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ADVANCED PRACTICE NURSING IN THE FAITH COMMUNITY SETTING: A CASE STUDY

by

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A doctoral thesis submitted in partial fulfillment of the requirements
for the degree of Doctor of Nursing Practice
in the College of Nursing
at the University of Central Florida
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2010

Major Professor: Susan Chase

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ABSTRACT

The purpose of this case study is to demonstrate the effectiveness of an Advanced Practice Nurse in providing spiritual and nursing care within a faith community setting. The study will describe the process of developing a Parish Nurse program using a Nurse Practitioner to offer wholistic health care to parishioners. It will also illustrate the collaborative process of developing a free health center within a faith-based organization using the Nurse Practitioner to manage the health center and deliver health care services.

In order to demonstrate the need for parish nurse care, the case study used an anonymous survey to provide insight into the health status of the congregation, as well as to determine perceived needs of parishioners. Excerpts from the researcher's journal and audiotaped interviews of parishioners and key leaders within the community were used to express congregants' experiences of receiving parish nurse care, and to convey the need for a free community health center in the target population. A utilization review was conducted to demonstrate the profile of the patients who have accessed the services of the health center.

The findings revealed three commons themes of parish nurse care: presence, spiritual support, and health care liaison. The study also revealed that parishioners had an expedited referral process and improved patient provider relationships. Additional findings determined that the free health center was able to be operated by many of the members of the faith-based organization, and it was effective in managing chronic conditions such as hypertension and diabetes.

Advanced Practice Nurses who are Parish Nurses have an opportunity to practice in a more wholistic manner, and to offer advanced-level care to both parishioners and the community at large to improve health outcomes.

In memory of

Patricia L. Black, RN, BSN, FCN

and dedicated to

all those that are called to a good work according to His purpose

ACKNOWLEDGMENTS

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To the Faculty and Staff of the College of Nursing at University of Central Florida, thank you for being there not only as professors, but as supporters and friends. A special thanks to Dr. Susan Chase and Dr. Pamela Ark, committee members and fellow Parish Nurses. You understand how important parish nursing is to the health of the congregation and community. Thanks for all your insight and pushing me until the end. May you be "healthy in body, as you are strong in spirit!"

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LIST OF ABBREVIATIONS

Advanced Registered Nurse Practitioner	ARNP
Board of Directors	BOD
Department of Health	DOH
Executive Board	EB
Faith-Based Organizations	FBOs
Faith Community Nurse	FCN
Health Care Ministry	HCM
Parish Nurse	PN

CHAPTER 1: INTRODUCTION

Those in the nursing field understand that humans are spiritual beings as well as physical beings. St Augustine stated, “That which is unseen is essential.” A person’s spiritual nature is the motivating force that directs him or her to make positive changes for the good of the whole being. Advanced practice nurses in the secular setting, in particular Nurse Practitioners, are rarely inquisitive about a person’s spiritual nature. Nurse Practitioners are not typically comfortable attending to the spiritual component of a person, largely because of how difficult it is to comprehend the human spirit since it cannot be seen or touched. This issue is largely due to the limited amount of education provided to nursing students about the importance of assessing and providing interventions to the spiritual aspect of a person. When omitting to address the spiritual nature of a person, Nurse Practitioners are neglecting to provide interventions to the influential power of a person’s spirit. One particular group of nurses understands the importance of maintaining the integrity of the human spirit during times of physical illness. Parish Nurses recognize the relevancy of spiritual care to the health and overall well-being of a person. This specialized practice of nursing is truly holistic because of the dynamic ability to apply interventions to the very essence of a person, which in turn affects the physical body.

The decision to become a Parish Nurse is a personal decision that many professional, licensed nurses choose to pursue based on their spiritual beliefs and perspectives on health care. A Parish Nurse (PN) is knowledgeable in two areas: professional nursing and spiritual care. The deliberate focus of the PN is the provide interventions that promote the spiritual health of a person. Parish Nurses implement interventions such as education, counseling, advocacy, and referral services; utilize resources available to the faith community; train and supervise volunteers from the faith community (American Nurses Association, 2005). The American

Nurses Association (ANA) made an addendum to the Scopes and Standards of Practice for the Parish Nurse to include Nurse Practitioners. This supplement allows the clinical expertise of the Advanced Registered Nurse Practitioner (ARNP) to be included in the role of the PN. The Advanced Practice Parish Nurse (APPN) incorporates evidence-based practice and theoretical knowledge in combination with the structure and spiritual beliefs of the faith community to yield a higher standard of care that is truly holistic in its delivery. APPNs not only provide traditional services, but also assess, diagnose, treat, and manage health conditions (American Nurses Association, 2005). Under this model, members of the faith community have access not only to information, but also to tangible health care services. The APPN, in collaboration with the faith-based organization, can extend these health care services to the community of individuals who lack access to health care.

The ability to access health care services for preventable conditions is problematic for those without health insurance. A person's age, employment status, area of residence, racial and ethnic background can have significant influence on whether or not a person has adequate health coverage. Limited access to health care is the largest contributor to the health disparity gap in the United States (Health Access California, 2007). Policymakers have not formulated a viable solution to provide health insurance to those who are uninsured, and are unable to access primary and secondary care services in the community.

Faith-based organizations (FBOs) or church groups are small communities within larger communities. By affecting the health of one church within a neighborhood, the health of an entire community where the church serves is improved. FBOs are becoming essential in helping the current health care system address the needs of some many without the ability to access health care (DeHaven, Hunter, Wilder, Walton, & Berry, 2004). The partnership between FBOs

and APPNs are central to the improving the overall health and well-being of the community at large.

The forthcoming case study will describe the capability and benefits of incorporating the knowledge base and skill set of a Nurse Practitioner into the role of a Parish Nurse by the development of a Parish Nurse program. In addition, the study will also demonstrate how the APPN can provide holistic care to the community through the development of a free community health center. More importantly, it will display evidence of the need for Advance Practice Nurses to practice wholistically both in faith-based settings as well as when providing care to individuals within the community.

Background

Spirituality is concerned with what motivates a person to move beyond current circumstances in order to achieve recovery and healing, or to accept an unfavorable diagnosis or prognosis. Spirituality is central to the ideology that within all individuals there is a soul that is responsible for their emotional responses, allowing them to find a meaningful connection with God (Oldnall, 1996). People who embrace their religious beliefs are able to find meaning and purpose from their situations, which allows them to secure hope that is gained from a relationship with the Divine. However, even if an individual has a personal relationship with God, it does not automatically afford them with a transcendent nature during times of physical distress (Coyle, 2002). It is difficult for faith leaders and organizations to provide the support needed to sustain a human being during times of illness. This is in part to the overwhelming number of people who have physical conditions that cause spiritual distress, as well as the limited knowledge of faith leaders in the area of health. Parish Nurses are capable of providing

the care needed during times of physical illness by offering health knowledge and spiritual care to a person simultaneously.

The PN or Faith Community Nurse (FCN) preparation is intended for a baccalaureate degree level of nursing practice. PNs must maintain a current license as a Registered Nurse in the state of licensure to practice. The role of a PN in many denominations is viewed as a part of the ministerial staff, and some churches have provided them titles such as Minister of Health or Congregational Health Pastor. Regardless of their title, it is the viewpoint of the researcher that Parish Nursing is a specialized ministry as well as a specialized area of nursing.

The APPN is holistic in the delivery of health care because of the incorporation of spiritual modalities such as meditation and prayer to enhance the effectiveness of treatment. The APPN demonstrates leadership in the ability to advance the specialty practice of Parish Nursing by designing, establishing, and implanting population-specific and patient-specific programs that are high quality, cost-effective, and wholistic (ANA, 2005).

As the U.S. population grows and becomes more diverse, the number of people experiencing poor health may also increase. The inability to receive care for preventable and treatable conditions due to limited access is the leading cause of health disparities among at risk groups (Health Access California, 2007). Addressing the current situation is vital in order to improve the current health status of vulnerable populations (CDC, 2002). The largest racial/ethnic populations in the United States include Non-Hispanic Blacks and Non-Hispanic Whites. In 2006, 24 million people of “color” were without health care coverage, specifically those between the ages of 55and 64. This group is in the most need for adequate health care coverage, since preventable health issues are typically problematic within this age group (Lillie-Blanton, 2008). Mortality rates from cardiovascular disease are higher among blacks; in fact, one

study found that heart disease accounted for nearly one-third of the overall mortality difference between African-American and Caucasian patients (Lavizzo-Mourey & Jung, 2005). The current problem with today's health care system is that policies and policymakers have not found a way to provide health care coverage to the masses.

The rising cost of health insurance has made it difficult for employers to continue paying a large percentage of an employee's health benefits. Because of this, employers are either decreasing their portion of the benefits package or passing the entire cost on to the employee. When this happens, many Americans are forced to either put gasoline in their automobile or pay for health care coverage that they may or may not use. The number of those who are uninsured is rising. In 2006, the number of uninsured individuals rose for the sixth consecutive year, to an astounding 47 million, with 8.7 million children being uninsured as well (Center on Budget and Policies Priorities, 2007).

Because of the gap in coverage, the burden of providing access to health services for uninsured and underinsured patients has fallen substantially on hospitals and public health facilities. Hospitals are committed to their communities and carry out missions that include a significant number of charitable services. In a report released in March 2004, The National Association of Community Health Centers (NACHC) reported that that there were over 110 million hospital emergency room visits in 2002, compared to 90 million in 1998. The report also noted that between 10% and 50% of all emergency room visits were for non-urgent and avoidable conditions (Long, 2004). It is the expectation that hospitals function in a financially responsible manner by managing limited resources effectively. Meeting the demands of stakeholders while balancing the needs of patients can be challenging for hospitals. Because of the limited number of private providers who provide charitable services, many patients

repeatedly present to the ER for primary care. Primary care providers are reluctant to provide care to the uninsured because of the liability risks, the large amount of time needed to coordinate indigent care, and the loss of revenue.

Health care reform has been problematic since the Theodore Roosevelt presidency and is a priority in the current White House administration. Past legislative efforts to expand coverage to those with pre-existing conditions, provide consumer protection to prevent the loss of benefits during times of catastrophic illness, set a standard for on-the-job benefits, and enact a universal system have failed or been vetoed. There have been no clear-cut tactics on how to make health care available to those who are uinsured, as well as affordable for both citizens and the federal government. Until health care reform comes to fruition on Capitol Hill, the American people must be able to access health care services within the communities where they reside.

Government leaders are in constant debate over providing uninsured Americans with health insurance. A better approach to this dilemma would be to supply funding to faith-based health initiatives that have Advanced Practice Nurses providing care. Even with insurance, co-pays can be financially difficult for some individuals to pay. The collaborative effort of faith-based organizations and the high level of care that can be provided by an ARNP can give uninsured individuals access to health care that is economically acceptable to stakeholders. In addition, because the primary role of the ARNP is primary care, cost will continue to decline because of the early detection of chronic illnesses and referrals to appropriate agencies for management.

Aim of Project

Using an Advanced Registered Nurse Practitioner, the aims of this project are to:

- Describe the process of implementing a Parish Nurse Program and demonstrate the benefits of advanced Parish Nurse care to parishioners.
- Describe the process of developing a free community health center through the collaborative efforts of an ARNP and FBO.

The first rationale for this case study is to provide evidence of the need for more education in the areas of spirituality and formal Parish Nurse training from accredited programs. The second rationale is to provide insight on the effectiveness of Parish Nurses to improve health outcomes through a holistic approach to care. Ideally, the study will supply evidence to policymakers concerning the effectiveness of Parish Nurses in improving not only the health outcomes of parishioners but the community as a whole. The study will also demonstrate the need for federal, state, and local policies to provide liability coverage for the protection of nurses that provide care within the faith community setting pro bono, and it will provide evidence that there continues to be a gap in care because of limited access to health care services. Finally, the purpose of this case study is demonstrate the need for more research in the area of Parish Nursing and spiritual care that is both qualitative and quantitative.

CHAPTER 2: THE LITERATURE

Health disparities as defined by Healthy People 2010 is the "unequal burden in disease morbidity and mortality rates experienced by ethnic and racial groups as compared to the dominant group" (Goldberg, Hayes, and Huntley, 2004). It is expected that the number of people experiencing poor health will increase; therefore, addressing the current situation is vital (CDC, 2002). The ability to seek medical treatment for preventable illnesses can be a financial burden for those without health insurance. It is difficult for people accustomed to having health insurance to understand the complexities of accessing health care for the unemployed, working poor, and uninsured.

In order to tackle the innumerable problems that have led to the current health care crisis, creative approaches must be devised to meet the growing needs of the community. One factor that has contributed to the state of the health care system is the high cost of an expanding elderly population. Future health care models must focus on health promotion and disease prevention and emphasize self-care and individual responsibility (Weis, Matheus, & Schank 1997). One resourceful approach to the addressing the overwhelming situation of health care is Parish Nursing.

Parish Nurse

Parish Nursing (PN) or Faith Community Nursing (FCN) is a specialized practice of professional nursing that considers spirituality as the cornerstone of practice. Parish nursing is an evolving mode of health care delivery that continues to develop and expand. The ability to find meaning in life situations is universal and essential to the well-being of a person. Without it, spiritual despair could ensue, leading to feelings of worthlessness and despondency (Dyson,

Cobb, & Forman, 1997). Researchers have concluded that illness, suffering, and the possibility of death challenge a person's meaning system. If individuals can derive meaning from their life, they are able to find tranquility amidst severe illness. Parish Nurses provide care to patients/parishioners to assist them in deriving meaning for their lives and implement interventions that promote transcendence despite an illness or health condition. Parish Nurses understand the spiritual distress a patient experiences during a hospitalization or recovery process, and can provide comfort and relief to the spiritually and mentally anguished patient.

The successfulness of the Parish Nurse (PN) within any denomination depends on the viewpoints of the Pastor regarding parish nursing. In order to integrate spirituality and health care in to the church, the PN and Pastor must develop a collaborative relationship (Thompson, 2010). In a national survey, Pastors in general felt it was important for the church to be involved with the health care needs of the congregation. However, in another study, Pastors expressed concern over whether FCNs could provide spiritual counseling to members of the congregation because many Pastors view spiritual care as their area of expertise (Thompson, 2010).

The role of the PN within the faith-based setting includes educator, teacher, advocate, personal health counselor, community liaison, volunteer coordinator, and interpreter of the close relationship between faith and health (McDermott & Burke, 1993.) Congregants convey positive attitudes toward PNs because of their availability and approachability (Chase-Ziolek & Gruca, 2000; Wallace, Tuck, Boland, & Witucki, 2002). Services most requested by congregants for the PN to perform include activities such as screening for diabetes and hypertension, and health education information such as smoking cessation (Baldwin, Humbles, Armmer, & Crammer, 2001). In the study done by Baldwin et.al, the participants did not report having difficulty accessing health care. Even though participants of this study did not demonstrate a need for

accessible health care, they did express the desire for ambulatory care services such as health examinations and immunizations to be available within the faith-based setting (Baldwin, et.al). Usually the PN would have to arrange for these services from physicians and family nurse practitioners outside of the parish. This sheds light on the possible expansion of services for members of the congregation who have an advanced practice FCN: the ability to provide direct hands-on patient care, a role not typically displayed in Parish Nursing.

The Advanced Practice Parish Nurse

Currently, there is a minimal amount of literature regarding the role of the Advanced Practice Nurse in the practice of parish nursing. Magilvy and Brown suggested that Parish Nursing is an advanced practice role that requires master's-level training because of its independent nature within the community (Bitner & Woodward, 2004). Bitner and Woodward noted that Advanced Practice Nursing and its utilization of the evidenced-based research could significantly impact the health outcomes of parishioners through early intervention of identified health risks. The ability to assess, diagnose, and prescribe medications for the treatment of conditions before they become chronic demonstrates how influential the advanced practice Parish Nurse could be in the faith community setting (American Nurses Association, 2005). The Advanced Practice Parish Nurse (APPN) can provide early detection screenings and manage chronic disease, which is often lacking in the current health care setting.

The ability of the APPN to practice at a higher level may prevent the occurrence of adverse medical events, leading to reduced hospitalizations and emergency room visits (McGinnis & Zoske, 2008).

In the current era of health care reform, there is a greater emphasis on finding creative and sustainable approaches to delivering health care. A case study reviewed the potential health outcomes of faith-based primary care clinics using Parish Nurses as a means of meeting the challenges of the health care crisis. It identified that the prevailing health conditions for consumers of the programs were hypertension, asthma, musculoskeletal disorders, and diabetes. In the case study by Hughes, Trofino, O'Brien, Mack, and Marinan (2001), Nurse Practitioners practicing in the Parish Nurse role found that having accessible health care in the confines of the parish was invaluable. Interventions provided by the ARNP PN lead to the early identification and prevention of chronic diseases, limited exacerbations, immediate referrals, and the easy exchange of health records. However, many of the clients in this study only came for one visit, despite active attempts for follow-up. Regardless, parishioners benefited from wholistic primary care services within a faith-based environment.

The literature presents many positive viewpoints regarding the need for FCNs in the congregation, yet many Parish Nurses are finding it difficult to be compensated for the services that they provide. Eighty-seven percent of FCNs report their role as volunteer and 13% report having salaried positions. Parishes have expressed concerns over the affordability of FCNs, either part-time or full-time, because this salary would exceed other salaried positions within the church, even the Pastors (McDermott & Burke). Advanced Practice Parish Nurse services, however, have the potential to be reimbursable from a variety of third-party-payer sources, allowing the APPN to generate revenue that could be allotted in part for their salary, without placing this burden on the congregation.

As people age, chronic conditions require complex treatments, facilitating the need for more advanced specialized care. This change in dynamics provides opportunities for Advanced

Practice Nurses who are also PNs to combine spiritual principles with enhanced nursing training. It is not the goal of the APPN to duplicate community services, but instead, to provide an avenue to meet unattended or unaddressed needs, enhance the health care delivery system, and improve access to underserved populations, which could potentially affect the health disparities present in our country (Schank, Weis, Matheus, 1996).

Faith-Based Organizations

A faith-based approach to providing opportunities to access health care is emerging around the country. Faith-based organizations (FBOs) are extending care and support beyond the walls of their individual organizations and demonstrating a wholistic approach to meeting the needs of those lack health care services. One approach to meeting the demands of the current health care crisis includes Christian faith-based free clinics that provide everything from basic primary care services to dental care (Elliott, 2010).

According to the Bureau of Primary Health Care Faith Partnership Initiative, which seeks to facilitate partnerships between FBOs and health providers, there are 43 million uninsured citizens in the United States. To date, there are no clear strategies on how to meet the needs of such a large group of individuals and provide them access to care. The results of a study looking at the effectiveness of faith-based health programs demonstrated that health programs can produce favorable effects in improving the health of consumers by increasing disease knowledge and reducing the risk of disease occurrences. Since there are more churches per capita in the United States than any other country, FBOs have the ability to contribute significantly to meeting the demands for community health (DeHaven, Hunter, Wilder, Walton & Berry, 2004).

APPN and Faith-Based Organization Collaboration

Barriers that have been identified in allowing FBOs to truly be effective in providing health care service to the uninsured is the lack of collaboration between larger health care systems, community health centers, and health care providers. A study examining the relationship between faith community health centers and neighborhood churches concluded that the partnership between the two groups was inhibited by the lack of communication and by interpersonal and organizational differences (Curlin, 2005). Parish Nurses may serve as the bridge in linking medicine and faith to improve collaboration between congregations and larger health care affiliates (Anderson, 2004).

The literature regarding the effectiveness of the ARNP in the parish setting is scarce. More research is needed to demonstrate the effect of faith-based health clinics in providing wholistic health care to the uninsured. Needless to say, the establishment of free health clinics within the faith-based setting is integral in helping the uninsured across America meet their health care needs.

CHAPTER 3: RESEARCH METHODS

Design

This qualitative descriptive case study describes the role of an Advance Practice Nurse in the faith community. The case study is a retrospective view of the evolution of an Advanced Parish Nurse Program and a free community health center. Included in the design is a straightforward quantitative analysis of the health conditions and needs of congregants and the utilization of services provided in the free community health center.

Population and Setting

The case study has two populations from which the sample was collected. The setting for both programs was within a local church in an urban area of southwest Orlando, Florida. The sample for the Advanced Parish Nurse Program is from congregants who attend the church. They are primarily African-Americans of diverse economic, educational, and social backgrounds, and they represent a variety of ages. The sample for the free community health center is from those who were uninsured in Orange County and who accessed care.

Data Sources

Data sources for the Parish Nurse Program included an anonymous survey to assess the needs of congregants, audiotaped interviews of a local Pastor and congregants who accessed care, as well as the researcher's journal and Parish Nurse notes. Data sources for the free community health center included a needs assessment and audiotaped interviews from key leaders within the community. In addition, a review of patient encounter forms provided data on the utilization of services by community and church members.

Data Analysis and Study Evaluation

Microsoft Excel® software analyzed survey data and patient encounter forms. The audiotaped interviews were transcribed verbatim. The interviewees read the transcribed interviews for accuracy. Transcribed interviews were read and re-read to determine the common themes of care. A pilot utilization review was completed to create a profile of those who were accessing care from the community. Members of the thesis committee reviewed and evaluated all components of the study. The Thesis Committee Chair evaluated the research design for construct validity. The committee evaluated the data collection process prior to initiating the study for reliability. Based upon the evaluation, the process was restructured.

Protection of Human Rights

Prior to the study being initiated, the researcher obtained approval from the University of Central Florida Internal Review Board. The researcher also obtained permission from the Pastor of the faith-based organization where the study was conducted. Anonymous surveys were available for congregants of the church. Participants were instructed to avoid putting names or identifying information on the surveys. A research assistant passed out surveys to participants. Only those who were 18 years of age or older participated in the survey. Participants left the completed anonymous surveys at the end of the table, which were then collected by the research assistant.

Participants that agreed to an interview read an Explanation of Research form prior to providing any information. Participants had to be 18 years of age or older to share personal health information. The participants had the opportunity to read the interviews once transcribed and to remove any information they wished from the transcribed data. All information used from

the personal journal and Parish Nurse notes was de-identified. Information obtained from the patient encounter forms remained confidential, as it did not include patient names or personal identifiable information.

CHAPTER 4: THE PROJECT

This chapter will describe how an Advanced Practice Nurse was used within a faith-based setting to provide holistic health care services. It will explain the simultaneous and related processes of developing a Parish Nurse program and launching a free community health center. The case study took place within a predominately African-American church located on the west side of Orange County, Florida. The case study will provide understanding of how Advanced Practice Nursing can be more holistic in its delivery of care through the incorporation of Parish Nurse training, and how Advanced Practice Parish Nurses can work within their scope of practice to provide expanded services to the congregation and community.

The first portion of the chapter will describe the process of initiating a Parish Nurse program using a licensed Advanced Registered Nurse Practitioner (ARNP) to deliver care. The first half of the study will provide insight into the necessary training of a Parish Nurse and outline the roles and responsibilities and the standard operating procedures of the Parish Nurse. The need and success of the program will be demonstrated through the viewpoints of a local Pastor, testimonials of parishioners, and survey responses, which determined what parishioners feel are their most prevalent needs from the Parish Nurse.

The second portion will focus on the establishment of a free community health center using an Advanced Practice Nurse to provide leadership to the health center staff and care to patients. Information collected from stakeholders in the community and the results from the needs assessment offer a perspective on the current status health care system and the need for more health care services. A review of the patient encounter forms and survey responses will evaluate the utilization of the clinic by the community and the congregation. In addition, the case

study will identify the gaps in care within the church and the need to expand services for those who fall within those gaps. The author is the Parish Nurse in the setting.

The Parish Nurse Program

The Health of the Congregation

In order for readers to understand the need for a Parish Nurse, the researcher conducted an anonymous survey to demonstrate the various health conditions affecting church members (Appendix B). The church has an adult membership of 1200 people, most of which are African-American. The researcher distributed 150 surveys, with 116 surveys returned (Table 1). The survey sample consisted of 88 females and 23 males; five of the respondents did not mark a gender. The majority of those who completed the survey were between the ages of 40 and 49. The survey demonstrated that on average respondents had at least two chronic health conditions. The most prevalent conditions were hypertension (48%), followed by diabetes (31%). Many of the respondents had hypertension and diabetes in combination, putting them at increased risk for complications that require hospitalization.

Table 1. Health Status of Congregants

Health Status	% N= 116
Asthma	18%
Arthritis	22%
Chronic Pain	10%
Cancer	8%
Depression/Anxiety	8%
Dementia	0
Diabetes	31%
Hypertension	48%
High Cholesterol	26%
HIV/AIDS	1%
Obesity	20%
Stress	13%
Stroke	5%
Other	3%

The church has various ministries to support the Pastor and help congregants with situations that arise in their personal lives. One ministry, the Health Care Ministry (HCM), is comprised of licensed nurses of all levels and lay workers. The role of the HCM is to provide screening health services and health education, and to respond to congregants during times of physical distress during worship services. With members' varying health conditions and frequent

number of hospitalizations, the congregation needed someone who could directly support them during times of illness crisis.

Pastoral Insights

When congregants were hospitalized or diagnosed with chronic illness, or if there was an impending death, they contacted the Pastor for guidance and prayer. The Pastor was able to provide support and prayer for parishioners; however, he was limited in his ability to help them understand their medical conditions. The Pastor felt congregants needed someone to provide personalized nursing care, which could help them take control of their health; the individual could also establish a trusting and therapeutic relationship with congregants.

It is also important that the relationship between the Pastor and the Parish Nurse be collaborative and that the Pastor support the Parish Nurse in moving the congregation to whole-person health. In order to understand how the Parish Nurse assists the Pastor and helps the congregation, a local Pastor of the African Methodist Episcopal Church, which has an established Parish Nurse Program, was asked to give his viewpoints:

> Becoming a Parish Nurse is a spiritual calling to combine health and spirituality to create wholeness. The Pastor of the church also has the same spiritual mandate: to help members find wholeness through faith in God. The relationship between the Pastor and Parish Nurse can be a great relationship because they both have the common goal of helping congregants achieve wholeness. The means towards that goal, however, is sometimes different and each person has to have an appreciation for the others' methodology to ascertain the goal.

The aspect of the Parish Nurse model that is most beneficial to the Pastor and other ministers is assisting with visits when members are hospitalized. The first visit is made by the Parish Nurse, and the Pastor is then called during critical situations. The Parish Nurse has the ability to direct parishioners in asking the right questions regarding health conditions, treatments, procedures, and restoration that I wouldn't know to ask. This increases the comfort level of the member/patient knowing they have a spiritual and knowledgeable person available to during their time of illness. She [the Parish Nurse] continues to follow up with the member or patient, which allows the member to feel connected to the church.

The role of the Parish Nurse develops out of need for the services, and utilization of services develops from the relationships formed between the Parish Nurse and the membership. When people determined they were in need of the Parish Nurse's services, they were willing and open to receive the care of the Parish Nurse because of the intentional development of relationships. In addition, they were given the assurance that their information would remain confidential. The husband of a member called me and commented on the care his hospitalized wife received from the Parish Nurse. He stated that not only was the Parish Nurse there, she knew what questions to ask when the members did not know what to ask. It made the parishioners feel comfortable, both in knowing that someone from the church was there, but that person was able to relay the information needed. It is my belief that a Parish Nurse should be in every church. The problem is that the local church may not see the need, nor be able to finance the role.

Until funding sources become available, the potential to globalize the Parish Nurse program is limited.

This interview expounds on the importance of the Parish Nurse having a relationship with both the Pastor and the parishioner. The Pastor in the interview understands that the Parish Nurse not only provides care to parishioner, but also assists the Pastor with the overwhelming number of those that are hospitalized. By being of assistance with the number of hospital visits, the Pastor has someone to share the load of caring for congregants. In addition, the interview illustrates how important being available to congregants is to the success of the program.

Answering the Call

The Pastor of the church where the study took place determined that members needed a Paraclete, which is Greek for Holy Spirit or Comforter, to walk alongside parishioners during times of illness. However, this took some time to come to fruition. A few years prior, one parishioner of the church who was also a Registered Nurse noticed the declining health of the congregation. She felt a spiritual calling to provide care to congregants of the church that would lead to improved health outcomes and experiences. With the support of the Pastor, she decided she wanted to provide wholistic care within the church setting. In preparing to take on the role, she completed a Parish Nurse Program and applied for a grant that would compensate for the care provided to parishioners. Unfortunately, before the program was implemented, she unexpectedly passed away.

After some time had passed, the Pastor decided to move forward with the Parish Nurse Program. The researcher, who worked closely with the RN, also felt a spiritual call to not only provide wholistic care to those parishioners, but to extend that care to those who were uninsured

and did not have access to health care services. Being a Nurse Practitioner, the researcher was approached by members when they were diagnosed with a medical condition or when they became ill; they even approached the researcher for treatment. In addition, the researcher understood that the largest contributor of health disparities for at-risk groups was the inability to access quality health care services. Seeing the growing need for congregants and the community, the researcher answered the call of being the Parish Nurse for not only the church but the community at large.

Parish Nurse Training

To prepare for the role of Parish Nurse and before initiating the formal program, the researcher, who was already an Adult Nurse Practitioner, completed an eight-day, 52-hour course on Parish Nursing. The course provided extensive information on the role of the Parish Nurse, covering a vast array of topics to equip the Parish Nurse for providing care within the parish setting. The course taught the researcher how to deliver spiritually based nursing to dying and grief-stricken members, as well as issues of unforgiveness and denial, which cause spiritual distress and loss of faith. Additional topics covered included documentation practices, legal issues, program development, financing, and self-care management.

The course also provided opportunities for those attending to contemplate their own spirituality and journal those thoughts daily throughout the course. One night during the course, participants participated in a healing service, which is an intervention that can help parishioners maintain their spiritual integrity by reflecting on their past experiences of overcoming an illness. Each participant was asked to share a personal story of healing. The following is an excerpt from

the journal of the researcher where each participant shared a personal story of healing and wholeness:

> A few months ago, I became very ill while traveling on vacation with my family. I do not remember ever being so ill. Ironically, the condition I suffered with was my area of nursing specialty. Initially, I was not worried about my condition because I had educated so many patients on this particular health condition. After two weeks of antibiotics and surgery, I found myself still very ill, still on antibiotics, and on my way to have another, more extensive surgery. It was at that point in time I found no comfort in what I knew medically or in the doctors that I had worked alongside for the last four years. I remember being very afraid, knowing that my condition was serious and could change me forever. I had become overwhelmed with worry that I felt my faith failing. I did not understand why this was happening to me. Feeling of guilt overwhelmed me, and truthfully, I thought I might die.
>
> While I was still in the hospital, I received a call that one of the leaders of the church had to be rushed to the hospital for a heart condition. They needed answers on what was being said, and how to respond. I had to turn away from myself and refocus my thoughts for a moment to address concerns of a fellow member regarding the leader's health condition. Later that evening, my husband and children came to visit me and shared with me what was going on at home. I begin to reflect on all the things that were important to me, such as my family and friends, and why I chose to become a nurse. This self-reflection helped me find meaning and purpose for my life, which strengthened my faith. I came to the realization that God had called me to do something very special in nursing,

yet at that time, I did not know exactly what. This revelation helped me structure my prayers for recovery, and healed me from worry and anger.

In reflecting on this during the course of the Parish Nurse training, the researcher concluded that the role of the Parish Nurse is to help people transcend the emotional impact of their illness by rediscovering their purpose, help them change their behaviors through spiritual empowerment, and encourage them to live victoriously by acting on their faith in God. At the end of the program, the participants took part in a commissioning ceremony and made a vow to provide care to those within their parish and their community.

Program Structure

The Parish Nurse Program was developed similar to how physicians would incorporate a Nurse Practitioner (NP) into their practice. Nurse Practitioner protocols are guidelines that govern NP practice. The Parish Nurse model uses a collaborating Pastor and protocols that guide PN practice. The Parish Nurse should operate according to the protocol outlined by the Pastor of the church.

Once the PN training was complete, the Pastor and the newly trained PN would jointly design the organizational structure and operation of the PN program. The PN would serve as an extension of the Pastor for hospitalized or homebound congregants. Within this model, the PN is a staff member who directly reports to the Pastor of the church. This decision was made because the PN is seen as a full-time salaried professional nursing position within the church; however, at the inception of the program, the researcher is fulfilling the position voluntarily. The role description, including the PN responsibilities, was developed collaboratively by the Pastor and

the Parish Nurse, and was guided by the Scopes and Standards of Practice for the Faith Community Nurse (ANA, 2005).

The roles and responsibilities of the Parish Nurse are as follows:

- Possesses a baccalaureate or higher degree
- Maintains current licensure as a Registered Nurse within the State of Florida
- Provides leadership within the congregation in the area of health care and health-related services
- Provides nursing and spiritual care services under direction and supervision of the Pastor and in collaboration with the HCM
- Provides coordination of care for members who are in need of referral services
- Provide spiritual counseling during times of physical distress
- Provides care to family members during times of illness and death
- Provides education regarding diagnosis, treatment recommendations, and medication
- Provides a plan of care to the HCM and various ministries within the church to meet the needs of individuals with chronic or life-altering medical conditions
- Acts as an advocate/liaison between members and their personal physicians and coordinates resources to assist in their care

Once the PN protocols were developed, the PN referral process was developed. Figure 1 demonstrates the process of accessing PN care services. In addition, it demonstrates the process of exchanging information with the PN using the support from other ministries within the church to provide comprehensive and wholistic care to congregants.

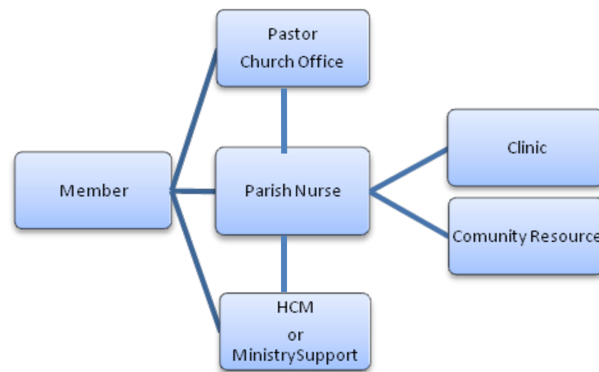

Figure 1. Parish Nurse Referral

Congregants notify the Pastor, church office, ministry support members, or the PN directly of hospitalizations, pending procedures, or need for health-related counseling. Depending upon which route the member takes, the PN is then notified to consult with the congregant either at their home or in the hospital. The PN contacts parishioners either by telephone or in person within 24 hours of receiving the notification and obtains baseline information. Once the structure of the PN Program was developed, the Pastor presented the program to the Advisory Council of the Church, and by unanimous vote the program was implemented.

The Parish Nurse Process

At the initial consultation with congregants, the PN completes an assessment of their health situation, including a history of the present illness and their potential physical, spiritual, and financial needs. A care plan is developed to help meet the members' needs using various ministry supports. Each member is notified that the assessment and care plan will be reviewed with the Pastor (Appendix D). Consent is obtained from parishioners prior to releasing any

health-related information to ministry support leaders (Appendix E). Members who decline to have their health information released to ministries are asked to specify what information they specifically want released, and only that information will be provided to the ministry leaders. Once the plan of care is disseminated to ministry leaders, interventions to meet the needs of the parishioner are recommended in the plan of care. The PN continues to provide support to members until they are recovered from their physical condition, decide they no longer need the services of the PN, or meet a peaceful death.

Parish Nurse Interventions

The primary responsibility of the Parish Nurse is to help parishioners maintain spiritual integrity by helping them understand their medical condition, and by providing interventions that motivate them to make decisions based on their spiritual beliefs and faith. One intervention is prayer. Prayers led by the Parish Nurse should specifically address the health condition, including the cause, testing, and treatment. The following is an example of an APPN prayer for a parishioner about to undergo surgery for a hysterectomy:

> Dear Heavenly Father,
>
> C.W. is preparing to go into surgery now. Lord I ask that you watch over her during the surgery and recovery. God, I ask that you please guide her surgeons and anesthesiologist during the operating procedure. Lord, we understand that doctors and nurses are human beings, but you are perfect in all that you do. Therefore, we ask that you prevent complications that could potentially occur with surgery. Minimize blood loss, prevent post-operative infections, and restore her to full health. Remove any doubt and fear, and

> let her mind reflect on the scripture, "Woman, thy faith has made thee whole." In Jesus' name, Amen.

Parish Nurses who pray with parishioners increase parishioners' comfort and confidence level, because the faith of the parishioner is that God will do exactly what was requested. The prayer provides a template of how parishioners should structure their individual prayers in order to minimize spiritual distress. Prayer can be initiated by anyone and have the same effect; however, prayers by the Parish Nurse are designed to demonstrate that health is supplied by God and uses health care providers as vessels for his healing power.

The APPN has the opportunity to act as a health care liaison for parishioners. The collegial relationship between parishioners' health care providers and the APPN allow information to be accurately transferred between the health care providers to parishioner via the APPN. The following is an example of the APPN acting as advocate or liaison for a parishioner:

> L.D. is a 49 y/o BM who presents to the ER via ambulance for nausea and vomiting, elevated blood sugar, elevated blood pressure, and jaundice. Upon entering the ER, the APPN notes the parishioner's BP is 220/130. The APPN asks the parishioner if he has been given something to bring down his blood pressure, and he responds "no." The parishioner gave the APPN permission to address his health condition with his health care providers. The APPN inquired to the attending physician what the plan of care was concerning the elevated blood pressure. The attending physician felt that the blood pressure was not high enough to cause alarm. The attending physician was notified that the researcher was a Nurse Practitioner and that the patient was in hypertensive crisis and should be treated immediately according to the guidelines. The APPN asked the attending

physician to administer Clonidine 0.1 mg to reduce the blood pressure. The attending physician obliged the request.

After all diagnostic tests returned normal, the parishioner continued to complain of chest-related pain in the mid-sternal area, and continued to vomit coffee ground emesis. Again, the APPN discussed the condition with the attending physician and requested that Pepcid or Protonix be given intravenously to the patient. The attending physician again agreed that this was a reasonable request and immediately ordered the treatment, which provided the patient with physical comfort.

This example demonstrates the ability of the APPN to effectively provide care to the parishioner by relaying the patient needs in professional terms to the care delivery team. During times of health crisis, this act of advocacy resulted in immediate treatment for the patient's complaints. In addition, it increased the comfort level of the parishioner and his family, thus increasing their faith in God and humankind knowing that there was familiar face concerned with their best interests.

Hosea chapter 4 verse 6 states, "My people perish for lack of knowledge." The more people know and understand, the better they are equipped to make decisions that promote their overall well-being. The role of the Parish Nurse is to provide congregants with health-related information that helps them make confident health-care decisions. The following is the case of a male who was diagnosed with hypertension, and despite being started on medications, continued to have an elevated blood pressure:

W.F. a 52-year-old man, recently has been diagnosed with hypertension and has been on medications for four weeks. He reports to the APPN that his blood pressure upon rising in

the morning is elevated greater than 160 systolic. He states that he notices that as the day progresses his blood pressure begins to come down, and then begins to rise again toward the evening. His medications included Atenolol 25 milligrams once daily, hydrochlorothiazide 25 milligrams once daily, and Lisinopril 20 milligrams once daily. He states that he takes all his medications in the morning, after breakfast.

After further investigation, the parishioner revealed that he doesn't eat dinner until late in the evening because of his work hours, usually 9 or 10 o'clock at night. The parishioner described his typical dinner meal, and the APPN noticed that the parishioner's diet was high in sodium from eating processed, pre-packaged and fast food meals. He was immediately educated on the importance of following a low-sodium diet. He admitted that his physician did tell him to avoid salty foods, but was unsure of exactly what foods were high in sodium. The APPN provided the parishioner a handout of foods he should avoid that were high in sodium. In addition, the APPN suggested to the patient that he discuss with his physician the possibility of taking one of his medications in the morning, and the other in the evening to provided better coverage of his blood pressure toward the end of the day. The APPN advised the patient to keep a log of his blood pressure and bring it in to his provider to demonstrate the times of day when his blood pressure is elevated. A few weeks passed and the patient reported having improved blood pressure because of changing his diet, and a change in his regimen by his primary care provider.

As a health educator, the APPN can provide an expert-level health education to parishioners to improve their health. It is important that parishioners understand they should follow the directions of their primary care provider. In addition, providing health education that

is specific to the patients' concerns increases the chance that they will remain adherent to treatments.

Many times the Parish Nurse has to incorporate multiple interventions to help parishioners move toward a difficult health care decision. The Parish Nurse must be able to help a parishioner understand what is happening physically and provide interventions that simultaneously support them spirituality. The following example demonstrates this with a family facing an end-of-life condition:

> A 32-year-old female is admitted to the hospital for a surgical procedure. While recovering she complains of a massive headache and subsequently suffers a brain aneurysm, leaving her in a permanent vegetative state. After multiple neurological tests, which do not confirm brain death, the family has to make a decision regarding her care. The Parish Nurse is asked to consult with the family regarding the decision. The family was unable to comprehend exactly what had occurred, and did not understand the terminology used to describe her diagnosis and prognosis.
>
> The APPN requested that a meeting take place between the family and the attending physician. The attending physician explained the information to the family regarding the diagnosis and the prognosis and the APPN reiterated the information in non-technical language. The physician used language such as "tracheostomy," and the APPN used the terms, "a tube in her neck to help her breathe on the respirator." The physician explained they could place a "peg tube in her abdomen," and the APPN replied, "that is a feeding tube placed in her stomach that goes to an outside pump that will feed her." After explaining all of this to the family, the APPN, with the physician present, explained that

she would never be able to do any of these things on her own, and that the breathing machine and other technology was sustaining her vital organs. The APPN explained in-depth that the patient would need long-term care, and would be at risk for the development of infection.

Once this was explained, the family was asked to reflect on the type of person she was, and what plans she had for her life. Then the family was asked if the patient would have wanted to live her life confined to a bed the rest of her life, unable to hug her child or participate in family functions. The family prayed together, and the leader of the prayer acknowledged that their faith was strong in God. That God would restore their loved one to the person she once was, or she would move to a better life in heaven. After reflecting on her life and praying together, the family was confidently able to make a decision to discontinue the ventilator. The APPN explained the extubation process to the family, and stayed with them until she was asystole.

Prior to meeting with the family, the APPN gained insight from the Pastor on how to care for the family spiritually during this difficult time. The Pastor provided guidance that, in an exchange of care roles, provided comfort and increased the confidence of the APPN. This intervention validates that fact that the APPN must maintain an open-door relationship with the Pastor, and substantiates the importance of self-care in this area of nursing. It is worth mentioning that the attending physician was grateful to have a liaison who could relay information to the family in terms they could understand and assist them in the decision-making process, which suggests that medical doctors are not exempt from needing spiritual care.

Parishioner Response to APPN Interventions

For this case study, members who accessed the services of the PN were invited to participate in an audiotaped interview describing their experience in receiving care from the Parish Nurse. The PN helped guide members through the hospital experience and advocated on their behalf if needed. The following describes the experience of a husband and wife being cared for by the Parish Nurse after he was hospitalized following back surgery.

> The husband responds: The Parish Nurse helps the Pastor. She helps by promoting confidence not just physically, but mentally and spiritually. Having a spiritual nurse, not just any nurse, made me feel more at home because she was a member of my church. If she was not a member, just knowing that you have someone that is a nurse and is spiritual with a strong belief in God made it easier to relate to her. I understood my health more, and she provided me with more reassurance in the care I was receiving. I feel Parish Nurses are needed very much.

> The wife responds: The Parish Nurse is a God-filled, professionally trained nurse that uses religion and skills to help the church and community as a whole. My husband was in the hospital, and initially, I did not know anything about the Parish Nurse program. Our Parish Nurse was there, and it demonstrated a good connection between the spiritual and health with everything that was going on. She was on top on everything in the hospital and monitored his condition. Just knowing that person was from my church and a spiritual person being in the nursing field made me grateful.

The interviewees provide evidence that the presence of the APPN is an intervention in and of itself. It is suggested that having the APPN visit when parishioners are hospitalized

provides comfort by the mere fact of being a nurse, and of having the same faith belief as the members. Additionally, APPNs being present also promoted feelings of care for the family members during the hospitalization and increased their comfort level by the APPN acting as a liaison and monitoring care.

The Parish Nurse acts as an advocate/liaison between members and their personal physicians and coordinates resources to assist in their care. One member who was hospitalized for five weeks during her third trimester of pregnancy completed the necessary paperwork for all health care information to be supplied to the PN during her lengthy hospital course. Being a Nurse Practitioner, the PN was able to establish collegial relationships with members of the parishioner's health care providers. The information received was therefore transferred to the patient/member in non-technical language. The patient/member provides an account of the care she received from the Parish Nurse while waiting to deliver her baby:

> I first heard about the Parish Nurse about two to three years ago. A very high-risk pregnancy, complicated by several pre-existing health issues, in addition to spiritual issues led me to seek care from the Parish Nurse. The Parish Nurse visited me weekly before I was hospitalized and called me every day or at least every other day to check on my health and see how I was doing spiritually throughout my illnesses and pregnancy. When I became hospitalized she helped me communicate with my doctors and guided me through what questions I needed to ask them. She also helped me to understand what was going on when the doctors used wording I could not understand. Being a Nurse Practitioner, she was able to contribute to the health care team, which gave me increased confidence in the care I was receiving. I had financial difficulty, and she found resources inside and outside the church to assist me.

> The greatest intervention provided to me by the Parish Nurse was prayer, prayer, prayer. When I was going into depression, she helped uplift me spiritually and prayed with me and made sure I was ok. She encouraged me continuously, and she shared scriptures with me and helped strengthen me and build my faith back up to where it was. My faith helped me to see things in a different light, to depend on God more. Without my faith, I probably would not have carried out the pregnancy.
>
> I felt comfortable sharing my personal information with the Parish Nurse. If she needed to disclose information, like when I was having financial struggles, she asked my permission before connecting me with resources. I am thankful that we have the Parish Nurse program for the constant care provided to me.

In this example, the interviewee states that the intervention most beneficial to her was prayer by the APPN. During times of physical distress, parishioners sometimes feel they are being punished for an illness and are unable to pray for themselves. These feelings of guilt will make a parishioner become spiritually distressed. The APPN's ability to pray for the parishioner during this time allowed the parishioner to connect to God through intercessory prayer. Because the prayers were being channeled through another source, comfort was brought to the parishioner, and she believed that the prayers of the APPN would be heard and granted.

Health education and counseling was provided to parishioners needing clarity on a particular diagnosis or medication regimen. Many individuals sought the care of the PN when having to make critical health care decisions. The following testimonial describes the account of

a woman who was diagnosed with recurrent breast cancer and how she sought advice from the PN:

> It makes a difference to have someone that you can sit or stand in front of that you feel confident in and comfortable with to share what is happening to you. Especially something that you do not have control of and that you have not accepted and gotten your hands around. I needed health-related information, and I went to the Parish Nurse. I received the information in simple terms, and I was able to understand my health condition, which allowed me to make decisions more clearly.
>
> She enabled me to know that God has provided resources that do not negate my faith. My faith helps me accept and understand my health condition, and gives me the courage to go through what God has allowed to happen to me. There is one thing to have faith and not do anything and just blindly say I am depending on my faith to heal me or get me through. I was able to understand through the Parish Nurse, yes have faith, but you must also take action. She said you have to deal with this; you have to do something; you cannot put your head in the sand.
>
> In talking to the Parish Nurse, she did not tell me what I wanted to hear but what I needed to hear, and that made a big difference. I did not like all of it, but I love that it was expressed. It made me stop procrastinating and do what I needed to do. I pray I am ready to deal with my situation. My faith gives me the will to do the best I can, no matter the circumstances. I would not be where I am in the decision-making process regarding my condition if I had not talked to the Parish Nurse.

The parishioner in this case immediately acknowledges that the APPN provides comfort and increases confidence by educating people so they can make informed decisions. By spiritually supporting and incorporating interventions, such as scriptural referencing, the APPN can help parishioners exercise their faith through active participation in their own health. The parishioner in this example was able to accept her health condition after being educated by the APPN on the resources available to her from God, and transcend above her current health condition because she now had hope.

To determine if the aforementioned viewpoints could be generalized to the congregation, the anonymous survey also asked members to identify what their perceived needs were for a Parish Nurse (Table 2). According to the survey, respondents reported that spiritual support and prayer (62%), followed by health counseling (37%) and hospital visitation (33%), to be the most needed services of the PN.

Table 2. Parish Nurse Services Survey

Service Needed	% ; N=116
Spiritual Support Prayer	62%
Health Counseling	37%
Hospital Visits	33%
Health care Liaison	29%
Monitoring Pressure/Blood Sugar	28%
Home Visits	26%
Assistance w/Living Wills	18%
Arranging Meals	8%
Pregnancy/Parenting Support	8%
Assistance w/Respite Care	4%
Other	2%

These results concur with the testimonials of the interviewed parishioners, and provide evidence of the need for PN services and the influence the APPN can make in the health care of parishioners.

Parishioners Outcomes to APPN Interventions

Three common themes of care were found among the three interviewed parishioners: presence, spiritual support, and health education. The APPN being available during hospital visits increased parishioners' confidence in the care they were receiving from hospital staff, which in turn improved their comfort level. Providing spiritual support and prayer for

parishioners allowed them to feel connected to God and the church. Parishioners felt that the Parish Nurse could relate to them and their situation through spiritual care. Feeling connected minimized feelings of hopelessness, fear, and loneliness. Finally, providing clear health education allowed parishioners to accept their diagnosis. In accepting their diagnosis, they were able to pray specific prayers for recovery, and hence became proactive in their health care.

There are additional findings attributed to the Parish Nurse also being Nurse Practitioners. Being an APPN allowed an easier exchange of information between parishioner and health care provider, and members of the patients' health care team easily accepted recommendations for care. Communicating directly with referred physicians expedited the referral process. In addition, being an APPN allowed for the early detection of conditions that required immediate treatment

The first half of the case study demonstrated the ability of an APPN to practice wholistically within a faith-based organization. The outcomes described are enhanced because of the incorporation of spiritual modalities into the practice of the Nurse Practitioner. The next half of the case will now describe the process of the developing a wholistic health center, using this model to provide care to the global community.

Health Center

The Idea for a Health Center

Faith-based organizations have many outreach programs that meet the needs of the community such as food banks, homeless shelters, and even health care. A link between FBOs and the APPN provides the opportunity to use a wholistic health care approach for the community at large by providing access to care to those who are uninsured and underserved. In

2003, the researcher became a Nurse Practitioner, after receiving a master's degree in nursing with an emphasis on adult health. After being employed in primary care for two years, the researcher had a desire to provide health care services for the large number of uninsured citizens and congregants who were in need of health care services. It is this thinking that led the researcher/Nurse Practitioner to the concept of a having a health clinic at the church. The idea was informally presented to the Pastor of the church, and with his approval, the feasibility of opening a health center was investigated.

Assessing the Need

An analysis of the current state of the local health care system was needed to determine where the gaps in health care service are, what demographic is affected by the current health care crisis, and what resources are currently available to those who are uninsured in Orange County, Florida. In 2007, the US Census Bureau reported that 42 million people were uninsured. Closer to home, in Florida, 4 million people were uninsured, and in Orange County, Florida, 285, 000 were lacking health care coverage.

A needs assessment was completed by collecting health information from administrators of local hospitals, private physicians' offices, and leaders in community health. Baseline data was obtained from these groups to determine the type of services being rendered (primary, secondary, and emergent) to those who are uninsured and what impact the services have on the organizations' financing and staffing. Meetings with stakeholders who would potentially benefit from the initiative were contacted to gain their perspective on the current health care crisis. The following information was assessed:

1. Profile of the population church and community

a. Demographics
b. Income level
c. Educational level
d. Immediate needs of surrounding community

2. Who benefits from health center at the church?
    a. Members
    b. Communities
    c. Hospitals
    d. Medical Providers
3. What is status of current health delivery system?
    a. Hospitals
    b. Federally qualified health centers
    c. Faith-based health centers
    d. VA clinics
    e. Private primary care offices
4. Who is willing to help?
    a. Pastors/Ministers
    b. Physicians/Dentists
    c. Nurses
    d. Pharmacists
    e. Case Managers
5. What funding resources are available?
    a. Grants

b. Private donations/Fundraisers

c. Hospital partnerships

d. Church-funded

Many administrators of local hospitals voiced concerns over the growing number of those receiving health care services in local Emergency Rooms (ERs) for non-emergent conditions. The following is an interview with a hospital administrator of a local hospital:

> The large numbers of those uninsured are using the Emergency Room for primary care services. We conducted an internal utilization review in 2008, which revealed 317 patients that had been admitted to the hospital on average seven times each. That is 2, 219 admissions for the same chronic conditions. The charges that resulted from providing pro bono care to these patients is an estimated $11 million in billable charges with $4 million in actual cost to the hospital.
>
> When we looked further, we discovered that the 317 patients were from the 32808 zip code are which is the Pine Hills area. The admission diagnoses were all for chronic conditions that can be easily managed in the outpatient setting if there was accessible access to care. The report showed the top five diagnoses: cardiovascular (non-chest pain related), diabetes gastrointestinal, infectious disease (non-HIV related), and respiratory.

Hospital administrators were informed of the plans to open a health care center in the area that is most problematic for hospital ERs. The administrators expressed an interest in supporting the initiative by exploring a collaboration in which uninsured patients from the 32808 zip code who were seen in the ER were referred to the health center for continuation of care.

Community health centers also provide care to the uninsured citizens of Orange County and have increased demands and cost due to the large number of individuals who access their centers daily. One CEO of a local Federal Qualified Health care Center provided the following insight into the state of health care in Orange County, Florida, and his viewpoints on how to improve the status quo:

> The ability to access health care in Orange County for the uninsured is difficult. Currently, there are 285,000 people in Orange County who do not have access to health care services. Most individuals have to seek care in local emergency rooms, only to find themselves right back a few short weeks later for the same preventable and manageable chronic health conditions. Limited access to health care increases the risk for communicable diseases and increases the financial burden placed on citizens who have to cover the cost of so many without health care coverage. Currently, there are about 11 health care locations that provide free health care to those who are uninsured or underinsured.
>
> I think it is an excellent idea to have churches develop health initiatives to meet this overwhelming demand for services. Ideally, I feel that a health center should be made available in every community within Orange County. It is important, however, that collaboration take place between faith-based organizations and the larger health care system to ensure that services are being provided while conserving the financial resources.

With the information obtained, the researcher determined that the biggest need for health care services in the community was for primary care to help patients who are uninsured manage

chronic health conditions such as diabetes, high blood pressure, and asthma. This care, however, should not duplicate existing services and should be collaborative with local health care agencies.

In order to avoid duplication, an Internet search of the available health centers within the 32811 and 32808 zip codes revealed three health centers currently in operation. The output data revealed only three health centers within a five-mile radius of the church supplied free or reduced medical services. Of the clinics in the immediate area, one provided primary care services, one provided free STD and pregnancy testing, and the other provided free acute care services.

Pine Hills Community Health is a Federally Qualified Health Center providing low-cost primary care services during the daytime hours. Patients have to pay a $20 co-pay in order to access care. Individuals seeking health care services sometimes are unable to afford the minimal charge for services. Lila Mitchell is a health care facility that previously provided pregnancy and STD testing. During the course of the case study, it further limited the services it offered by only meeting the needs of women who were pregnant.

Shepherd's Hope, a well-established faith-based organization in the local area, provides free health care to uninsured citizens with acute conditions only. The services are provided by volunteer licensed health care providers during the evening. The following interview by a Nurse Practitioner provides insight into volunteer health care services:

> Shepherd's Hope provides primary care services to the uninsured and homeless. We primarily see patients who need acute or episodic care, such as for bronchitis or vaginitis, to prevent them from accessing care in the ER. Patients with chronic conditions like hypertension and diabetes are referred to PCAN clinics [Primary Care Access Network].

Typically, each volunteer provider sees about 10-15 patients, and there are usually 2-3 licensed volunteer health care providers a night. Patients are seen on a first-come, first-served basis, and patients are usually in line two hours before the clinic opens.

Shepherd's Hope is an outreach ministry of the Methodist church and is funded through the faith community, private donations, and grants. What drew me to provide services at Shepherd's Hope was a personal desire to want to help so many that are uninsured, and in a faith-based setting. The sovereign immunity protection is also a huge incentive to want to volunteer because it protects the provider from any malpractice liability claims. In addition, the infrastructure of the organization is well-developed. It has a paid staff such as clinic and volunteer coordinators who ensure that volunteers have a good experience. The infrastructure has allowed the organization to be sustainable for many years.

Shepherd's Hope operated a clinic within the community that the church serves, but due to circumstances beyond its control, had to relocate the clinic 12 miles from the citizens that needed the services the most. Enough information was provided to determine that members of the church and community would benefit from the establishment of a free "medical home" at the church for primary and secondary care services. The initiative was presented at the FBO's quarterly Advisory Council, and a unanimous vote was rendered to move forward with the development of the free health center.

The Infrastructure

A steering committee was formed to help launch the project. The committee consisted of members of the church with diverse backgrounds in health care, administration, finance, and

social services. The infrastructure development of the health center included organizational structure, funding resources, volunteerism, health center policies, and marketing.

The health center was developed as a separate 501(c)(3) non-profit organization named Mt. Sinai Center for Health and Wellness Inc. This was done to maximize funding opportunities, because many foundations and grants will not donate funds to faith-based organizations. Non-profit 501(c)(3) organizations are required to have a Board of Directors (BOD) at the inception. The initial BOD, which would serve as the governing body of the organization, included two members of the community and three members of the church. The Pastor on the BOD was named CEO of the health center, a physician on the BOD volunteered to be the Medical Director, and the Advanced Practice Parish Nurse would become the Chief Operating Officer. The steering committee became the Executive Board (EB) or "working board." The EB consists of a Case Manager, Clinic Coordinator, Public Relations Coordinator, and an Administrative Assistant.

A mission statement was devised using the information gathered from the needs assessment, which incorporated the overall mission of the FBO: "To wholistically meet the physical, emotional, mental, and spiritual needs of people within the community and empower them to live healthy lives."

Since health care services were going to be provided free of charge, the health center registered with the Florida the Department of Health under the Volunteer Health Care Provider Program. This program provides sovereign immunity protection to health care organizations and licensed health care professionals who provide free health care services. Sovereign immunity protection prevents a volunteer health care professional from being named in any medical malpractice claims. In order to receive sovereign immunity protection, the organization and providers must limit their services to individuals who have an income at or below 200% of the

Federal Poverty Guidelines. The Department of Health does not require individuals to provide proof of income, so patients are allowed to self-declare what their income is.

It was imperative to acquire legal representation well-versed in health care law for the health center. A congregant who works for a law firm informed the senior partners of the initiative. A meeting was held between the attorneys and the CEO and COO to discuss the mission and legal needs of the health center. The law firm agreed to provide full legal representation pro-bono except for any pass-through fees. Finally, it was important that the church was covered for any liability issues since operating a health center is not part of its usual activities. Additional general liability coverage was purchased to cover any claims arising in the event that a patient should become injured in an exam room.

Financing the Health Center

“Free” does not mean no-costs, so a strong funding stream had to be developed in order to sustain the health center. Funding sources would include governmental and foundation grants, fundraising, private donations, and support by the faith community itself. A first-year budget was developed to determine how much funding would be needed. To minimize the budgetary needs, it was decided that no salaries would be paid during the first year, and all positions would be fulfilled voluntarily until the health center was financially able to pay a volunteer and clinic coordinator. The EB decided that 80% of all funds would go toward direct patient care services, such as laboratory and radiology testing. The remaining 20% would be used for operating expenses, which included office supplies, medical equipment, utilities, etc. Local hospitals, medical practices, and members of the church were petitioned to donate needed medical supplies

and equipment. Items that were donated included two exam tables, Otoscope and Ophthalmoscope, Nebulizer, Pap smear supplies, etc.

Two grants were applied for the first year, but both were denied. Most grant funding required organizations to have been established for two or more years and demonstrated self-sustainability; since this was a new health center, this was difficult to exhibit. A sub-committee under the EB was created to organize and promote fundraising events. The goal for the first year of fundraising was $22, 500. Three fundraising events have been held by the health center, which yielded net proceeds of approximately $9,000 within the first year of the health center opening.

Volunteers

The health center staff was comprised completely of volunteers. The staffing mix included licensed health care professionals, case managers, and administrative support personnel. Medical and administrative volunteers were used to staff the clinic. All volunteers completed volunteer orientation and HIPAA training, and were required to sign a contract acknowledging that they would not be compensated for any services rendered in the center.

Licensed health care providers were required to complete a Volunteer Health Care Provider Contract by the Florida Department of Health in order to volunteer and qualify for sovereign immunity. All physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, pharmacists, and any other profession that holds a state license was able to receive these benefits. This document was filed with the local Department of Health representative and in the administrative office of the health center. Also, each Nurse Practitioner and Physician Assistant signed a collaborative agreement with the volunteer Medical Director. This agreement used

standard language regarding the ability for Nurse Practitioners and Physician Assistants to provide care according the scope of practice outlined by the Florida Department of Health.

Volunteers were asked to donate a minimum of three hours every two months. Volunteer assignments were made three weeks in advance. Each volunteer had their hours recorded, and documentation of the total number of hours volunteered was provided to each volunteer upon their request. Additionally, the volunteer database reported that 87 individuals signed up to volunteer, with 97 % of them being actual members of the church.

Health Center Policies

It was important to create policies to govern the practice of the health center. Only patients over the age of 18 were permitted to be seen in the clinic, unless they were emancipated by the court at 16. Proof of the emancipation would be required before anyone under 18 could be interviewed for eligibility. Patients who did not meet the eligibility requirements, such as those who needed psychiatric care, were pregnant, or needed STD testing were determined inappropriate for services.

Patients were required to sign in every night. Patients were asked to schedule an appointment; however, walk-ins were also accepted and were seen on a first-come, first-served basis. Each provider was not scheduled more than 10 patients per night, and the maximum number of patients to be seen each clinic night would not exceed 20, depending on the number of providers volunteering. Walk-ins were accepted up until one hour prior to closing or until the maximum number of patients had been reached. Patients were asked to keep all scheduled appointments, and calls regarding cancellations were asked to be made 24 hours in advance.

Prior to having services rendered, patients had to go through screening and eligibility. In order to be eligible for services, patients must have demonstrated an income at or below 200% of the Federal Poverty Guidelines. This was a necessary process because it is the component that ensures sovereign immunity for the volunteer health care providers. The Florida Department of Health did not require individuals to show proof of income; however, consumers of this program did have to supply documentation of their residency status as well as their income. This validation process reassured health care providers that the health center was not in competition with their private practices, and also emphasized to potential financial contributors that the services being rendered were for those who truly needed them. Forms of documentation included four weeks of pay stubs, unemployment compensation letter or denial letter, disability benefits letter, income tax statements, or a notarized letter of support from a relative or friend. Because of the detailed nature of the eligibility process and the need for accuracy, volunteer eligibility coordinators were limited to no more than 3-4 individuals trained to perform the task.

After eligibility determination was completed, patients were triaged by a staff nurse. Patients who presented with chest pain, a blood pressure greater than 200 systolically, or temperature greater than 103 were referred to the nearest emergency room and transferred via ambulance or with a family member. A review of the patient sign-in sheet revealed that the average number of visits each week was five.

Providers were asked to prescribe low-cost medications from discount drug formularies where many medications can be purchased for $4 for a 30-day supply, or $10 for a 90-day supply. Providers who prescribed brand-name medications not part of the discount formulary plans referred patients to a volunteer Case Manager who could arrange Patient Assistance Programs; these programs provide free medications to individuals that meet eligibility

requirements and are sponsored by the drug companies themselves. Providers were prohibited from prescribing narcotic pain or sleep medications.

Patients with poorly controlled conditions, such as diabetes, or who needed help with lifestyle behaviors such as smoking cessation, were referred to health education classes conducted at the church. Patients who needed to be evaluated and treated by a specialist were also referred to the volunteer Case Manager. Case management was responsible for assisting all patients who needed to be referred to a specialist; specialists were also extended sovereign immunity for services provided pro-bono. In the event a patient could not be seen by a contracted specialist, the patient was referred to the nearest Primary Care Access Network (PCAN) clinic, which has a large volume of specialists that provide specialty care. Local diagnostic centers agreed to provide discounted services for diagnostic testing. In the event patients could not afford the minimal charge for diagnostic testing, the health center covered the cost of these services.

Phone calls and faxes were received through dedicated lines separate from the church office. The outgoing message announced the days and hours of operation and clearly instructed patients to go to the nearest emergency room if they were experiencing a life-threatening situation. The voice mail messages were checked at the beginning and end of every day by a member of the Executive Board. Once the message was received, it was dispatched to the Advanced Practice Parish Nurse, and patients had their phone calls returned in 24 hours. Patients with conditions that were determined to require immediate attention were referred to the nearest emergency room. All calls coming into the clinic were logged and documented in the patient's chart.

Health Center Patient Profile

The clinic has 87 registered patients. Of those, only five patients from the congregation received care inside of the health center. A review of the patient encounter forms revealed that 95% of those who were treated in the clinic were African-American and female. The top two diagnoses of patients seen in the clinic are hypertension (52%) and diabetes (30%).

Findings

The eligibility process prevented many of the congregants from utilizing the services provided at the health center. In order for the APPN and other licensed health care providers to receive sovereign immunity protection, patients that access the health center must not have any form of health insurance. Of those surveyed, 85% have private insurance.

Table 3. Health Insurance Status of Congregants

Health Status	% N=116
Medicare	18%
Medicaid	6%
Private Insurance	61%
Uninsured	9%

Lastly, in reviewing the volunteer log, many of the professionals that volunteered routinely were members of the FBO. The volunteer log reveals that the FBO currently has two Registered Nurses, one Licensed Practical Nurse, two Clinical Social Workers, one Dentist, and

two Medical Assistants. This illustrates that not only is the health center an outlet for the NP to practice wholistic services, but it also provides an avenue for many other health care professionals to use their talents by offering their services. Also, because these professionals are connected to the FBO, they are motivated by their faith doctrine to provide these services to those without access to health care. This allows the health center to be constantly and adequately staffed, without being solely dependent on volunteers from outside of the FBO.

The case study demonstrates the vast services offered to both the community and parishioners in the area of health. The majority of the volunteers that provided care were members of the church. The study demonstrates the ability of a Nurse Practitioner to provide Parish Nurse services as well as manage and provide care within a faith-based health center. However, it also demonstrates a new gap that is formed when parishioners are unable to access the advanced level of care that can be provided by the APPN within the health center. Implications for use of this data will be covered in the next chapter.

CHAPTER 5: DISCUSSION

This case study demonstrated the ability of a Nurse Practitioner to incorporate the advanced knowledgebase and skill set of nursing into a faith-based organization to develop a Parish Nurse Program and free health center for the uninsured. The case study presented reflects the interactions of one Parish Nurse and one church; however, the insights gained provide foundational evidence to support the importance of understanding spirituality and how it impacts health. The case study also demonstrates the ability of nursing to evolve continuously in practice and research. There are many inferences and implications that can be made from the case study that suggest that Parish Nursing has moved from the basic role of blood pressure and blood sugar monitoring to a full practice specialized in wholistic care.

Parish Nursing is not focused on the amount of medication a person is taking or the surgery a person is about to undergo. The goal of the interventions applied in the Parish Nurse model is to help people understand that their life has meaning and purpose and those decisions regarding their health are essential in helping making sure their purpose is fulfilled. When people feel their life has meaning or purpose, they are able to transcend above physical infirmities and make health decisions that promote their overall health. When people identify their reason for living, they are more confident and motivated to ensure that their life's mission is fulfilled. As with the self-testimonial of the researcher, understanding the reason for someone's existence helps remove fear and anxiety and helps them fulfill their destiny. The most prominent role of the researcher in the case study was providing spiritual support to parishioners by being present. In order for congregants to want to receive this care, Parish Nurses must have be connected and have a relationship with parishioners.

Parishioner-Parish Nurse Relationship

The concept of availability is what promotes the relationship between a Parish Nurse and parishioners. Health education, prayer, and being present were the most used interventions to maintain spiritual integrity during times of physical illness. When parishioners understand their health conditions, they are able to be more specific in their spiritual practices, such as with prayer or scriptural reading.

Being available to congregants and meeting with them individually to counsel them on their health conditions promotes the therapeutic relationship between the parishioner and the Parish Nurse. When a therapeutic relationship exists between a patient and a health care provider, the patient is more apt to be adherent to treatment regimens. When a trusting and therapeutic relationship exists between congregants and the Parish Nurse, congregants better understand their higher purpose and make health care decisions that help make ensure their purpose is fulfilled.

Parish Nurse-Pastor Relationship

At one point in time, patients felt they were getting sub-optimal care when being seen by a Nurse Practitioner. Once a physician demonstrated and promoted the confidence he or she had in a Nurse Practitioner, patients became more comfortable and confident in Nurse Practitioners as well. This same analogy applies to the Pastor and the Parish Nurse. Pastors must assist in promoting the relationship between the Parish Nurse and parishioners. Pastors must ensure parishioners that the Parish Nurse is an extension and enhancement of Pastoral care. In this case study, there was a mutual respect for the role of the Pastor and the role of the Parish Nurse. The Pastor promoted the Parish Nurse program by making the Parish Nurse the first point of contact

for hospitalized or homebound members, and he encouraged members to seek the counsel of the Parish Nurse for health-related matters. Pastoral support was influential in the high utilization of the Parish Nurse program. Likewise, the Parish Nurse understood the limitations in meeting the spiritual needs of parishioners and collaborated with the Pastor routinely for guidance. It is important that Pastors and Parish Nurses have a mutual respect for each discipline and work together to meet the needs of parishioners.

Advanced Parish Nurse Practice

The requirements for providing spiritual care to parishioners do not supply enough evidence to suggest the need for Parish Nurses to have a master's-level education. The survey results, however, demonstrate that parishioners have physical conditions and needs that allow master- and doctorally-prepared Parish Nurses to utilize their advanced licensure and knowledgebase in the faith community setting. APPNs have the opportunity to provide parishioners with individualized health education, leading patients to make more informed decisions about their health care. In addition, the title "Nurse Practitioner" is recognized by partners in health, and therefore provides the opportunity for APPNs to collaborate with parishioners' primary care providers on a professional level, which in turn enhances the patient's health management. The collaboration between Advanced Practice Nursing and faith supports Parish Nursing as the model of wholistic care. The care provided by APPNs to parishioners could result in the earlier recognition and treatment of disease, leading to better outcomes both physically and spiritually. The APPN's ability to practice on an expanded scope provides opportunity for the FBO to offer charitable health care services.

Providing free health care to the uninsured was achieved by the development of a free health clinic for the uninsured. The utilization of the clinic services by the community is low considering the large number of those who are uninsured. There are a variety of reasons that could explain the poor utilization of the clinic. Poor support from the larger health care system, location of the clinic, days and hours of operation, the availability of larger and more comprehensive community health centers, and poor marketing are all potential factors that have contributed to the low response rate of the services provided. The clinic has only been operational for seven months, however, and awareness of the services is spreading through word of mouth.

Limitations

There were several limitations related to the case study. The first limitation is the small sample size of the survey participants. The membership of the church is 1200 adults, and the sample represents only 12% of the membership. It is therefore difficult to generalize the findings to the entire congregation. A second limitation was parishioner bias. The researcher who is the APPN in the case study is also a congregant of the church. The established relationship between the parishioners and the congregants could pose favorable bias that resulted in positive feedback of those who accessed care. Thirdly, the APPN in the case study has relationships established with health care providers within the community, which could have improved the patient-provider relationships. Another limitation is researcher bias. The researcher cannot assume that the positive outcomes or resolutions of parishioners were solely because of the interventions provided by the APPN. Many members of the church visited with parishioners, including the Pastor. With regards to the health center, because the patient encounter forms were limited to

new patient encounter forms, individuals diagnosed with hypertension and diabetes on subsequent visits could be missing.

Recommendations

Self-Care Management

It is recommended that APPNs and PNs incorporate opportunities to provide self-care throughout their practice of parish nursing. Congregants' needs can be demanding and complex, which can be mentally and physically exhausting . PNs should meet regularly with the Pastor to discuss emotional stressors and feelings of fatigue, and should incorporate daily self-care interventions such as mediation, exercise, inspirational reading, and prayer. As with any other profession, PNs should be sure to take vacations and find moments for rest and relaxation. These recommendations will allow the PN to provide care with clarity and compassion.

Education and Certification

Like many specialties, Parish Nursing requires education that goes beyond what is provided in undergraduate and graduate-level nursing. Parish Nursing is a specialized practice of nursing that requires specialized training. Just as many nurses choose a particular area of nursing, such as labor and delivery or critical care, Parish Nursing is a personal choice that follows a biopsychosocial-spiritual approach to care. Hospital organizations and accreditation agencies are now requiring nurses to assess and provide interventions that address spirituality, yet nursing schools put little emphasis on understanding, assessing, and providing interventions for a person's spiritual being. Parish nursing has the opportunity to be the model for demonstrating the effectiveness of spiritual care in improving health outcomes.

In order to effectively do this, Parish Nursing must be viewed as a specialized practice requiring certification. Faith-based organizations that wish to incorporate a Parish Nurse program should require nurses to complete a formal Parish Nurse training program. Formal Parish Nurse training helps the nurse understand how people view both health and their spiritual person. The course helps the nurse understand the paradigm shift from patient care to parishioner care. While it is easy for traditional nurses to apply their mindset to Parish Nursing, Parish Nurse education helps nurses understand the intervention differences in the clinical versus parish setting. Parish Nurses who operate outside of the scope of the Parish Nurse could jeopardize their licensure. Understanding the boundaries of Parish Nursing and the legal issues were essential components of the training for the researcher.

Liability and Compensation

The liability issues limited the ability of the APPN to expand care services to parishioners, hence causing an internal gap in health care services offered by the faith-based organization. Legal obligations present barriers for the APPN to function to the full scope of practice. Florida law requires that Nurse Practitioners have a collaboration agreement with a licensed physician, a set of practice protocols, and professional liability insurance. Nurse Practitioners who provide care within the faith community setting should be held to the same standards of care as any other Nurse Practitioner working within a specialty practice.

Nurse Practitioner PNs should not be exempt from carrying malpractice insurance, because parishioners have the same risks as those in the general population. The only exception that should be considered is if the APPN provides services pro bono. In this case, sovereign immunity protection should be extended to the APPN, much like it would be extended to a

specialist providing care to a patient from the health center. Faith-based organizations are known for providing an abundant number of charitable care to those who are in need. Policies need to be revised to extend sovereign immunity protection to FBOs and licensed health care professionals who provide health care services as part of their charitable services.

It is recommended that services provided by the APPN be compensated and that liability coverage be supplied to the APPN by the FBO until policies change. The role is considered to be at minimum a part-time position. Services provided by a Nurse Practitioner are reimbursable. Most of the parishioners surveyed have health insurance, and the revenue obtained from third-party payers can be in part be allotted to cover the salary of the APPN. Additionally, from the time this case study was initiated, the landmark health care reform bill was passed, which will expand health insurance coverage to 20 million more Americans. Nurse Practitioners and faith-based organizations will be essential in meeting the new demand of those with insurance coverage in 2014. Therefore, it is imperative that FBOs and APPNs begin learning the process of third-party billing so they may provide care when the time arises.

Research

Qualitative and quantitative research is necessary to examine the benefits of parish nursing on parishioner health outcomes. Research must examine the connection between spirituality and a variety of complex issues such as death and dying, coping strategies, resiliency, and treatment adherence. Furthermore, continued research is needed to examine the potential of this paradigm to impact the health and well-being of individuals, and to the total health care delivery system.

Conclusion

Nursing programs are obligated to educate future nurses on spiritual care practices and develop standards of care for addressing spiritual issues. It is essential that Parish Nursing advance the profession by developing a certification process. Most specialty nursing professions use the certification status to demonstrate expertise in a field of nursing, and Parish Nursing should be no exception.

The role of the Advanced Practice Nurse within a faith-based organization is unique in its functionality. The Advanced Practice Nurse is not only able to provide the traditional care of the Parish Nurse but is able to wholistically, comprehensively, and competently provide care to parishioners and the community at large. Advanced Practice Nursing and faith-based organizations have the potential to be the benchmarks of wholistic care within the community.

APPENDIX A: IRB APPROVAL LETTER

University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Approval of Exempt Human Research

From: **UCF Institutional Review Board #1**
FWA00000351, IRB00001138

To: **Chianta S. Lindsey**

Date: **May 10, 2010**

Dear Researcher:

On 5/10/2010, the IRB approved the following activity as human participant research that is exempt from regulation:

Type of Review: Exempt Determination
Project Title: Advanced Practice Nursing In the Faith Community Setting: A Case Study
Investigator: Chianta S Lindsey
IRB Number: SBE-10-06916
Funding Agency:
Grant Title:
Research ID: N/A

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these changes affect the exempt status of the human research, please contact the IRB. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

In the conduct of this research, you are responsible to follow the requirements of the Investigator Manual.

On behalf of Joseph Bielitzki, DVM, UCF IRB Chair, this letter is signed by:

Signature applied by Joanne Muratori on 05/10/2010 10:05:58 AM EDT

Joanne Muratori

IRB Coordinator

APPENDIX B: EXPLANATION OF RESEARCH

Version 1.0 10-21-2009

EXPLANATION OF RESEARCH

Title of Project: **Advanced Practice Nursing in the Faith Community Setting: A Case Study**

Principal Investigator: **Chianta S. Lindsey, ARNP, MSN, FCN**

Faculty Supervisor: **Dr. Susan Chase**

You are being invited to take part in a research study. Whether you take part is up to you.

- The purpose of this study is to describe the role of the Parish Nurse in a faith community or church setting, demonstrate the impact the services makes in the lives of those that access the services, and determine the need to expand services to parishioners according to level of practice in which an advanced practice nurse is capable to perform.
- As a participant you will be interviewed and asked to describe in your experience with receiving care, counseling, or support from the parish nurse, and what impact, if any, did it make in your personal health situation.
- An interview will be conducted it will take approximately 30 minutes in order to capture the richness of your experience. The interviews will be conducted in a private location and at a time that is mutually agreed upon by the participant and the researcher. The interview will be audiotape recorded. You will not be asked to state your name or any personal identifying information. The recording device with recorded interviews will be kept in a locked box only accessible to the primary investigator. Once the interviews have been transcribed, all the information will be permanently erased from the recording device. If at any point prior to **May 31, 2010** you wish to withdraw your interview from the research study please contact the researcher at the number or email listed below immediately and the information will be not be used in the research analysis.

You must be 18 years of age or older to take part in this research study.

Study contact for questions about the study or to report a problem: If you have questions, concerns, or complaints *Chianta Lindsey, Doctoral Candidate, Doctor of Nursing Practice Program, College of Nursing, (407) 484-5073 or by email at chianta.lindsey@yahoo.com. In addition you may contact, Dr. Susan Chase. Faculty Supervisor, Graduate Dean at College of Nursing (407) 823-3079 or by email at schase@mail.ucf.edu.*

IRB contact about your rights in the study or to report a complaint: Research at the University of Central Florida involving human participants is carried out under the oversight of the Institutional Review Board (UCF IRB). This research has been reviewed and approved by the IRB. For information about the rights of people who take part in research, please contact: Institutional Review Board, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823-2901.

Thank you for your participation.

APPENDIX C: PARISH NURSE HEALTH SERVICES SURVEY

PILOT PARISH NURSE PROGRAM

Mt. Sinai M.B. Church Health Services Survey

DEMOGRAPHICS
Age Group: ☐ under20 ☐ 20-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ 60-69 ☐70-79 ☐ 80 and over Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Gender: ☐ Male ☐ Female Employment Status: ☐ full-time ☐part-time ☐unemployed ☐ retired Health Insurance: ☐ Medicare ☐ Medicaid ☐ Private ☐ Uninsured
HEALTH STATUS: Do you or a family member have any of the following health conditions:
☐ Asthma ☐ Arthritis ☐ Chronic Pain ☐ Depression/Anxiety ☐Dementia ☐ Diabetes ☐ High Blood Pressure ☐ Cancer ☐ High Cholesterol ☐ HIV/AIDS ☐ Stroke ☐ Obesity ☐ Stress
WHAT PARISH NURSE SERVICES MIGHT YOU FIND MOST BENEFICIAL TO YOU
☐ Spiritual Support and Prayer ☐ Hospital Visits ☐ Health Care Liaison (between yourself and medical providers) ☐ Home Visits ☐ Health Counseling (assistance with understanding medical choices, medications, procedures) ☐ Assisting with Respite Care ☐ Arranging Meals ☐ Monitoring Blood Pressure/Blood Sugar ☐ Assistance with Living Wills ☐Pregnancy/Parenting Support ☐ Other: ______________________
WHAT ADVANCED PARISH NURSE SERVICES WOULD YOU LIKE AVAILABLE TO YOU AT YOUR CHURCH
☐ Urgent Care Services (Colds/Flus, Stomach Virus, Injury, etc) ☐ Routine Primary Care ☐General/School/Work Physicals ☐Vaccinations ☐ Emergency Medication Refill Service ☐At Home Medical Care ☐ Advanced Health Screenings: Breast Exams, Prostate Exams, EKG, ☐ X-ray and Labs ☐ Specialist Referral Services
HOW OFTEN WOULD YOU ACCESS ABOVE SERVICES?
☐As Primary Health Care Service ☐ As Needed for Urgent Care ☐ Occasionally Depending on Need ☐Once a Year for Health Physical ☐ Never

APPENDIX D: PARISH NURSE NOTE

Mt. Sinai Missionary Baptist Church
Parish Nurse Progress Notes
and
Plan of Care

Date: Member: Member

Location at Time Visit: Members Home

Status: Recently discharged from Dr. Phillips hospital for nausea, vomiting, dehydration, and gastroparesis (stomach immobility)

Address:

Phone: 000-000-0000

History of Present Condition:

Member is a 37-year-old female who recently joined the membership approximately a month ago. She was recently admitted to the hospital after becoming diaphoretic and extremely thirsty. She states she then quickly developed nausea, vomiting, and diarrhea and was admitted to the hospital for the aforementioned symptoms and dehydration. During her hospital course she developed chest pain, which was thought to be related to her known heart disease. EKG was negative, and cardiac reasons were quickly ruled out, although she continued to have the discomfort. She was consulted by GI who performed motility studies, small bowel series, and upper endoscopy. She was diagnosed with having gastroparesis with no understanding as to why this developed in a person who is non-diabetic. She was discharged home on antibiotics.

Spiritual Assessment:

At our initial meeting "member" seems very pleased to meet with me. In inquiring how she was feeling she immediately begin to cry and explain that she has been dealing with illness her entire life. She explains that she suffers from chronic back pain status post a surgical procedure, heart disease, and hypertension. She feels she is always afflicted with one physical aliment or another and doesn't understand why she continues to go through with medical problems. She shares that because of a medical condition she had to undergo a hysterectomy at a young age preventing her from ever being able to conceive children. She voices that she has a twin sister who a year after her hysterectomy became pregnant, and she had difficulty accepting this when she has tried to live her life for God and her sister has not confessed Christ (at least not at that time) as her Savior. She reports having a strong faith in God and knows that he holds her life in his hands, but today she is "angry and tired" of always being ill, and always being in pain. This has led her o have periods of depression.
She voices some feelings of guilt that she is not working to help her husband to sustain them financially, but states he is very understanding of her medical condition, and feels their marriage is very strong. They have been married for 7 years and together for 10. She understands that God

does answer prayer in his time, but wonders when he will answer her prayers. Despite her multiple medical problems she admits that "God has truly been good to me and my husband."

She shares that she misses her old friends and her old church, and that she was very involved in various activities within the church. She relocated to be close to her mother who had to undergo heart surgery, and to assist her with taking care of her small nieces and nephews. She enjoys children and has provided childcare from time to time since relocating here in Orlando. She does have family in Orlando; however she states that she has very little support from them.

Intervention/Education: At today's visit I spoke with "member" at length of her need to seek second opinions and solutions to her chronic condition. I recommended several physicians to her that I felt could provide her with some insight. I advised her to get a copy of her medical records, and I would review these with her in detail. At presents, she is not delusional nor does not express thoughts or behaviors that indicate that she may be suicidal.

I shared with her various scriptures that could lend her strength, (Referenced scriptures from: Romans 8; Psalm 34; 1 Peter 5; 2 Corinthians 12). It is the hope that these scriptures will help her to understand that God does hear her prayers and that despite her physical ailments her spiritual being is renewed day by day, and God would provide her with everything she needed to make it through each day. I advised her to look at her test and trials as a means to have a testimony. To focus on each day, and rejoice that she made it through the day, no matter what level of pain she is experiencing or had experienced, because the Lord declares that his "grace is sufficient". She received this well.

I informed her of our intranet Sinai CONNECT and explain the wealth of information and ministries that she could become a part of. We took a tour of the sight and advised her to review the 7 DAY FAST from NEGATIVITY. In addition I shared with her a blog post from one of the members entitled "Before your Breakthrough." She found this to be very comforting.

I shared with "member" that I would seek the help of various ministries in the Church to help her with her illness and transition period. I also encourage her to seek opportunities within the Church to volunteer her time and talents on days when she was physically doing well. She was accepting of all the information and recommendations presented to her.

She understands that all the information provided regarding her health is held confidential between myself and Pastor, and that would only be disclosed to designated ministries with her written consent once the plan of care was approved by the Pastor.

Medical Diagnosis: Heart Disease, Hypertension, Gastroparesis, Depression

Spiritual Diagnosis: 1) Spiritual Distress related to feelings that God is not hearing her prayers regarding her health; 2) Hopelessness related to feelings that she will never have a life free from illness 3) Ineffective Coping Mechanisms

Recommended Ministry Support and Interventions: Interventions for “member” should be directed to strengthen her faith in God, connect her with ministries that can help her cope with her physical infirmities, and restore her joy in the Lord and in life.

1) Minster Wives: Immediate visit by the Minster Wives so that she can develop supportive relationships
2) Parish Nurse/ Health Care Ministry: The Parish Nurse will help her seek second opinions from health care professionals in the area to determine the extent of her disease process and how can her chronic pain be better managed
3) Administrative Staff: Explore opportunities for volunteerism to help divert thinking from health conditions and provide service to the ministries of the Church
4) Young Peoples Ministry: Participation in Youth events which can help her foster her love for children
5) Total Wellness Program: Seek support classes for individuals who are living with chronic pain
6) New Members Assimilation, SWA: Encourage her to seek opportunities to develop new friendships
7) Christian Education: Encourage her to attend bible study during the Noon Day and Evening
8) Couples Ministry: To gain marital support from older married couples to gain insight on how to keep the marriage strong during times of illness and financial stress.

Next Scheduled visit:

Chianta Lindsey, ARNP, MSN, FCN

Parish Nurse Mt. Sinai M.B. Church

APPENDIX E: CONSENT TO RELEASE INFORMATION

MT. SINAI MISSIONARY BAPTIST CHURCH
PARISH NURSE SERVICE
CONSENT TO RELEASE INFORMATION

I, _________________________________ understand that the Parish Nurse collaborates with the Pastor, Dr. Larry G. Mills directly regarding all member health care issues. I understand that any information obtain by the Parish Nurse will remain confidential between the Pastor and the Parish Nurse. I understand that any information I directly release to Church Support Staff, Ministry Leaders, and Congregants is not bound by this consent form. I therefore give permission for my health information to be released in/to:

___ Bulletin
___ Sinai Connect
___ Church Office Support Staff
___ All MSMBC Ministries
___ Tribe Leaders
___ Health Care Ministry
___ Deacon/Deaconess Ministry
___ Homebound Ministry
___ Other (specify): _________________________________

I wish to release only the following information:
___ Condition/Surgery: _________________________________
___Hospital Location: __________________________________
___Financial Needs: ___________________________________
___Prayer Requests: ___________________________________

_________________________________ _______________________
Signature Date

I, _________________________________ understand that the Parish Nurse collaborates with the Pastor, Dr. Larry G. Mills directly regarding all member health care issues. I understand that any information obtain by the Parish Nurse will remain confidential between the Pastor and the Parish Nurse. I therefore do not wish for my health information to be released to any other support staff or ministries at this time.

_________________________________ _______________________
Signature Date

_________________________________ _______________________
Parish Nurse Signature Date

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