Faith Community Nursing:

CE 2.5 contact hours

SUPPORTING Healthy People 2020 INITIATIVES

By Maria Pappas-Rogich and Michalene King

ABSTRACT: *One innovative community-based setting to promote health is the faith community, where care is provided by a faith community nurse (FCN). This descriptive study describes the practice of FCNs, FCN functions and standards, identifies* Healthy People 2020 *Leading Health Indicators being addressed by FCNs, and explores how the FCN model of community-based practice can support implementation of* Healthy People 2020.

KEY WORDS: *faith community nursing, health promotion,* Healthy People 2020, *nursing functions, standards of practice*

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Early healthcare was centered in religious institutions, with physical and spiritual needs addressed simultaneously. Florence Nightingale (1860) strongly emphasized the need for nursing to honor the psychological and spiritual aspects of patients to promote health. But as scientific knowledge increased, healthcare in the 19th and 20th centuries became more concerned with curing illness, and nurses provided medically prescribed treatments. Care for the patient's spirit and soul became less important, and the church's historical focus on health and healing was relegated to hospitals and healthcare organizations.

Today nurses are again intertwining the promotion of health into religious institutions. One innovative community-based practice setting is the faith community, where care is provided by a faith community nurse (FCN). Faith community practice wholly integrates body, mind, and spirit, offering a promising mechanism for promoting the health, healing, and wellness of individuals, families, and communities.

SPECIALTY PRACTICE

The primary focus of faith community nursing is intentional care of the spirit, differentiating this specialty practice from the general practice of the registered nurse. The FCN understands health to be a dynamic process that embodies spiritual, psychological, physical, and social dimensions of the person. FCNs serve in multiple faith traditions (Christian, Jewish, Muslim, Hindu, etc.) (American Nurses Association [ANA] & Health Ministries Association [HMA], 2012). The practice of faith community nursing in all faith traditions is consistent with the basic assumptions that we care for self and others as an expression of God's love.

Faith community nursing challenges the profession to reclaim the spiritual dimension of care, challenges the healthcare system to provide whole person care, and challenges the faith community to restore its healing mission. This specialty practice holds that all persons are sacred and must be treated with respect and dignity. Compelled by these beliefs, the FCN serves, advocating with compassion, mercy, and justice. The FCN assists and supports individuals, families, and communities in becoming more active partners in the stewardship of

personal and communal health resources. He or she works to integrate faith and healing, focusing on the promotion of health within the context of the values, beliefs, and practices of the faith community and providing compassion, respect, and presence—the core of good healthcare (ANA & HMA, 2012).

One classic model describing FCN practice is the seven functions of health educator, personal health counselor, referral advisor, health advocate, integrator of faith and health, developer of support groups, and volunteer coordinator (Patterson, 2003; Westberg, 1990). As a member of the health ministry team, the FCN emphasizes the spiritual dimension, while incorporating physical, emotional, and social aspects of nursing with individuals, families, and faith communities (Gustafson, 2008).

INFLUENCING CHANGE

From a socioecological perspective, churches can influence individual behaviors at multiple levels. The existence of social networks and social support through churches provides a context for health promotion programming. Health interventions that incorporate spiritual and cultural contextualization are effective to create change.

Evidence indicates that church-based programs have produced significant impacts on a variety of health behaviors, particularly in the areas of nutrition and physical activity (Dandridge, 2014). Health messages may be perceived as more important and have a more lasting effect on individual behavioral change by making the link between healthy behavior and taking care of God's child. Health messages often are shared with extended family members because churches are family oriented.

A crucial FCN role is to provide health teaching and health promotion appropriate for the faith community and individuals' spiritual beliefs and practices. The FCN encourages healthy lifestyles, provides support and encouragement, and intervenes before health problems become acute or require hospitalization or rehospitalization (Harris, 2011). In a wholistic approach to health promotion, the mind, body, and spirit are intertwined, as every human experience has mind-body-spirit components. A primary FCN practice objective is to touch the entire congregation with information, knowledge, and skills that will help raise awareness of the relationship between health and spiritual well-being. Spiritual care is an important function, lending support in times of joy and sorrow, in health and illness, from birth to death, and in times of stress. Presence is used as a powerful intervention in spiritual care. Combining prayer and other contemplative or spiritual practices is a healing modality frequently offered by and expected from parish nurses (Gustafson, 2008, p. 1038).

In addition to participating in group and population activities, the FCN meets regularly with the pastoral staff and coordinates with other community leaders. Together, they identify individuals who may require further assessment or support; become aware of issues that need to be clarified, supported, or addressed; and identify individuals, groups, or issues that have not yet become a part of the congregational wellness program. Home visits, phone calls, and visits to hospitals or community agencies are part of many FCNs' weekly activities. Agendas might include advocacy and interpreting through a healthcare provider, monitoring the progress of dementia, supporting a new mother, leading a support group, and providing compassionate touch, prayer, and visualization (Gustafson, 2008).

HEALTHY PEOPLE 2020

Healthy People is a U.S. government initiative aimed at improving the health of the nation. The program has released national goals and objectives every 10 years since *Healthy People 1990* (HealthyPeople.gov, 2014a). The *Healthy People* initiative was designed to serve as a roadmap for improving health. The vision, mission, and overarching goals provide structure and guidance for achieving health objectives, offering specific, important areas

of emphasis where action must be taken if people are to achieve better health. It includes national health promotion and disease prevention goals, objectives, and leading health indicators that serve as a model to develop goals and objectives to improve the health of a community. Quality of life encompasses more than activities of daily living, health status, disease categories, or functional ability "because it directs attention to the more complete social, psychological and spiritual being" (HealthyPeople.gov, 2014b). *Healthy People 2020* identifies 12 leading health indicators with accompanying health challenges that highlight individual behaviors, physical and social environmental factors, and important health system issues (HealthyPeople.gov, 2014c).

New initiatives in *Healthy People 2020* include adolescent health; blood disorders and blood safety; dementias, including Alzheimer's disease; early and middle childhood; genomics; global health; health-related quality of life and well-being; healthcare-associated infections; lesbian, gay, bisexual, and transgender health; older adults; preparedness; sleep health; and social determinants of health (U.S. Department of Health & Human Services, 2010). The graphic framework of *Healthy People 2020* in Figure 1 illustrates the overlap among social determinants of health (physical environment, social environment, individual behavior, health services, biology, genetics), one while emphasizing the collective impact of the determinants on health outcomes.

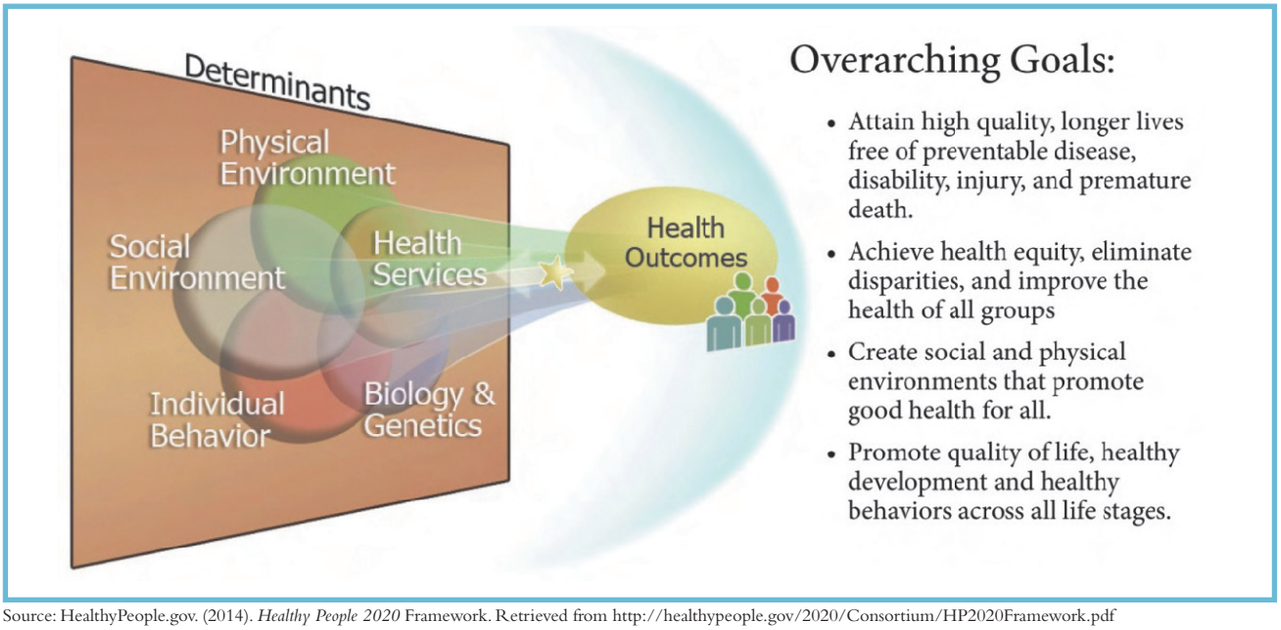
Collaborating with existing and developing community health services is an objective of *Healthy People 2020* (2014b). Many of the benefits of church-based health programs stem from their presence and credibility with individuals and neighborhoods. Some of these benefits include trust within the neighborhood, integrated personal relationships within the community, experience directly serving those in need, commitment and desire to help those in need, and established leadership within the community—all useful in implementing *Healthy People* initiatives.

Although FCNs are poised to perform activities to meet *Healthy People* goals, only two studies were identified that discussed parish/faith community nursing and *Healthy People*. Weis, Matheus, and Schank (1997) examined parish nursing as an evolving model of care within faith communities. This descriptive retrospective study of 11 parish nurses used data collected from monthly reports for a period of one year, and from interviews of the parish nurses. Findings revealed the parish nurses identified the following *Healthy People 2000* objectives in their practice: "blood pressure knowledge and control, overweight prevalence & weight loss practices, vigorous physical activity, breast self-examination and mammogram, home fire safety, stress management, reduction of heart disease and stroke, reduction of child abuse, and maintenance of Activities of Daily Living" (p. 370).

King and Pappas-Rogich (2011) explored *Healthy People 2010* health indicators implemented by FCNs while working with elderly clients. Results of their study indicated that FCNs who partner with community health services developed to address *Healthy People 2010* initiatives, may provide more seamless and efficient services to the elders in the community.

Church-based health promotion can reach broad populations and have great potential for reducing health disparities, a major objective of *Healthy People 2020* (2014b). Tuck and Wallace (2000) found that parish nursing is an established method for healthcare

Figure 1: *Healthy People 2020:* A Society in Which All People Live Long, Healthy Lives.



Source: HealthyPeople.gov. (2014). *Healthy People 2020* Framework. Retrieved from http://healthypeople.gov/2020/Consortium/HP2020Framework.pdf

delivery well received by the community. Parish nursing was seen as an alternative approach for providing care in the community to a variety of clients (e.g., age, sex, health, or illness problems), and frequently provided continuity of care in a disjointed health delivery system. The researchers also found FCN practice offers the opportunity to blend physical, social, emotional, and spiritual life into one caregiving experience.

FCNs are ideal to advance *Healthy People 2020* nationwide. However, knowledge about ways FCNs are implementing *Healthy People* initiatives is minimal. Further research is needed on this topic to better understand how FCNs can help enact *Healthy People* objectives.

DO FCNs PROMOTE *HEALTHY PEOPLE?*

A descriptive study was designed to identify how often FCNs use the seven classic functions and *Faith Community Nursing Scope and Standards of Practice*, and how often FCNs implement *Healthy People 2020* Health Indicators in their practice. The research question posed was: "Does the FCN model of community-based practice support implementation of strategies to address health indicators set forth by *Healthy People 2020* and FCN functions and standards?"

The authors previously developed the "Parish Nurse Questionnaire," which contained demographic information about parish nurses, congregations served, and services offered by the parish nurse. The "Parish Nurse Questionnaire" was developed using *Healthy People 2010* Leading Health Indicators, the seven functions of the parish nurse, and the *Scope and Standards of Practice for Faith Community Nurses* (ANA & HMA, 2012; Healthy-People.gov, 2010; Patterson, 2003). The survey was sent to four expert parish nurses to establish face validity, completed by a national sample of 118 parish nurses, and subsequently modified based on results and feedback. No psychometric testing was performed on the instrument, as the sample was not adequate to conduct that evaluation.

A revised survey was developed for this study, the "Faith Community Nurse Questionnaire," to include terminology recommended by nurses working in faith communities and to reflect *Healthy People 2020* health indicators. The questionnaire can be found online as supplemental digital content (SDC) at http://links.lww.com/NCF-JCN/A35.

Following approval by the Duquesne University Institutional Review Board, the survey was placed on the internet site Survey Monkey. An informational flyer describing the research project and information about accessing the survey was sent to four organizations that support FCNs. Three were national/international and the fourth was a hospital-based program for parish nurses/health ministers that maintains a national list serve. Of the four organizations, only the International Parish Nurse Resource Center (IPNRC) placed this message on their website for the data collection period of three months.

After seeing the study message on the IPNRC website, FCNs were instructed to go to the Survey Monkey website to participate. Once they clicked on the survey, the first page contained an explanation of the survey, purpose of the study, information requested of participants, and a statement that choosing to participate implied informed consent. The Survey Monkey package contained security software so that no survey results could be linked to a particular computer or FCN, ensuring anonymity. Survey results were tabulated using basic statistical functions found in Survey Monkey; all data including text responses were downloaded and analyzed by both authors.

FCN PRACTICE IN NORTH AMERICA

Two hundred and forty-seven (N = 247) FCNs completed the survey. Participants were 26 to 80 years of age; 85% were between 51 and 71 years, and primarily Caucasian (95%) and female (97%). Years of FCN practice ranged from 1 to 21 with a mean of 15 years. The majority (92%) had received formal FCN education such as the IPNRC *Foundations in Faith Community Nursing* curriculum or a college course. There were more volunteer (68%) than paid FCNs, and 58% worked 10 or fewer hours per week. The most common nursing degree was a BSN (38%). Sixty-nine percent based their practice on a needs assessment, which is recommended by FCN educational programs. Respondents were not asked whether they implemented a formal (i.e., Patterson, 2003, p. 119), or more informal needs assessment for planning programs and services.

A crucial FCN role is to provide health teaching and health promotion appropriate for the faith community and individuals' spiritual beliefs and practices.

The FCNs practiced in 38 U.S. states and Canada (n = 2); three practiced in two states. Twenty-seven (27) faith denominations were represented; the top three were Catholic (23%), Lutheran (19%), and Methodist (15%). The congregation size most represented was churches with more than 150 members (80%) and a weekly attendance of more than 150 (63%). The predominant racial/ethnic church group was Caucasian (79%), and the age most often served was 65 years and

Table 1: Faith Community Nurses Implementation of the Seven Functions of FCN Practice

Function	% of FCNs Implementing Function In Their Practice*				
	Weekly	Monthly	Yearly	Never	Other-Explain
Offer Health Counseling	44.9	29.8	6.2	4.9	14.2
Promote Health Education	23.0	50.9	8.4	1.3	16.4
Facilitate Support Group(s)	9.5	23.5	10.0	39.8	17.2
Refer Healthcare and Social services	22.4	40.8	5.4	3.1	28.3
Integrate Faith and Health	50.2	24.0	6.0	4.1	15.7
Advocate for Health	25.7	30.6	8.6	6.8	28.4
Coordinate Volunteers	20.2	30.7	8.7	14.7	25.7

*Values represent percentage of the total sample (N = 247). To see how questions were asked, view the Faith Community Nurse Questionnaire online at http://links.lww.com/NCF-JCN/A35.

older (79%). Settings for FCN practice were: urban (47%), rural (29%), inner city (6%), and other (18%), such as small towns, suburbs, townships, retirement homes, outside city limits, and homeless clients. Complete demographic data for the sample can be found online as SDC at http://links.lww.com/NCF-JCN/A35.

FCN Functions. Findings related to the seven FCN functions are displayed in Table 1. The most frequently cited functions occurring on a *weekly* basis were health counseling (44.9%) and integrating faith and health (50.2%). Four functions occurred most frequently on a *monthly* basis: health educator (50.9%), referrals (40.8%), advocacy (30.6%), and coordinating volunteers (30.7%). One function reported most frequently as *never* was facilitator of support groups (39.8%). Depending upon the function listed, FCNs marked *other* 14% to 28% of the time and indicated the function was provided "as needed," "not at this time," and various frequencies from "daily" to "annual health fair."

Healthy People 2020 Indicators. Frequency of implementing *Healthy People 2020* health indicators are displayed in Table 2. The indicator accomplished most frequently on a *weekly* basis was promotion of physical activity (33.5%). Two indicators were frequently done on a *monthly* basis: promote good nutrition and healthy weight (33.2%) and promote emotional health and well-being (30.1%). Two functions conducted most frequently on a *yearly* basis were to encourage the reduction or elimination of tobacco use (29.8%), and promote safety and reduction of violence through education and counseling (30.1%). Three functions occurred most frequently as *never* done: promoting responsible sexual behavior (49.5%), promoting healthy environments (35.2%), and encouraging the reduction or elimination of substance abuse through education and lifestyle changes (29.3%). The function to assist clients to access quality healthcare was most frequently marked as *other* (35%), and respondents indicated as needed, as requested, variable, and examples of free services were listed, including free clinics and free mammograms. As this question also asked about rides to appointments, some respondents reported they were able to offer rides to appointments, whereas others were unable to, due to the regulations of their faith communities.

Community Partnerships. A total of 133 FCNs responded "Yes" to a question about community partnerships; 43 different types of partnerships were reported. The 10 most frequently listed types of partnerships are in Table 3.

DISCUSSION AND RECOMMENDATIONS

The FCNs reported varying frequencies for services that align with the seven identified roles of faith community nursing. This may be reflective of the needs expressed by the congregations served, time commitment (the majority worked 10 hours a week or fewer), and available resources to develop and support health promotion activities. Health counseling and integrating faith and health occurred with the most frequency, suggesting faith community members may seek the FCN before going to other healthcare providers. If the FCN attends weekly meetings and church services (reported by 89.8% of the FCNs), community members may seek counseling at that time. To help integrate faith and health, many FCNs begin each offered program with a prayer or inspirational reading.

There may be several explanations for functions that were reported as being provided monthly. The FCN as a health educator may offer monthly programs or write educational articles for bulletins or newsletters on a monthly basis. The other three functions (referrals, advocacy, coordinating volunteers) are accomplished on an "as needed" basis. One function was reported most frequently as "never," which was facilitator of support groups. It is unknown whether the FCNs did not establish a support group, or developed one and delegated leadership to an expert facilitator in a particular field, such as divorce or substance abuse.

The selected *Healthy People 2020* indicators were marked with varying frequencies. This may be due to demographics of the congregation, available resources, and beliefs of the denomination. FCNs in this survey implemented promotion of physical activity most frequently, followed with equal frequencies of promoting good nutrition, healthy weight, and emotional health. These findings are supported by Rydholm and Thornquist (2005), who found that FCNs demonstrated effectiveness in encouraging and sustaining change in lifestyle habits and reducing risk that resulted in weight loss, and they increased physical activity (p. 20). These results also support the *Healthy People 2020* indicator that good nutrition, physical activity, and a healthy body weight are essential parts of a person's overall health and well-being. Encouraging and educating parishioners to eat a healthful diet, participate in regular physical activity, and

achieve and maintain a healthy body weight are critical to improving the health of faith community members at every age. FCN-sponsored activities may include exercise programs, weight reduction group meetings, and educational meetings or newsletters about good nutrition.

FCNs reported they performed activities that promoted emotional health and well-being at least on a monthly basis. *Healthy People 2020* (2014b) stresses that mental health is essential to a person's well-being, healthy family and interpersonal relationships, and the ability to live a full and productive life. As many churches are intentionally becoming centers to which people can turn for healthcare with a spiritual or emotional dimension, FCNs are in a position to foster healthy interpersonal relationships through qualified counseling and appropriate referral.

Table 2: Faith Community Nurses Reported Use of Selected *Healthy People 2020* Health Indicators*

Healthy People 2020 Indicator	% of FCNs Using Indicator In Their Practice				
	Weekly	Monthly	Yearly	Never	Other
Promote Daily Physical Activity	33.5	28	13.3	5.5	19.7
Promote Good Nutrition and Healthier Weight	24.0	33.2	17.5	5.1	20.3
Reduce or Eliminate Tobacco Use	11.2	13.5	29.8	16.3	29.3
Reduce or Eliminate Substance Abuse	6.0	12.6	25.6	29.3	26.5
Promote Responsible Sexual Behavior	3.8	4.8	20.5	49.5	21.4
Promote Emotional Health and Well-Being	24.1	30.1	15.3	6.5	24.1
Promote Safety or Reduction of Violence	6.2	15.2	31.3	27.5	19.9
Promote Healthy Environments/ Recycling	16.9	10.3	22.1	35.2	15.5

*To see how questions were asked, view the Faith Community Nurse Questionnaire online at http://links.lww.com/NCF-JCN/A35.

Table 3: Faith Community Nurses' Top 10 Partnerships with Other Agencies (*n* = 133)*

Agencies	# of FCNs Reporting Partnership
1. Hospitals	32
2. Hospital-sponsored or health system-sponsored FCN programs	30
3. Local health departments	29
4. Senior service agencies	18
5. Faith-sponsored agencies	15
6. Hospice	10
7. Physicians	9
8. Visiting nurses/home health	7
9. United Way agencies	7
10. Assisted living/nursing homes	7

*Total sample *N* = 247; *n* = 133 FCNs responded "Yes" to, "Have you developed any partnerships with agencies such as hospitals, health departments or other services? If yes, please explain." FCNs listed 43 different partnerships; the top 10 are reported here. Some FCNs reported more than one partnership.

Web Resources

- Healthy People 2020—http://healthypeople.gov
- IPNRC—http://www.churchhealthcenter.org/fcnhome
- FCN Scope & Standards of Practice—http://www.nursebooks.org/Main-Menu/Standards/A—G/Faith-Community-Nursing.aspx

FCNs at least yearly address tobacco use and the promotion of safety and reduction of violence. These activities may be accomplished by offering periodic educational programs, annual health fairs, or referral to appropriate community resources. *Healthy People 2020* health indicators marked "never" with the highest frequency were promoting responsible sexual behavior and encouraging clients to reduce or eliminate substance abuse. This may be due to the culture or religious tenets of the particular faith community in which these nurses practiced, or the comfort and experience level of the individual FCN.

These results suggest that promoting "healthy environments through education and promotion of recycling" is not a priority of FCN practice. In the future, education for FCNs should include information about recycling and the environment, as it relates to personal health. This could be an easy addition to many FCN's practices and an extension of biblical stewardship.

Incorporating *Healthy People* information into FCN initial preparation courses, such as the IPNRC *Foundations of Faith Community Nursing* and into continuing education and communication with FCNs is important. Teaching *Healthy People* content to FCNs can be a critical step toward integrating *Healthy People* initiatives into faith communities.

Although the sample size was adequate, it was a convenience sample of FCNs who viewed the IPNRC website. During the period of time the survey was available, the IPNRC moved to another state. This led to some confusion, which may have

resulted in fewer FCNs being able to discover the study. A second limitation involved the survey instrument. We did not include specific indications for some of the functions of the FCN, including "integrator of faith and health." The FCNs answered this question based on their own perception of that function. The survey can be modified in the future to allow FCNs to give examples of this and other functions. Another limitation was the overwhelmingly Caucasian representation in the sample and faith communities. Future research should include more diverse representation. Continuing research is needed with FCNs to assess their impact on the health of the communities they serve, including implementation of *Healthy People* health initiatives.

This study provided a glimpse into the nature of FCNs' health promotion interventions, as they serve faith communities. It is clear the FCN model of community-based practice can be used to implement *Healthy People 2020* objectives and follow established FCN functions and standards. FCNs are in a key position to highlight individual behaviors, physical and social environmental factors, and important health system issues that greatly impact health.

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