Introducing HEALTH MINISTRY *in a* RURAL AMERICAN CHURCH

By Cathy Abell and Maire Blankenship

ABSTRACT: *Americans living in rural areas often encounter health disparities, due, in part, to lack of access to healthcare. Establishing health promotion programs in rural church settings presents opportunities for nurses and other healthcare professionals to serve their communities and live out Christian faith. This article describes a health ministry program that was successfully implemented in a small, rural church using the Healthy People 2020 MAP-IT framework.*

KEY WORDS: *access, faith community nursing, Healthy People 2020, MAP-IT, rural health disparities*

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Americans living in rural areas often encounter health disparities, due, in part, to lack of access (Rural Health Information Hub, 2017) (Sidebar 1: *Healthcare in Rural America*). It is imperative that healthcare professionals develop unique activities to aide in meeting the health needs of this underserved population. As a strong affiliation with religion is a noted characteristic of individuals in rural areas (Martin, Williams, Crawford, & King, 2017), establishing health promotion programs in the church setting is an opportunity for nurses and other healthcare professionals to serve their community. Individuals who identify with a particular faith and attend church regularly often speak of their church as family and have a close connection with their faith community. This creates a win-win situation. As the role of faith community nurses (FCNs) continues to grow, there is great opportunity to provide care that integrates health and faith (Savage, Kub, & Groves, 2016) (Sidebar 2: *Starting Health Ministry in Rural Areas*). The affiliation with religion often is stronger in rural areas (Martin et al.). Rural community members can benefit significantly from health education activities offered in their church, an environment in which they feel comfortable and supported.

Throughout the history of the church, ministry to the members has played an important role. Early Christians ministered to those who were sick in order to demonstrate God's love (Church Health, 2019). For example, the Daughters of Charity are known for caring for individuals since 1633. Among other acts of kindness, they've cared for the wounded during times of war, provided care in health institutions, and worked to establish additional health facilities and nursing schools (Capparelli, 2005). Mother Teresa of Calcutta provides a notable example of one person caring for many disenfranchised individuals, whether the poor, homeless, or sick (Cannon, 2013). She petitioned to leave the Sisters of Loreto to go and live among the poor. After spending 4 months training with the Medical Mission Sisters, Mother Teresa started her new journey of serving those in greatest need. Mother Teresa herself sought out the most poor and sick off the streets and brought them to her home, often to die under her care. She quickly began to educate the children in the slum areas, as well as provide medical help for others who resided there (Decelles, 2016).

Presently, there is a resurgence of the value of assimilating faith and health.

Presently, there is a resurgence of communities valuing the assimilation of faith and health (Church Health, 2019). Nurses have a great opportunity to provide service to their church communities. The challenges and barriers to health access in rural areas are unique. FCNs are positioned to cover many of the gaps. This article describes implementation of a health ministry program in a Catholic parish in a rural southern American state.

SIDEBAR 1.
Healthcare in Rural America

The United States Census Bureau identifies two types of urban areas:

Urbanized Areas (UAs) of 50,000 or more people; Urban Clusters (UCs) of at least 2,500 and less than 50,000 people. The Census does not actually define "rural." The term encompasses all population, housing, and territory not included within an urban area. Whatever is not urban is considered rural (Health Resources & Services Administration, 2018, para 2).

The National Rural Health Association (NRHA, 2019) notes the demographic trends of rural areas include lower median incomes, a high proportion of seniors, higher acuity levels, and lower life expectancies. In contrast to urban families, "rural households had lower median household income ($52,386 compared with $54,296)" (U.S. Census Bureau, 2016, para 10). In addition, the U.S. Census Bureau states, "adults in rural areas had a median age of 51, making them older compared with adults in urban areas with a median age of 45" (para 7).

About 24% of children in rural areas live in poverty (NRHA, 2019). Similar to the general population, the fastest growing age-group in rural America are those 85 years and older. Obesity, lung cancer, chronic obstructive pulmonary disease, and heart disease are more common in rural areas. A study in the *American Journal of Preventive Medicine* indicates, "consistent overall increases in U.S. life expectancy was noted during the past 40 years, from 70.8 years in 1970 to 78.7 years in 2010. However, the study reveals the rural-urban gap [only] widening from 0.4 years in 1969 to 1971, to 2 years in 2005 to 2009" (Singh & Siahpush, 2014, e19).

With nearly one-quarter of the U.S. population living in rural areas, access to healthcare is challenging. Smaller, rural hospitals are closing; rural Americans must drive much farther to the nearest acute care facility. According to the Pew Research Center (2018),

> Twenty-three percent of rural residents surveyed said access to good doctors and hospitals is a major problem in their community, whereas only 18% of urban residents and 9% of suburban residents agreed… Travel times are also much higher in rural areas—17 minutes compared to 12 minutes in the suburbs and 10 minutes in urban areas. Among the percentile farthest away, it takes an average of 34 minutes to get to the nearest hospital, but in the closest percentile, only about six minutes. (para 1; 2)

The National Quality Forum (NQF, 2018) notes that the problem in rural areas related to accessing care also impacts quality of care. To improve rural care access, the NQF report focuses on three recommendations: ***availability, accessibility,*** and ***affordability***.

Availability: The most important elements of healthcare availability in rural areas are access to after-hours and same-day appointments, access to

specialty care, and timeliness of care. Faith community nurses are positioned to help meet these problematic elements of care and may be the only healthcare provider available within many miles.

They can be part of a team-based approach crucial to boost availability and promote timeliness of appointments as they can build effective referral relationships and strong care coordination with referral sites.

Accessibility: To obtain healthcare service in rural areas, the NQF 2018 report focuses on language interpretation, health information, health literacy, transportation, and physical accommodation (transportation). The report recommends interpreter services via phone or web-based platforms when interpreters are not available, and calls for better access to information from payers, particularly about providers who are in-network or out-of-network. Regarding health literacy, educating both patients and clinicians about the importance of patient engagement, and improving clinician–patient communication are highly recommended.

According to Rural Health Information Hub (2017), services available in rural areas are less likely to include specialized and highly sophisticated or high-intensity care. For some services, such as emergency medical services, the lower level of care available, when added to the increased time to services caused by distance, can be the difference between life or death.

In addition to the geographical barriers to accessing healthcare, there are fewer primary care and other providers in rural areas. Rural physicians comprise only 10% of the total physicians in the U.S., and there is an ongoing shortage (American Academy of Family Physicians, 2019). Physician assistants and nurse practitioners are filling some of the gap in primary care in rural communities.

Another challenge is the rate at which rural healthcare facilities are closing. The National Rural Health Association teamed with the University of North Carolina and iVantage, a health analytics firm, to conduct a study identifying current and potential rural hospital closures. Their research targeted approximately 2,000 rural hospitals in America and labeled 210 as "most vulnerable," meaning these hospitals could close at any time. Another 463 hospitals were labeled as "at risk," meaning the hospitals had only a few more years of sustainability, unless major adjustments were made. Closing such hospitals not only presents a disadvantage to the healthcare of the community, but also to the socioeconomic needs in terms of jobs because hospitals are often a major employer (iVantage, 2016).

Public transportation to health facilities is dismal in rural areas. The NQF 2018 report offers several recommendations:

- Establish partnerships with transportation services, such as taxis (public transportation is often nonexistent in rural areas)
- Contract with bus services
- Hire drivers
- Work with community partners, such as nursing homes, when conducting community needs assessments.

Affordability: Rural populations tend to have more elderly and residents with lower incomes; this correlates with a higher rate of specific illnesses or disorders compared with urban settings (Rural Health Information Hub, 2017). The uninsured rate is higher in rural counties (nonmetropolitan) than in the urban (metropolitan) counties, as reported by the U.S. Department of Health and Human Services (2017). The NQF report (2018) notes that total out-of-pocket costs and delayed care because of the inability to pay are the essential aspects of affordability for rural residents. Faith community nurses (FCNs) can assist rural patients to afford care by helping them identify health concerns early and avoid urgent or more intensive care after problems become severe. FCNs can help individuals understand their insurance coverage, monitor out-of-pocket expense balances, and increase literacy about insurance, such as the financial implications of picking a high-deductible plan.

Approximately 20% to 25% of the U.S. population lives in rural areas.

With nearly 25% of the U.S. population living in rural areas, FCNs can make a substantial impact in local communities. ***Availability, accessibility,*** and ***affordability*** are barriers to healthcare across large portions of the country. Nurses living in rural settings can situate themselves in faith communities to promote healthy concepts through local health ministry programs. **—Cathy Walker, *JCN* Associate Editor**

The parish where this program was implemented is located in a county with approximately 18,500 residents as of July 1, 2018. Nearly 25% of the population is under 18 years of age, and 16.6% is age 65 and older. The reported educational level of persons 25 years old and up includes 84.8% having a high school diploma or higher, and 15.1% holding a bachelor's degree or higher (United States Census Bureau, n.d.).

USING THE *MAP-IT* FRAMEWORK

The health ministry program started as a result of a few parish members' impromptu discussions regarding this community's need. The initial focus of the program was providing health education regarding a variety of topics.

The *MAP-IT* framework noted by Healthy People 2020 was adopted for implementation of this specific health ministry program. Similar to the nursing process, the steps of this framework include *Mobilize, Assess, Plan, Implement,* and *Track* (Healthy People, 2019). The MAP-IT framework is a valuable tool in both implementation and evaluation of programs. The ease of application means it can be utilized by healthcare professionals with varying levels of expertise and in different situations (Healthy People). Table 1, drawn from Healthy People 2020 and our experience, lays out questions to ask and answer using the MAP-IT framework.

The first step, *mobilize*, included meeting with key leaders of the church to gain support and discuss the program's focus. Following discussion with the priest, meetings were held with the parish council. Overwhelming encouragement was received for the initiation of a health ministry program with a focus on health education. With increasing complexity of the health system, offering education to increase health literacy is vital. The Agency for Healthcare Research and Quality (2018) notes the practice of "Health Literacy

Universal Precautions," where providers assume that all patients have some difficulty with understanding health information. Improving individuals' health literacy has been acknowledged as important for individuals seeking care, as well as improving patient outcomes (Savage et al., 2016). Church leaders recognized health literacy—understanding how to improve health and communicate with healthcare providers—as an important need.

The next steps were to *assess* and *plan*. A needs assessment was conducted as part of a research project to assess parishioners' perceptions of offering a health education program on-site and assess topics of interest and time preference. The assessment was developed by one of the authors (Abell, 2016) and was provided during weekend Masses. There was a positive response about the perception of the usefulness of an onsite health ministry program. Additionally, those offering input demonstrated an interest in various topics (Abell). With limited financial resources, planning for expenses was important. To address the financial cost of the program, a grant of $2,050 was written and successfully obtained through a diocesan funding opportunity that supports Catholic ministries. The money was utilized for refreshments and $25.00 gift cards as tokens of appreciation for speakers. After the fiscal year for which the grant was obtained, money not utilized was returned to the diocesan fund as an act of stewardship.

Finding the best time for the program was a challenge. Plans were established to offer the health education activities as a monthly event. Initially, the schedule of the sessions varied in order to continue assessing the time that would facilitate greatest attendance. The first program was offered on a Friday, just prior to a First Friday Mass. This was followed by sessions held following the First Saturday Mass, and then a session after a weekday 8:00 a.m. Mass. The noon weekday Mass typically had the largest attendance and became the consistent time for the health education programs.

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With completion of the assessment and planning phase, the next step involved putting the findings into practice. *Implementation* included developing programs to provide multiple health education topics, including: colon cancer; stroke awareness; Zika virus; shingles; eye diseases; selecting a long-term-care facility; diabetes; anointing of the sick; lab results; health for your back; hypertension; anemia; tips for calling 911; balance; drug abuse; progressive relaxation; estate planning; total eclipse-eye protection; end-of-life decisions; genetics; Alzheimer's disease/dementia; and communicating with healthcare providers. In addition to nurses, speakers included a(n) health educator, astronomer, physician, geneticist, nursing home administrator, paramedic, drug task force representatives, attorney, and pastor. Speakers were invited by a member of the church who served as a facilitator of the health ministry program. Speakers were asked to be prepared to present for approximately 30 minutes and then allow time for questions. Programs lasted an hour, and attendees socialized before and after the presentations. Speakers utilized a variety of presentation strategies including informal lecture, Power Point slides, use of models, demonstrations, and return demonstrations.

Part of implementation included providing information regarding planned health education activities. This was done through publicizing events in weekly bulletins, posting on the church's Facebook page, and announcing events at parish meetings and masses.

Part of evaluating a program includes ongoing data collection and *tracking*. This takes time but is invaluable to demonstrate the success of a program. It is important to decide what data are significant and should be collected (Byrnes, 2014). For this program, records maintained include numbers of people attending sessions, the topics, and expenses. Updates are provided to the parish council and the finance committee to demonstrate popularity and value of the program, evident by consistent growth in attendees. With financial resources often limited in small, rural churches, keeping leaders informed of the success of programs is important in receiving ongoing program funding.

LESSONS LEARNED

As reported by Williams, Glanz, Kegler, and Davis (2012), having support from the pastor or priest is important to the success of a church-based health program. We found this to

TABLE 1. *Questions to Ask and Answer Using the MAP-IT Framework*

MOBILIZE	• What is the vision and mission of the project/coalition/ministry? • Why do I want to bring people together? • Who should be represented? • Who are the potential partners (organizations and businesses) in my community? To keep identified partners engaged, ask key stakeholders to: • Facilitate community input through meetings, events, or advisory groups. • Develop and present education and training programs. • Lead fundraising and policy initiatives. • Provide technical assistance in planning or evaluation.
ASSESS	• What are the needs of the community? • Who is affected and how? • What resources do we have? • What resources do we need?
PLAN	• What is our goal? • What do we need to do to reach our goal? Who will do it? • How will we know when we have reached our goal? • What are the steps for a detailed workplan that lays out concrete action steps, identifies who is responsible for completing what actions, and sets a timeline and/or deadlines?
IMPLEMENT	• Are we following our plan? • What can we do better? • What changes need to be made?
TRACK	• Are we evaluating our work? • What data are significant and need to be recorded? • What data need to be reported, and to whom? • Did we follow the plan? • What did we change? • Did we reach our goal(s)?

Note. Revised from Healthy People (2019). Used with permission.

be true, as well. In addition to attending most sessions, the pastor served as a presenter for specific sessions and kept people informed of upcoming events.

Participants enjoyed refreshments during educational programs. The first session was held just prior to Mass. With the requirement of abstaining from food and drink 1 hour prior to receiving Communion (Canon Law Society of America, 1983), this prevented having food at the health education event, which may have affected attendance. When the educational sessions were offered after Mass, attendance increased, and participants enjoyed refreshments and socialization. It is important not only to plan ahead for topics, but to be flexible to offer timely topics. For example, during the summer, when much was being publicized about Zika virus, this topic was of interest. Also, during the time surrounding a total eclipse of the sun, many had questions about what to expect and how to protect their eyes, while experiencing the eclipse.

Nurses and other healthcare professionals have a great opportunity to provide service to their church communities.

A valuable lesson learned was to network with health and other community organizations to find a variety of speakers with expertise in diverse topics, such as acute care, long-term care, primary care, and emergency care agencies, and public health. Partnerships could be established with nursing academic instructors. Additionally, collaborating with other health-related academic units in college or university


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Web Resources

- **Rural Health Information Hub**—https://www.ruralhealthinfo.org/topics/healthcare-access
- **Westberg Institute**—https://westberginstitute.org
- **Community Tool Box**—https://ctb.ku.edu/en
- ***MAP-IT***—https://www.healthypeople.gov/2020/tools-and-resources/Program-Planning
- **AHRQ Health Literacy Toolkit**—https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html

settings could result in more resources. These programs could include social work, physical therapy, dental hygiene, speech therapy, dietetics, and recreation.

In addition to the program being low cost, sustainability was enhanced by tracking and maintaining concise, accurate records. The documented success of the program led to the health ministry program becoming a line item in the annual budget. One serendipitous finding was the value of bringing others from the community into the church. This offered an excellent opportunity to share faith and increase awareness of activities being held at the church.

CONCLUSION

Being involved in health ministry in a church setting can not only be helpful to participants, but also be a blessing for those involved in initiating and facilitating such programs. Nurses involved in clinical practice can share their expertise. Nurse educators could include health ministry education as a community clinical experience for students. In addition to gaining community clinical experience, this would allow students to work alongside nurses, giving back to their communities.

More research is needed to evaluate outcomes of health education and/or promotion programs offered in churches (Campbell et al., 2007). Quantitative research could include examining outcomes of program interventions on subjects' knowledge regarding various health-related topics or changes in health behaviors, such as modifications of dietary intake habits. Longer-term outcomes could explore health changes, such as weight loss or lowering blood sugar or blood pressure. Qualitative research could examine participants' thoughts and beliefs regarding benefits of attending such programs. Additionally, more leaders of health education programs should disseminate descriptions of programs to encourage others in the development of more programs, especially in rural areas.

Health needs in rural communities can be greater, due to lack of proximity to care and to health education programs typically offered in urban areas. FCNs have the expertise to offer and/or coordinate health education. They

SIDEBAR 2. *Starting Health Ministry in Rural Areas: A JCN Interview*

Kris Mauk (KM): Through the eyes of a Faith Community Nurse (FCN), what can you tell us about starting a rural health ministry?
Sharon Hinton (SH): The key is to get involvement of the whole community. Look for partners who are already in service, like those who gather items for the clothes closets, or those who serve meals for the elderly. Find out who are the people who are doing things. Those are the partners you want, not just those who could donate money or goods. Also, try to remember the farm families for whom transportation may be a challenge. There are no taxis, buses, or public transportation, especially in remote areas, and families may only have one vehicle, so remember to provide transportation to attend events.

KM: Can you give an example of getting the whole community involved?

SH: In my small rural area in Texas, I served the Methodist church that had a large kitchen, the Assembly of God church that had a bus, and the African American Baptist church with lots of willing volunteers. As the FCN, I coordinated the strengths of everyone to meet the needs of the rural community. The church with the bus helped transport people to the Methodist church with the kitchen for meals. The Baptist church provided volunteers to help with food preparation and distribution. By working together, the churches were able to meet needs that they could not supply alone.

KM: What advice would you give to those who want to start some type of ministry, like the one described in this article, but don't know where to begin?

SH: First, and foremost, after you have heard God speak to you about starting a ministry, *listen to what the people want.* As nurses, we know what health education people need, but we must go beyond the traditional assessment and see what the community wants. For example, when I first started as an FCN, I noticed that the women in the rural farm community looked tired. So, I developed this beautiful program for women (one of the best programs I ever developed!), but nobody came! When I finally talked to the women, I listened. I stopped what I wanted to do and what I thought was best and did what the mothers asked for—a farm safety program for kids. As nurses, we might be right about the educational needs, but start with what the people say they need. This approach gained me overwhelming support. Businesses donated money and supplies to the cause. Farmers came in for a day. The community became an integral part of teaching farm safety for the children.

KM: What are some of the challenges nurses should expect in rural ministries?

SH: No funding. No nearby resources, like hospitals and other organizations such as the American Heart Association or the Red Cross. The people who are the helpers and workers are already working. Some nurses may not realize that a lot of state departments of health do have money allocated for rural areas; however, the health departments don't know how to find the nurses to help them. You have to get established as a nurse in the rural community, and then make the state aware of what you are doing.

KM: What are the benefits of churches pursuing a project like this on their own?

SH: The rewards are huge! When you give these folks a way to find education, or share education, they take it and run with it. People in rural areas don't have much to work with. For example, those at the Hispanic Assembly of God church wanted their women parishioners to learn how to take blood pressures (BPs). So, I taught them how. These ladies kept coming back to me for more BP supplies. I asked them why, and found that they were checking everyone's BPs, not just the people in their own church. They were going to nearby neighbors and door-to-door taking BPs for everyone. That's what I mean by giving rural communities the tools they need, and then watch the wealth of knowledge spread as they share!**—Sharon T. Hinton, *JCN* Contributing Editor and National Project Manager, Westberg Institute, and Kristen L. Mauk, *JCN* Senior Editor**

can be leaders in initiating rural community health education within the church and to the surrounding rural area. As programs grow, FCN-led health ministry can grow to offer health assessments, transitional care, and other health resources for the rural community.

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