will be developed by the Health and Wellness Ministry. If there is an ongoing intervention, such as a support group, evaluations will be done at least annually to seek feedback from participants. The first impact evaluation will be done at the completion of the kick-off program, "*Get My People Going*" in the form of a survey, as stated in process evaluation.

Outcome evaluation determines whether the program met the stated long-term goals and objectives (McKenzie & Smeltzer, 1997). The goals of this ministry are to: encourage healthy lifestyles and encourage preventive practices; empower individuals within the congregation; build a responsive church community that recognizes and addresses the needs of others; build healthy relationships; and interweave the spiritual component of wholistic health with physical and emotional aspects of health. It is beyond the scope of this project to complete outcome evaluation. Initial plans for outcome evaluation include measurement of pre-post changes in two subjective measures, one related to self-reported health status and the other self-reported quality of life on an annual basis. The self-report of health question would be (Compared to other persons your age, would you say that your health is: Excellent, good, fair, poor?); this measure of health status has established reliability and validity in the literature. The self-rated quality of life question will be (Thinking about what is important to you, how would you rate your quality of life overall: Excellent, very good, fair, poor?) (CDC, Health-Related Quality Of Life [HRQOL]).

The process of evaluating a program or activity begins with the initial program planning. The purpose of evaluating this program is to improve it and to determine its effectiveness (McKenzie & Smeltzer, 1997). The evaluation process took place before and during program implementation and will continue after the implementation of this program in order to assist in sound decisions regarding the worth and effectiveness of the health promotion programs offered at the Church of The Apostles.

Summary and Conclusions

The overall goal of this project was to identify and develop an implementation plan for a faith community nursing program at the Church of The Apostles in Coventry, Rhode Island. In doing so, this author hoped to understand how the relationship between faith community nursing/health ministries and faith members influences the physical, emotional, and spiritual aspects of members' lives. Faith community nursing is an independent practice of professional nursing that focuses on health promotion within the context of the faith community's values, beliefs, and practices. A needs assessment was completed in order to determine what health promotion intervention activities were needed. A health questionnaire and focus group were two approaches used to complete the needs assessment.

The faith community nurse should not shoulder the sole responsibility for promoting a program or proving the need for the Health and Wellness Ministry presence. The promotion and integration of this ministry lies in the collective efforts of leadership, congregants, and the Health and Wellness Ministry. Partnerships and collaboration with the Health and Wellness Ministry, the pastor and church leadership, and community connections will be essential to sustaining this ministry and avoiding burnout. Communication and visibility will also be crucial for the maintenance and survival of the faith community nursing program. Staying in view at church events, in the newsletter, and during services will help the faith community remember and consider the program when health needs arise. By making the Health and Wellness Ministry a program for and

of the membership, it will be embraced by the entire faith community as a necessity rather than a one-time event/project.

The Church of The Apostles is faith community that creates an atmosphere that is hope filled. It welcomes the unfamiliar, lives fully, nurtures its members, cares for others, questions, readily shares of self, exemplifies a sense of community, and welcomes challenges graciously. This faith community understands and identifies with members' personal struggles related to physical, emotional, spiritual, and social health and is committed to supporting the implementation of a Health and Wellness Ministry and establishing the role of a faith community nurse. Having church leadership and a church community that creates a supportive environment for the nurse and the congregants was a key factor in the development of this project. Leadership that recognizes the interconnectedness between spirituality and health, the importance of wholistic health, the sharing of the same values and beliefs, and commitment to providing the resources necessary was invaluable. This congregation has the necessary support systems and resources to implement a health promotion program and influence the quality of member's lives.

Limitations in the development of the project are acknowledged. Participation in the health questionnaire was lower than hoped for (33%), but it is believed that the results can be generalized to the congregation. Initially, the Health and Wellness Ministry was comprised of health care professionals, with the exception of one member. Though it is important for all members of the ministry to have a strong knowledge in health, increasing the non-professionals involved in the ministry will help provide different

perspectives, and they may be more in touch with non-professional wants and needs. Following the kick-off event, an open invitation was made to the members of the congregation for participation in the Health and Wellness Ministry.

In conclusion, faith community nursing is a community-based nursing practice model that gives nurses the opportunity to address the physical, emotional, cultural, and spiritual needs of faith communities. Neuman Systems Model supports this form of nursing practice as evidenced by a wholistic approach to care, the use of the nursing process, and interventions aimed at the three levels of prevention. The major focus of the nursing process is to maintain client system stability by accurately assessing stressors and needs and assisting the client with adjustment and maintaining optimal well-being by implementing appropriate interventions. Although faith community nursing shares many qualities with other areas of nursing, the congregational context for care creates a distinctive set of experiences that impact both the client (congregant) and the nurse. Health promotion and faith communities can complement each other. Health promotion can serve to remind faith communities of their health and healing missions, whereas faith communities can remind health promotion of the importance of including the spiritual component, resulting in a wholistic health practice.

Recommendations and Implications for Advanced Practice Nursing

Most of us already know how we can become healthier. We live in the age of self-help. Talk shows, books, magazines galore tell us how to deal with stress, deal with our anger, exercise more, eat less, improve our sex lives, slow aging, and lower our cholesterol. The problem is that we fail to have the commitment for the long term. In general, most people have the best results sticking with a course of action when they are part of a group or a community. We need each other to encourage us, to celebrate with us when we succeed, and to support and uplift us when we having trouble staying on course. When we serve others, most of us are helped in our own struggle. People with strong faith who suffer from physical illness have significantly better health outcomes than less religious people (McNamara, 2006). A lot of this may have to do with faith communities offering a mental health component. A faith community offers a group of people to support us and a community that encourages a healthy lifestyle. Faith communities also emphasize the spiritual component, something few other communities can. Healthy faith communities help us find purpose, meaning, hope, gratitude, and reverence, all things that have a profound affect upon our health.

Ivanov and Blue (2008) suggested that the health of the citizens of the United States is dependent on nurses who have knowledge, skills, and abilities to deliver health care services effectively. Advanced practice nurses (APNs) have the knowledge and skills to carry out and operationalize the three public health core functions, assessment, policy development, and assurance through the ten essential public health services (Joel, 2004). The core public health function of assessment includes activities that involve the

collecting, analyzing, and disseminating of information on both the health and health-related aspects of a community or a specific population. Policy development is both a core function of public health and a core intervention strategy used by public health nursing specialists. Policy development in the public arena seeks to build constituencies that can help bring about change in public policy. The third core public health function, assurance, focuses on the responsibility of public health agencies to ensure that activities have been appropriately carried out to meet public health goals and plans (Ivanoc & Blue, 2008).

Hemstrom, Ambrose, Donahue, Glick, Lai, and Preechawong (2005) used a selected set of examples of student graduate work to illustrate the utility and comprehensive scope of community health nursing. The study illustrated how clinical specialist in community health nursing addressed health problems in populations and communities in ways that were different from and complementary to strategies used by practitioners of individualized patient care. One example of the program development project included parish nursing. There are opportunities for APNs in public health and community leadership in the faith community setting. From a nursing perspective, serving as a faith-based nurse provides the opportunity to integrate one's faith and one's profession in a community health setting. Faith community nursing, with an emphasis on health promotion and spiritual care, is one way of bringing the services of nurses to the community (Solari-Twadell & McDermott, 1999). Chase-Ziolek and Gruca (2000) suggested that partnership is an important concept in community health, and particularly important for nurses when working in innovative community settings such as

congregations. From a public health perspective, congregations can be effective partners to reach some underserved populations as they gather to worship and serve. Public health nurses have an integral role in helping people increase quality of life. The functions of a faith-based nurse as a health educator, group facilitator, counselor, client advocate, and liaison to community resources are complementary to the population-focused practice of community-oriented clinical nurse specialist (CNS) activities and can positively affect client/congregants outcomes (Pravecek, 2005).

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Appendix A

The Neuman Systems Model (Nursing Theoretical Framework)

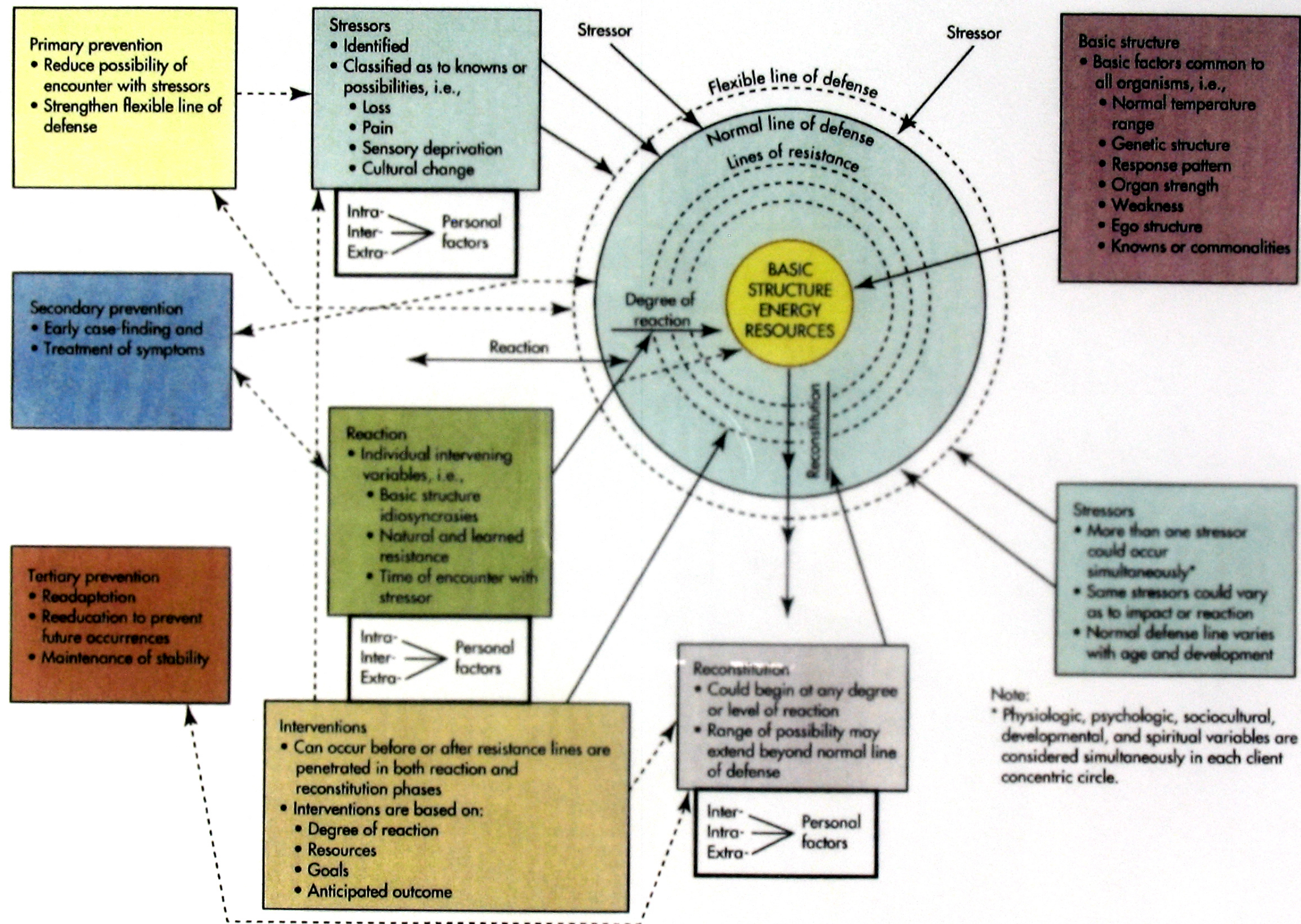


Figure 1. The Neuman Systems Model. (Copyright 1970, Betty Newman.)

Appendix B

The PRECED-PROCEED Model of Community Health Promotion and Evaluation

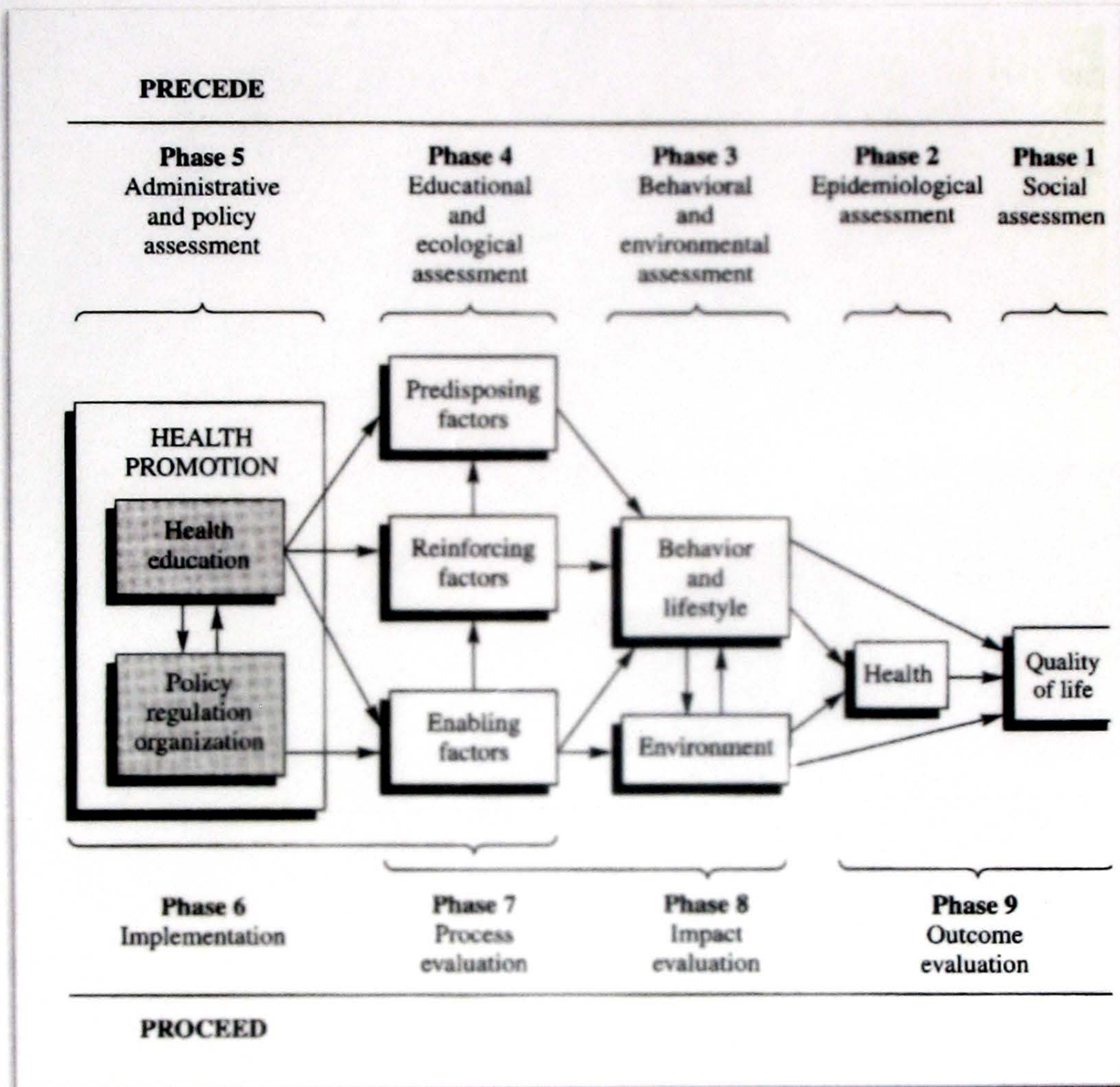


Figure 2. PRECEDE-PROCEED Model (Copyright 1999, Green & Kreuter.)

Appendix C

IRB Approval Letter

Please note that the following email serves as your official notification of approval from the Rhode Island College Committee on Human Participants in Research (CHPR). Please print out this notice for your records.

Rhode Island College
Committee on Human Participants in Research
NOTICE OF APPROVAL

Responsible Investigator:
Submitted By: Sharon Galloway

CHPR Protocol #248
Title: Faith Community Nursing

Approval Date: 2009-11-04
Continuing Review Deadline: 2010-09-05
Expiration Date: 2010-11-04

The Committee on Human Participants in Research (CHPR) has APPROVED the above Full Review protocol through the Expedited Review process. Please review your protocol submission page at the following URL for any additional Committee comments:

http://www.ric.edu/orga/chpr/dept_grants_form.php?targetTable=grants_full_reviews&id=248

As an investigator of human subjects, your responsibilities also include the following:

1. Report all adverse events and unanticipated problems involving human subjects to the Office of Research and Grants Administration (ORGA) within three (3) days of your knowledge of the occurrence and submit an adverse events form.
2. Submit a complete Continuing Review/Close-out form by 2010-09-05 and/or when the study has been completed.
3. Discontinue all work pertaining to this protocol if a continuing review approval is not finalized by the expiration date, 2010-11-04.
4. Submit all proposed changes to the protocol through the addendum process and receive approval from the CHPR before implementation of the changes.
5. Keep all research data and consent documents in your possession for at least three (3) years after the completion of the research activities.

For further questions, please contact:

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Thank you.

Submissions may be reviewed at http://www.ric.edu/orga/chpr/dept_grants.php

Appendix D
Health Questionnaire

To help plan for health ministry in our faith community, your assistance in answering the following questions is important. There is no need to sign your name. All information is confidential and will be used for planning programs in this church.

Put an X by the correct answer.

1. **Age:** Under 20 21-29 30-39 40-49 50-59 60-69 70-79 80+

2. **Gender:** Male Female

3. **Martial Status:** Single Married Divorced/Separated Widowed

4. **Employment Status:** Yes No Full-time Part time Retired Homemaker

Student

Planning retirement within 5 years

5. **Children:** Yes No **Ages of Children** _____

6. **How do you rate your health?** Excellent Good Fair Poor

7. **Health Status: Please check if you have or have had any of the following conditions.**

Place a "C" by any current conditions and a "P" by those conditions you have had.

Heart disease
 High blood pressure
 Arthritis
 Diabetes
 Depression

Lung disease
 Cancer
 Mental illness
 Chronic disability
 Other _____

8. **Support groups can be developed to meet the interests of the greatest number of people. Please indicate if you would participate in any of the following.**

Diabetes
 Weight control
 parents of preschoolers
 Single parents
 Living with chronic illness/disability
 Families of person with mental health problems

Arthritis
 Caregiving to aged relatives
 Parents of elementary schoolers
 Unemployed/underemployed
 Caregiving to chronically ill/disabled
 Other _____

9. The following are health promotion classes that may enhance your emotional, physical, and spiritual health. Classes will be developed to meet the interests of the greatest number of people. Please indicate if you participate in any of the following. You may mark as many as you would participate in on a regular basis.

- | | |
|---|---|
| <input type="checkbox"/> Healthy eating | <input type="checkbox"/> Prayer |
| <input type="checkbox"/> Aging process | <input type="checkbox"/> Stress reduction |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Time management |
| <input type="checkbox"/> "Break a habit" | <input type="checkbox"/> Communicating skills |
| <input type="checkbox"/> Women's health issues | <input type="checkbox"/> Preretirement planning |
| <input type="checkbox"/> Adolescent health issues | <input type="checkbox"/> Men's health issues |

Sexuality:

- | | |
|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Teen | <input type="checkbox"/> Young adult |
| <input type="checkbox"/> Middle age | <input type="checkbox"/> Elderly |

10. What day of the week and time would you be willing to attend a class or group?

- Monday Tuesday Wednesday Thursday Friday Saturday Sunday
- Morning Afternoon Evening

11. What is(are) your major health concerns(s)? This includes physical, emotional, and spiritual.

12. If you have experience in any health topic and would be willing to teach or share your experience, please put your name and telephone number on the provided index card and place it in the box labeled "Health & Wellness Ministry" in the narthex.

Thank you for taking the time to complete this survey.

Adopted from Solari-Twadell & McDermott (1999)

Appendix E

Focus Group IRB Approved Letter of Invitation

Letter Inviting Focus Group Participation

Dear _____,

I would like to invite you to attend a focus group at the Church of The Apostles to aid in the development of a faith community nursing program. As one dimension of developing a faith community nursing program at the Church of The Apostles, I will be facilitating a focus group to gather input around health-related issues. My goal is to gather a representative sample of our Congregation to discuss these issues in order to determine what health-related services and health-related education you would like to see implemented at the church. Your input is valuable in helping create a program that reflects the needs of our Congregation across the life span.

Participation in this focus group is voluntary. It is my intention to audio tape the session, however, upon transcription you will not be identified and your input will remain anonymous. Information obtained will only be available to me and the members of the Rhode Island College nursing faculty helping me implement this ministry in the life of our Congregation. The health and wellness ministry committee members will review the data after transcription is complete and all identifiable information is removed. The information will serve to help me and the health and wellness committee determine health-related priorities and create interventions for future health education and health promotion programs at the Church of The Apostles.

Please do consider joining me for this session on _____, 2009 at _____. If you would like to participate, please respond to Sharon Galloway by calling (401) 524-5971 or email me at galloways@warwickschools.org. Please respond by _____, 2009

Thanks you in advance for your support, as the Church of The Apostles seeks to make "Healthy people in healthy communities," our church.

I am, sincerely yours in Christ,

Sharon Galloway, RN, MED

Approved For Use
Date 11/3/09 - 11/2/10
RIC Committee on Human
Participants in Research

Appendix F

Focus Group Script

The following questions were used to guide group discussions:

1. What are some of the things about your health or your family's health that concern you at this time? (What is your greatest concern about your health?)
2. When you are not feeling well, who do you usually talk to?
3. Do you believe the church has a role to play in helping to meet the health needs of church members? In your opinion, how important is this?
4. What types of services would you like to see the church and parish nurse work to establish to help you better meet your health needs?
5. Do you know someone in the church community who may be having trouble obtaining health care when they need it?
6. The church wants to do their part in helping to promote and maintain the health of people in its faith community. Is there a problem with excess alcohol use in our community? What about drug abuse? Spousal abuse? Child abuse?
7. Is there anything about your health that you would be interested in learning?
8. How do you think this church might help you and others members to be healthy?
9. What might you be able to contribute to the health ministry in this congregation

Appendix G
Implementation Timetable

Implementation Timetable for the Development of Faith Community Nursing Program

Tasks	A 09	S	O	N	D	J 10	F	M	A	M	J	J	A	S
Develop background and purpose	X													
Rough draft of literature review	X													
Submission program development proposal	X													
Submit proposal to RIC IRB for approval			X											
Meet with stakeholders (Church Council)	X	X												
Begin needs assessment		X												
Formulation of a health and wellness ministry		X												
Creation of a mission statement		X												
Health questionnaire				X										
Focus group				X										
Completion of needs assessment							X							

Implementation Timetable for the Development of a Faith Community Nursing Program

(continued)

Tasks	A 09	S	O	N	D	J 10	F	M	A	M	J	J	A	S
Creation of goals, objectives, and intervention activities							X							
Process evaluation (ongoing)		X	X	X	X	X	X	X						
Kick-off event						X	X							
Secure funding and resources						X								
Grant proposal									X					
Health fair												X	X	X

Appendix H
Program Budget

Program Budget for the Faith Community Nursing Program

<u>Category</u>	<u>Funds</u>
*Basic FCN education (one time expenses)	\$2,000.00
Continuing education	\$700.00
Reference books	\$400.00
Health promotion/education supplies	\$500.00
*Locked file cabinet	\$250.00
*Locked supply cabinet	\$350.00
*Lap top computer	\$1,400.00
*Portable Printer	\$600.00
*Data software	\$350.00
*Cell Phone/beeper	\$350.00
Office supplies	\$100.00
Stationary, postage, and printing	\$100.00
Liability insurance	\$120.00
*Medical equipment	\$500.00
Professional membership fees (HMA)	\$250.00
<u>Purchased services (speakers/programs)</u>	<u>\$400.00</u>
Total cost	\$8,370.00
Annual cost	\$2,480.00
* Represents initial start-up expenses	

Appendix I
“Get My People Going”
Program Survey

Survey - Get My People GOING!!

Please take a moment to complete the following survey, which will help us know if this program was helpful to you.

1. What is your age group? (Check one) Under 21 _____
 21-39 _____ 40-49 _____ 50-59 _____ 60-69 _____ 70+ _____
2. Which three areas did you focus on?
 - ✓ _____ I needed to exercise more.
 - ✓ _____ I needed to drink more water.
 - ✓ _____ I needed to stop smoking.
 - ✓ _____ I needed to eat more fruits and vegetables.
 - ✓ _____ I needed to lose some weight.
 - ✓ _____ I needed to get more sleep.
 - ✓ _____ I needed to spend more time with friends.
 - ✓ _____ I needed more purpose in life.
 - ✓ _____ I needed to deepen my spiritual life.
 - ✓ _____ Other: _____
3. Did you make positive changes in all three areas? _____
4. Did you make positive changes in two areas? _____
 If so, which two? _____ and _____
5. Did you make positive changes in one area? _____
 If so, which one? _____
6. Did you lose weight? _____
7. Did you reduce your blood pressure? _____
8. Was it helpful to check in with a buddy? _____
9. Did you learn anything from the materials? _____
10. Would you like the congregation to sponsor another wellness program? _____

Comments: