

Faith Community Nursing

Bridging the Gap between Effective Healthcare and Biblical Ministry

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Abstract

The United States' traditional health care system is unprepared to combat the growing rates of chronic illness in its population. With over 90% of those aged 66 years and older living with a chronic illness, an emphasis on preventative care must be enacted. Faith community nursing is a viable and effective option for long-term preventative management of chronic illnesses in the community. Faith community nursing fits both the mission of the Christian church and the needs of the healthcare community and greater awareness of this must be achieved in both the faith and healthcare sectors to bring about maximum results.

Faith Community Nursing

Bridging the Gap between Effective Healthcare and Biblical Ministry

Faith and medicine, though not often linked in today's medical practice, have a long and productive history that is being continued by faith community nurses (FCNs). While today's traditional medical systems are hard-pressed to find access to local communities in a way that will empower and motivate members to pursue consistently healthier lifestyles, FCNs have an unprecedented track record in the United States of America (U.S.A.) for promoting whole-person health outside of medical building walls. Faith community nursing is a specialty recognized by the American Nursing Association in which nurses support their patients with whole-person care. They minister to both the physical and spiritual needs of their clients; combatting chronic illnesses while pointing to the importance of faith. While FCNs can be found in diverse faith communities across the globe, this paper will focus on the unique niche that FCNs can fill within the Christian community. Faith community nursing is the natural outflow of gospel-centric healthcare and a great asset to the healthcare community.

Chronic Illnesses in the United States

Chronic diseases have increased at unprecedented rates over the last several decades, so much so that they are considered among the top issues plaguing the medical system today (Bauer, Briss, & Goodman, 2014). The Center for Disease Control (CDC) reports that illnesses such as chronic obstructive pulmonary disease (COPD), cardiac disease, diabetes mellitus (DM) type II, obesity, and osteoarthritis are considered both chronic and preventable (CDC staff, 2015). These diseases account for 70% of the top ten causes of death in the U.S.A., and just about half of the American adult population are

suffering from at least one. About 90% of Americans over 60 are afflicted by at least one chronic illness (Dyess & Chase, 2010). Obesity, both an illness itself and a precursor to many of the other chronic illnesses, affects over one-third of the adult population and one-fifth of the children in the U.S.A. In addition, osteoarthritis, a disease that comes from wear and tear of the joints, is the number one reason for disability in the U.S.A. (CDC staff, 2015).

While each of these diseases has a genetic component, proper diet, exercise, and other healthy habits are protective against them (CDC staff, 2015). Even though many Americans have information about how to prevent these diseases at their fingertips through the internet, about half of adults in the U.S.A. still do not exercise at the Department of Health's recommended level of moderate exercise 150 minutes per week, or eat within healthy guidelines (U.S.A. Department of Health Staff, 2008). Those who have been diagnosed with risk factors related to cardiac problems only seek to control those issues about 50% of the time (CDC staff, 2015).

The World Health Organization has reported that control of these risk factors would result in the elimination of about 80% of cardiac illnesses, strokes, and DM type II diagnoses. In addition, cancers—such as lung and cervical—would drop by 40% (World Health Organization, 2005). By the time these patients arrive in the hospital, years of consistent abuse of their bodies have already occurred. In fact over 66% of adults who are treated and released from hospitals are diagnosed with two or more chronic conditions, and one third of adults who are released have four or more (Steiner & Freidman, 2013).

Expenditures Related to Chronic Illness

The number of uncontrolled chronic illnesses is causing enormous expenditures to be incurred. Healthcare takes up 17.9% of the United States' Gross Domestic Product; this translates to about \$8,915 per person, which is \$2.8 trillion in total, being spent to make sure our country stays healthy each year (Yeaworth, 2014). Medicare accounts for 20% of this expenditure with \$421.2 billion invested, and Medicaid is not far behind with \$412 billion invested. With the Affordable Care Act (ACA) now in place, these numbers will only continue to rise because of Medicare and Medicaid expansions. Individuals can expect to pay around \$768 per year from their own finances (Yeaworth).

The healthcare sector has recognized that these rising costs are not feasible for long-term success and something must be done to bring these costs down (Yeaworth, 2014). Earlier discharges, the limiting of resources, and more outpatient treatments have all been discussed as possible solutions. However, because much of healthcare is centralized to the acute-care setting many people are left without the necessary tools and resources to care for themselves outside of the hospital. Readmissions are common and account for \$26 billion worth of healthcare spending each year. The ACA has already begun to give acute-care settings incentives toward preventing readmissions by allowing Medicare to keep back 1% of fiscal reimbursements from care centers with high numbers of readmissions (Yeaworth).

Solution to Transitional Care

In response to these issues, hospitals have attempted to pay closer attention to ensuring that their patients have the resources and knowledge they need for transitioning out of the hospital successfully (Yeaworth, 2014). This includes case management, more

tightly regulated follow-ups, and incorporating community resources. FCNs are being utilized at higher rates because of their unique ties to clients outside of the hospital walls. Given the medical backgrounds, familiarization with the acute-care setting, and knowledge of how to manage chronic illnesses that FCNs possess, they are especially well-suited to these kinds of case-management situations. FCNs are also well trained in healthcare teaching and advocacy. When patients are reintroduced into communities, the FCN that is responsible for their area is able to provide personalized care, one on one time, and a calming presence. FCNs can help to organize meals, house cleaning, and medication schedules. FCNs not only have the technical skills, but the very nature of their work is ministry-focused, giving them a personal interest in each person's care (Yeaworth & Sailors, 2014).

A History of Faith Community Nursing

Faith community nursing was introduced to the United States by Dr. Granger E. Westberg in the hopes of providing an alternate system for the prevention of chronic illnesses. Now known as the author of *Good Grief* and *The Parish Nurse*, he began as a parish pastor in the Lutheran church. He loved serving his congregation, but his life was drastically altered after a week-long hospital chaplaincy rotation (1990). He began to envision a healthcare system that saw the person as a whole. Because body, mind, and spirit could not be separated, he felt that treating them as separate entities would not facilitate whole-person healing. As he began to pursue the integration of this kind of care in the healthcare system, he quickly realized that nurses had been standing in this gap for many years prior (Westberg, 1990).

Through his studies, Westberg found that many individuals had gone into nursing with the hope of helping others and caring for patients as a whole; catering to physical, spiritual, and intellectual needs (1990). However, many nurses became frustrated over the course of their careers when heavy patient loads, strict rules, and tight schedules prevented them from providing the compassionate and individualistic care that they hoped to give. Nurses also became frustrated at the realization that up to one third of the diseases seen in the hospital could have been prevented if someone had intervened before the patient became acutely ill. Through these surveys, Westberg determined that not only was there a desire in nurses to help prevent these illnesses from occurring, but there was also a desire in the clergy to provide their chronically ill congregants with better health-oriented resources (1990).

Westberg's model involved a nurse who functioned as a consultant within the church setting (1990). The nurse could have an office within the church or visit hurting individuals within the community. There would be no stipulations for those who wanted to see utilize the nurse's services. Be it a health problem or something of the heart, community members could come and speak with the staff nurse. The nurse could advise of healthier living for long-term effectiveness, encourage a visit with a physician if needed, or identify and obtain pertinent resources for the client (Westberg).

Westberg observed that nurses were trained in such a way that they were a natural bridge between the hard science of the medical system and the spirit-focused care that he envisioned (1990). Nursing schools often incorporate the values of compassion, understanding, and alleviation of suffering into their curriculum. Westberg emphasized

that nurses “have one foot in the sciences and one foot in the humanities” (1990, para. 32).

In addition, his research also led him to the conclusion that while the rest of medical professionals were still very much in the mindset of acute care, the close proximity of nurses to the suffering of their patients predisposed them to be advocates for preventative care (Westberg, 1990). Nurses entered into their profession with the whole-person in mind, but large patient loads and facility regulations often kept them from this goal. By providing nurses with the church as another outlet for caring for clients, more preventative care could be accomplished (Westberg).

The Church As an Outlet for Preventative Care

Westberg suggested that there were five organizations that the average person could interact with in regard to illness prevention: the home, public health organizations, the school, the workplace, and the church. While churches often offer enrichment and spiritual renewal, he believed that they could do so much more. By delving into the medical side of wellness, churches could both fill a niche that communities desperately need and at the same time provide a new outlet for ministry to people who remain otherwise unreachable.

His background in the church gave him unique insight into the compatibility between the changing landscape of healthcare and the message of Christ. While the American church has not often linked healthcare into their ministry, healthcare has been a part of the Christian church’s tapestry since its inception. Jesus Christ himself had compassion on the people He came in contact with through the act of healing. As is recorded in the Bible, he completed at least 30-40 healing miracles during his time on

earth (Strong in Faith Staff, 2007). He healed the blind, the lame, the sick, and even raised the dead. He showed mercy to those who were hurting regardless of their societal status, gender, and education level. He even described his true followers as those who would visit the sick and give to the poor (Matthew 25:36). Showing compassion to others through the healing of illness and meeting of basic needs was a part of the very core of Jesus' ministry.

In addition, a central tenet of the Christian faith is that the joyous salvation that has been received by Christ's followers is not meant to be kept to themselves. In one of His last addresses to His followers, Christ tells them to go into the world and share the message of good news that He died to set sinners free (Mark 16:15, New International Version). Throughout church history, this has included going wherever there were people who had not heard the name of Christ and what He had done. Christians have made a tradition of sharing the gospel through both words and actions as they go—sharing the good news of Christ by mouth, and emulating his compassion through acts of kindness and justice.

FCNs can help to foster connections with those who have not heard the gospel through coordinating free clinics, doing regular blood pressure checks, and providing free medical advice to the public. When Christian FCNs use their skills to serve both the inner faith community and the surrounding neighborhoods, they are able to effectively communicate the good news that Jesus Christ taught while he was on earth; no one is out of God's reach, and there is forgiveness and compassion for all through the blood of Christ.

Other biblical support for faith community nursing can be found in the books of James and Timothy. In both books, the writers advocate caring for widows and orphans as a direct responsibility of church members. In James 1:27, the author compares the genuine and uncorrupted practicing of Christianity with "...look[ing] after orphans and widows in their distress..." (NIV). FCNs can help churches better identify and serve both of these populations through providing another dimension of care in the form of health services.

Those who would object to the merging of healthcare and the church could appeal to the fact that physical health is not the church's domain. While this has been the case in recent years, it was not always this way. Today, many look to the government and private corporations for their healthcare and see the church as a place to go for social interaction and spiritual enrichment. However, helping the needy and the broken is a core teaching throughout the Bible, culminating in the life and work of Jesus Christ. In addition, a review of health ministry research reveals no shortage of international ministries utilizing healthcare as a way to show Christian compassion throughout the world, but very little about health ministry in the US. There is no reason that healthcare would be an efficacious ministry outlet in the rest of the world and not in America.

A Brief History of Medicine in the Early Church

Christ's followers were known throughout early history as those who offered care to the sick. In his book *Medicine and Healthcare in Early Christianity*, Gary Ferngren suggests that the early Christians' concern for those who were ill came from their understanding of "...agape, a self-giving love of one's fellow human beings that reflected the incarnational and redemptive love of God in Jesus Christ" (2009, p. 114). This belief

led to a deep conviction in early Christ followers that they must meet the needs of others at whatever the cost.

Beginning in even the first century, the entire early church structure was set up in a way that allowed for church members to identify the hurting and ill and allocate resources to them (Ferngren, 2009). Priests and deacons formed the top two tiers of ministry—the deacons went to visit those who were in need and reported them to the priests. The priests decided how to best allocate the church's funds to help those identified by the deacons, and the deacons both served the ill and instructed the rest of the congregation how best to offer their services as volunteers (Ferngren).

By the third century the church in Rome was responsible for the care of over 1,500 widows and needy persons in seven districts of the city (Ferngren, 2009). By the fifth century this was doubled to 3,000. The fact that the entire structure of the church was created in a way to best maximize their ability to give help to others suggests that the early church saw caring for the ill as inextricably linked to their responsibilities as Christians. And more importantly, this concern for the health of others permeated every part of the congregation, reaching from the clergy to the laypeople. Their interest in the health of others could not even be stopped by persecution at the time of the Cyprian plague. While pagan rituals recommended deserting the sick, Christians risked their lives, both because of persecution and because of disease—to take care of those who were ill (Ferngren).

In the fourth century, the first institutions dedicated to care of the ill were created. Christians founded the Basileias which included “inpatient facilities, professional medical care for patients, and charitable care” (Ferngren, 2009, p. 124). This hospital housed

Christians who offered care in the Christian tradition but were educated in secular medicine. This was possible because of the legacy Christians had built as those who cared for any and all in the community and it laid the foundation for the large-scale health care that is seen today (Ferngren).

This concern for those in need did not exist prior to Christian influence in either the private or public sectors (Ferngren, 2009). Governments did not count the public health amongst their responsibilities. Individuals only took on importance after the introduction of the Christian teaching of Imago Dei—that every human is created in the image of God and therefore possesses intrinsic value. Prior to this, the gods were seen as rulers who acted on whims of anger and could only be soothed by magistrates—there was no help for those who were afflicted with illness and therefore no reason to care for them (Ferngren).

This legacy of care extended throughout church history. In 1751 the Quakers founded the first hospital in the United States and throughout the 19th and 20th centuries hospital care was mostly for impoverished patients (Morris & Miller, 2014). In the 1930s richer patients began to realize that those in hospitals fared better, so they began to go to hospitals as well. The real split between healthcare and the church began in the 1960s when healthcare became too expensive for religious groups to be the sole funders. Medical care business-oriented and the poor found themselves without access to affordable forms of healthcare once again (Morris & Miller).

This brief history demonstrates that caring for the sick and needy was integrated into the very structure of the church from the beginning. The American government has stepped into the healthcare and charity arenas, but that does not mean that it has a sole

right to provide such care. Private institutions have made businesses out of healthcare but that does not mean they are the best providers. In fact, American Christians can offer a type of care sorely lacking in hospitals; care that emphasizes the unique value of each person, is rooted in selfless love, and encourages the interconnectedness of the community.

Discussion of Impact in Today's Church

Today's churches could also benefit from the installation of an FCN in their communities simply because it takes back the Christian healing heritage and offers a ministry outlet deeply grounded in serving and caring for others as the New Testament prescribes. FCNs offer churches a tangible example of how funds can be used to serve their communities and a convicting reminder that even so-called "secular" skills can be used for the glory of God (Yeaworth & Ronette, 2014). In this way, the nurse takes on a similar role to that of the early deacon in recognizing who is in need, reporting this to the pastoral team so funds can be allocated, and directing volunteers to use their skills (Fengren, 2009).

FCNs offer churches a unique opportunity to not only care for their current congregational members, but also to provide avenues for outreach to the outside community as well. Jesus Christ's final command to His followers while He was on earth was to go out into the world and share the truth of His gospel (Mark 16:15-16, NIV). Current evangelism models that are utilized by churches can sometimes focus on bringing large crowds in for a one-time event, such as a block party or concert. However, while this meets a desire for fun and entertainment, it does not meet a core need of the person in a sustainable and integral way. By connecting members of the community surrounding

the church with a caring and helping hand, connections that can be nurtured over a period of time may be created (Balint & George, 2015).

FCNs are able to set up health clinics, educational seminars, and blood pressure checks for the external community as well as the congregation (Yeaworth & Ronette, 2014). By reaching out to those who might not usually enter the church building on a Sunday, FCNs are setting up long-term connections with those who may not have had the opportunity to hear about the love of Christ. In this way, faith community nursing can become truly gospel-centered; the goal being not only to offer physical healing, but also to provide the truth that leads to spiritual life.

Faith Community Nursing Preparation

As faith community nursing evolved, the American Nurses Association saw its potential as a certified nursing specialty. It was certified as a specialty in 1997 (Health Ministries Association Staff, 2010) FCNs were effective in their community care and a natural progression toward recognition in the nursing community was inevitable. A scope and standards of practice exists to govern faith community nursing and to ensure that their practice is ethical and efficacious (Health Ministries Association Staff).

Preparation for becoming certified as an FCN includes involvement in a faith community, population health education, and ongoing personal education for the nurse (ANCC Staff, 2014). A nurse must prove his or her dedication to safety, and ability to communicate effectively with both clients and the clergy. The nurse must commit to consulting with the clergy for spiritual issues related to care and should utilize the resources provided to better integrate the spiritual and the physical care provided (ANCC Staff). Many nursing schools now offer courses to better prepare nurses for faith

community nursing. These courses include detailed education related to holistic care, spiritual integration, and population health (Church Health Center Staff, n.d.).

Faith Community Nursing in Practice

Faith community nursing utilizes the congregational setting to provide community healthcare engagement that could not be accomplished in a hospital. Much of hospital care involves acute exacerbations of a disease process; patients do not often have interactions with health personnel unless something is terribly wrong. This works in the when clients are suffering from obviously malignant diseases, but it is the clients with chronic, slowly developing diseases who slip through the cracks. Furthermore, one study found that patients treated using the acute care model cannot readily identify the purpose or helpfulness of the care received. Clients desire an approach that will further their life holistically and qualitatively. Research also states that these patients prefer a caregiver who is warm and driven by values (Dyess & Chase, 2010). Faith community nursing meets all of these requirements and has shown remarkable efficacy in promoting healthy living.

According to studies as early as 2005, faith community nursing was already beginning to have an impact on preventing and treating chronic illnesses (Rydholm, 2006). It was found that late access to care was one of the largest factors in extra cost to the healthcare system. One of FCN's primary responsibilities is assessing adults within the community for risk factors and symptoms that should be dealt with medically. Especially when dealing with elderly who are afraid to lose their independence and life-stability, FCNs are skilled in helping people to see that admitting their weaknesses in order to gain help is a benefit to them, their families, and their caregivers (Rydholm).

FCNs have reported helping patients obtain pacemakers, identifying high blood pressure and headaches before impending stroke, and helping those who were having heart attacks to recognize shortness of breath as a warning sign (Rydholm, 2006). In one study, twenty-five elderly people were encouraged by FCNs to seek medical attention when signs of impending sepsis were observed. Each of these patients was given medication before they became critical and their illness paths were interrupted. Ten cases of worsening pulmonary edema were identified by FCNs and treated at a point when reversal was possible without artificial breathing support (Rydholm).

In each of these cases, what could have been life-threatening was easily treated and people who could have lost autonomy, preserved it. Many of these patients would not have been seen in a hospital until they were deteriorating so entirely that the symptoms could no longer be ignored; including confusion, inability to breathe, or total collapse. However, because someone trained to look for signs and symptoms of illness resided within the church's intimate community, *members were not only identified as ill, but were also empowered by the education of someone who cared for them.*

Effective Nursing Interventions

Many of the core responsibilities of the FCN have reported to have positive effects. One effective intervention that the study from 2005 reported was chronic illness self-care coaching (Rydholm, 2006). Those in the community who were suffering from illnesses including COPD, Alzheimer's disease, Parkinson's disease, multiple sclerosis, various mental health disorders, cancer, and many others, were able to find personalized instruction in the FCN.

Risky health habits including addictive behavior and excessive weight gain were also noted to have been reduced because of FCN support and education. Those who suffered from anxious feelings due to impending procedures, use of new home equipment, and new medications were all more likely to call and be calmed by an FCN. This is critical because chronic disease management relies on the patient feeling competent and motivated to do what is necessary when away from a formal healthcare setting (Rydholm, 2006). With the extra support of an FCN who can be called upon for further instruction and support after a hospital visit, healthcare regimens are possibly more likely to be followed.

The advocacy that the FCNs were able to take part in was also noteworthy. Vulnerable older adults who were being abused, neglected, or who were a danger to themselves, were all supported by FCNs (Rydholm, 2006). The FCNs who were familiar with the older adults were more readily able to identify risk factors and changes in behavior in order to respond and ensure that the elderly were given the proper care. One exemplar detailed how an FCN took a community elder to the hospital when she noted symptoms of an acute urinary tract infection. She stayed with the elder for over four hours to ensure that he received the needed medical attention. It was discovered at that time that he had a renal mass. The study also found that FCNs were effective identifiers of elder abuse—at least three elders in the study were safely relocated away from their abusers because of the intervention of an FCN (Rydholm).

Other interventions included referrals to more formal care, and helping elders obtain medical supplies (Rydholm, 2006). This can include both connecting elders with those who can give them these supplies and devising creative solutions to combat routine

problems. One nurse tacked pictures of an elder person's family to his speed dial buttons so he could call them despite no longer understanding numbers (Rydholm).

Finally, the central intervention that FCNs employ is faith/health integration (Shores, 2014). FCNs see it as their duty to not only care for each of the aforementioned physical needs, but also those of a spiritual nature. Each person who comes in contact with an FCN will be taught the correlation between physical health and spiritual health and the necessity of both. Specific interventions range from helping with end of life issues to clarifying values to employing humor. Those who have been involved with FCNs with regards to spiritual interventions have spoken of how important it is to have someone who is knowledgeable both in their faith and in medicine. This way anxiety and confusion can be met with prayer and spiritual encouragement. The patients of FCNs report that they better understand the importance of balancing their mental, spiritual, emotional, and physical health (Shores).

These interventions are especially beneficial to those with chronic and debilitating illnesses (Shores, 2014). Clients with debilitating chronic illnesses have stated that FCNs help them recognize that they are valuable and can contribute to the congregation. FCNs help these people and others find hope in their situations even just by providing only their presence. Parishioners spoke of contacting the nurse during acute emergencies and how comforting it was to have the nurse stay with them, offering support and medical advice. Nurses also gave rides to services when needed, offered homebound communion to those who could not come to services, spent one on one time that would not be feasible in a formal setting, helped patients with understanding the mental and spiritual benefits of forgiveness, and provided insight into spiritual issues (Shores).

Faith Community Nursing and Flexibility

Unlike many acute care providers, FCNs have the freedom and flexibility to meet with patients on a continual basis for extended periods of time (Balint & George, 2015). While hospital staff and private practitioners dedicate teaching efforts and support to those who come into their facilities, FCNs bring their healthcare expertise into the community. This kind of access to medical knowledge helps restore dignity to the individual (Granger, 1990).

American healthcare has lost the personal touch of small-scale health facilities. While care in large hospitals is often regulated based on the most recent standards and the technology used is advanced and efficacious, there is not often enough room for personal health counseling and educating. According to a survey conducted in 2014 with over 3,000 participating nurses, six in ten hospital nurses did not feel that they had adequate personal time with patients. Navigating these large institutions can be intimidating for the average person. The FCN serves as a liaison between the complex world of health care and the client in order to facilitate confidence, calm, and to increase the likelihood that clients will seek out help for their health issues. FCNs can even alert clients to health care options they are unaware of (Granger, 1990).

If patients are not in need of acute care, FCNs have the ability to offer long-term, flexible support to those in the community who might not usually receive it, either because of lack of finances or lack of personal support. An example of this care was recorded in a case study in which a woman approached a health clinic being run by an FCN (Balint & George, 2015). The client came at first for the food and clothing being offered, but the volunteer staff brought her to the FCN when she told them about having

trouble breathing, feeling sick to her stomach, and experiencing some dizziness (Balint & George).

When the client met with the FCN she discussed a prior myocardial infarction, type II diabetes, and hypertension (Balint & George, 2015). She lamented to the FCN about her desire to move in a healthy direction with her life and the obstacles to getting there. She often found change hard and did not know how to adequately monitor her glucose, administer the medications she was given, and maintain a healthy diet. Her only support included her church and the help she got from the clinic (Balint & George).

After listening to her story, the FCN did a full physical assessment and found her blood pressure to be 158/92mmHg, respiratory rate 18bpm, and a glucose level of 168mg/dL (Balint & George, 2015). After this assessment, both the FCN and the woman discussed goals for her health, including nutrition and exercise. At the time of the study, the FCN and the woman had met four times for education, encouragement, recording of progress, and scripture reading. Together, the nurse and the client went through the purpose and proper administration of the client's medicines, and discussed the MyPlate method for controlling her portions. At the fourth visit, the client had begun to make lifestyle changes that resulted in a blood pressure of 130/64mmHg, a loss of two pounds, and a respiratory rate of 18bpm. Together they celebrated her achievements, identified her weaknesses, and discussed what moving forward would look like (Balint & George).

This particular client would not have benefited from the traditional medical system because she needed some form of personal, long-term support. While she was likely taught about her disease processes and medications at the time of her diagnosis, she lacked the social and medical support she needed to make those teachings a permanent

part of her life. Lifestyle changes including dieting and exercising are hard to make even when someone is surrounded by people who love and care for them. To try to do so alone is often more than a person can handle. The FCN offered medical and social support that the client could count on, even if just for one meeting every two weeks and because she is a volunteer, there is no stress on the client to provide payment. Even the little bit of progress she made in the first two months is a huge step in the right direction for disease prevention.

Mental Health Support

FCNs also offer mental health support to communities. Mental health and wellness have been directly linked to the development and maintenance of positive coping skills as well as to the support and level of connection that is experienced from the environment. FCNs, because they are holistic in their approach, integrate the teaching of coping skills, referral to support groups, and personal listening and time into their plans of care (Anaebere & DeLilly, 2012).

The FCN is often able to offer counsel in areas of life that are not often entrusted to others (Granger, 1990). It was found that men over forty would come to the church's FCN in order to ask about some kind of health problem. However, after a short period of discussing the issue, they would then move to their life. This included concerns, anxieties, and personal outlook. It made these men more comfortable to have the physical ailment to break the ice and then move into sharing their hearts (Granger). Other topics discussed with clients included spiritual doubts, end of life decisions, and personal insecurities (Shores, 2014). FCNs were also trusted counsel for parents who wished to talk with their teenagers about sexual issues and for older adults who needed help with

daily life (Granger, 1990). They have a unique window into client's most vulnerable moments to offer advice and plan practical steps for better care.

Granger Westberg felt that it was important that an FCN be a mature Christian precisely because she was in an optimal position to provide spiritual counsel in areas that people might not disclose to others (1990). The stresses that these kinds of illnesses place on a person's future, familial relationships, and self-identity can bring the patient to the place of desiring both comfort and answers from their spiritual tradition. An FCN is present and willing to listen in these moments, and if he or she is spiritually mature, the FCN can also offer spiritual insight and calming (Westberg).

Healthcare Costs Saved Due to FCNs

Documentation for faith community nurses has not only led to greater efficiency, connectedness, and accountability, but it has also helped researchers track the impact of FCNs on their communities and the amount of money that has been saved through their work (Miller & Carson, 2010). According to research compiled from the documentation of FCNs, the Faith Community Health Network has been in contact with 13,650 patients (Yeaworth & Sailors, 2014). Two thirds of the patients were over sixty-six years old, most were church members, and almost three quarters of the contacts were women. Another network of FCNs, the Henry Ford Macomb network (HFMN), recorded over 751,900 group contacts and 26,600 individual contacts, in attempts to teach, screen, and offer services (Yeaworth & Sailors).

The HFMN developed a tool to show how much money is saved by the work of faith community nurses (Yeaworth & Sailors, 2014). This tool is used to calculate the cost saved by using a projected cost per day for medical care that could have been

incurred if a patient had not been identified and sent to treatment early by an FCN. This and other tools have projected that between 2005 and 2012, FCNs helped patient's save \$1,910,630. This is separate from the \$2,629,725 that was saved because of the amount of volunteer work given by the FCNs. However, it is difficult to estimate exact amounts of money saved, especially in the case of illnesses that were prevented.

The estimates also do not include every activity that the nurses are involved in, such as community clinics that offer free medications and screenings by physicians, as well as the personal time and funds that the nurses volunteer to ensure that community members are fed (Yeaworth & Sailors, 2014). One example of this is a nurse who contacts local grocery stores in order to identify fruits and vegetables that will be thrown out. She goes to collect these discarded foods and gives the unspoiled items to those in need. Other activities that are not quantifiable but did contribute to savings include exercise programs, counseling, and connecting individuals who need support (Yeaworth & Sailors).

Access for the Poor

The poorest of the community are the ones who benefit the most from the installation of an FCN into the church. Even with new healthcare reforms, millions are still left without insurance or without access to preventative care—the recent Affordable Care Act will leave many with insurance only for acute care issues (Balint & George, 2014). In addition, physicians are becoming less likely to take on Medicare and Medicaid patients because of their low payouts (Decker, 2011). Faith community nurses ensure that even those who do not have access to health insurance can get the health support and

education that they need. By supporting an FCN to do this, churches are fulfilling their call to serve the poor.

Faith and Healthcare Together

The reason that many FCNs choose faith community nursing over other forms of nursing can be attributed to a deep conviction that a holistic approach should include a focus on the spiritual aspect of a client's life. Just as Jesus Christ healed people's bodies, he also came to heal their broken spirits. Dr. Scott Morris, the head of the Church Health Center (CHC) in Memphis, Tennessee, recalls a day in which a young girl came with her Spanish-speaking family to a faith based clinic and acted as translator (Morris & Miller, 2014). The young girl complained of a stomach ache and after further investigation, Dr. Morris was able to identify the cause; the young girl's father had left the family homeless in pursuit of another woman and the stress of this caused physical manifestations. Because of the CHC's connection to faith communities, Dr. Morris was able to connect the young family with a warm and welcoming Spanish-speaking church. The family was taken out of the homeless shelter and embraced by their new church home (Morris & Miller).

Another client seen at the CHC came in when she was morbidly obese, suffering from four chronic illnesses, and mother to three children for whom she did not have the resources to care properly (Morris & Miller, 2014). Over the course of two years the staff worked with her to combat her illnesses, obesity, and self-hatred. She lost 200lbs, and three of her chronic illnesses—diabetes, hypertension, and hypercholesterolemia—were cured. Through spiritual encouragement she came to understand that she was loved by God and her self-hatred no longer held its power (Morris & Miller).

Stories like these are what make community faith nursing truly special. All of the hospitals in the world could not offer the communal support that a group of selfless, loving volunteers can. These volunteers are there for the client whenever the client is in need because the client is more than a patient—they are created in the image of God (Morris & Miller, 2014). Faith community nurses can meet the needs of the client in the way that is best for the client; even if this only includes providing a listening ear.

Moving Forward

When clergy were asked to take a survey to assess their knowledge of FCNs and the work they do, the clergy were found to be mostly positive toward the idea of having an FCN as a part of their ministry (Thompson, 2010). However, many could not yet see the holistic niche that the FCNs filled. Pastors were limited in their vision for how mature Christian nurses could be trained and utilized for ministerial purposes, as well. The study that found these results was limited in the number of pastors that it assessed—thirty four in a geographic area. It would be beneficial to use the tools provided by the Thompson study to gather more information about American clergy and their understanding of the role of FCNs. This can help those who wish to become FCNs better prepare when they are presenting the idea to clergy, and it can also help with knowing how to better provide educational materials to clergy about the potential for FCNs in their communities (Thompson).

The involvement of the whole church that occurs with the installation of an FCN cannot be understated. One example of this is Dundee Presbyterian Church. Because members had a difficult time envisioning how healthcare and ministry could complement each other, the church was initially reluctant to bring an FCN on staff. However, the

church members soon found that the nurses played a pivotal role in not only caring for the congregation, but also in engaging the congregants to serve others (Yeaworth & Ronette, 2014). New opportunities for members included delivering food to those who have been identified as needy by the FCN, transporting patients as well as necessary equipment, and encouraging other medical professionals to use their skills to serve others. FCNs have been responsible for creating committees of lay people who are willing to do necessary tasks for those who are suffering from health issues. This has resulted in the ushers being trained to use basic cardiac life support, pediatricians and cardiologists from the congregation presenting at health fairs, and over 200 members of Dundee church receiving care from a staff FCN (Yeaworth & Ronette).

Conclusion

Faith community nursing is a specialty worth further supporting and researching. It has been proven over the last three decades that bringing FCNs into communities leads to better prevention of illnesses, improved access to healthcare for impoverished clients, and more integrated social support. FCNs serve as well-educated resources to communities who can help point clients where they need to go, whether it's to immediate acute care intervention, resource acquisition, support groups, or an educational program.

It is important that churches have the resources and knowledge to understand how an FCN can positively impact their congregation. Faith community nursing provides a much needed service to the congregation, opens up doors for Christian volunteering, and provides opportunities for a Christian to talk with people who would otherwise remain to themselves. In addition, it is a part of the rich heritage of Christianity and fits perfectly in with its core teachings.

As faith communities nursing grows as a specialty and chronic disease prevalence rises in the population, it will be important to continue researching and documenting the positive effects that faith community nursing is responsible for. If the research continues to show benefits similar to those detailed in this paper, both churches and the traditional medical system may need to seriously consider working together to make faith community nursing a regular part of the American life.

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