BUILDING HEALTHY COMMUNITIES THROUGH MEDICAL-RELIGIOUS PARTNERSHIPS

Second Edition

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and
W. DANIEL HALE, PH.D.

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SECOND EDITION

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To our parents

Wilford and Evelyn Bennett

William and Frances Hale

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CONTENTS

FOREWORD

With health care reform in the air, this is the perfect time for this book, which describes creative models of how to make health care available through medical-religious partnerships. It explains how these partnerships can work by an interdisciplinary approach modeled in the book itself. Its organization by major illnesses, with information on each disease, highlights its medical perspective, which is rare for this genre of books. Extensive resources, including agencies and books on each illness, help provide the information needed to develop effective collaborative models.

Recent scientific studies have demonstrated the major role that religion can play in good health outcomes. In addition, patients and physicians are recognizing the importance of spiritual resources in the prevention of and recovery from illness. Congregations are seeing an expanding role in health care. A 2007 National Council of Churches survey of 6,000 congregations reported that 70 percent are engaged in health ministry. This favorable response is echoed by the authors' studies of various denominations.

The changing face of illness in the United States, from infectious diseases to more chronic illness plus the graying of our population, means that congregational support and educational programs are a key resource for long-term care needs as well as prevention strategies. The chapters on diabetes, dementia, mental illness, etc., specifically illustrate the congregation's role in addressing these and other illnesses.

Providing accurate, clear, and accessible health information is only one step to prevention. Motivating people to act on it is difficult, and congregations can be outstanding partners in that regard. Illustrative and effective programs, some of which have received large grants, encourage others to undertake such ministry, which can help reduce the $2.4 trillion annual

expenditures in the United States as well as reduce the number of uninsured Americans, now at almost 46 million (2007 figures).

Some churches cannot undertake major programs, so the authors' suggestions for modest projects—such as training patient advocates and offering respite care programs, screenings, support groups, and informational mailings—enable almost any congregation to become involved in meeting health care needs. One creative program for church members was a "living wills party," hosted by a registered nurse in her home, which provided information and encouraged people to fill out an advance directive.

There is a particular need for destigmatization of mental illness, which affects members of religious communities and their families in about the same proportion—that is, 30 percent—as the general population. In this book we find clear, unbiased information with specifics on congregational approaches to mental illness, including ways for encouraging open sharing about personal mental health issues.

In addition to the chapters on disease, there are practical ones on advance directives and communicating with health care providers, a subject that touches many people. The section on lifestyle-related problems, addressed by exercise and diet, tobacco-cessation programs, etc., is brilliant, as all objections are answered with practical suggestions.

This book is a resource for lay people, health care professionals, pastors, community agency staff, and many others who are committed to meeting the health-related needs of all people.

The Rev. Dr. Abigail Rian Evans
Charlotte W. Newcombe Professor of Practical Theology
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PREFACE

We prepared the original edition of *Building Healthy Communities through Medical-Religious Partnerships* because experience convinced us that partnerships between health care systems and religious congregations had tremendous potential to meet many of the difficult challenges our country faces as the population continues to age and the number of people with chronic conditions continues to increase. We had witnessed enthusiastic clergy, parish nurses, and congregational volunteers, supported by dedicated medical professionals, offering programs that helped people maintain their health, independence, and dignity. Almost a decade later, we are even more convinced of the valuable role that medical-religious partnerships can play in addressing the health needs of communities throughout our nation. The challenges described in the original volume are even greater now, and the models and resources that can be studied and employed by those interested in developing these partnerships have multiplied.

People who share our belief that health care systems, medical professionals, and religious congregations should join forces to minister to the health needs of their community will find in this book not only strong support for their belief but also detailed information and advice on programs that have proven successful in a diverse group of congregations and communities over the past decade. We report on innovative medical-religious partnership programs organized by Baptist, Catholic, Methodist, and Seventh Day Adventist health systems, along with other programs initiated and supported by health systems that have no current or historical ties to a national or local religious organization. We share stories of health programs offered by congregations representing a wide range of faiths and denominations (e.g., African Methodist Episcopal, Baptist, Catholic, Christian and

Missionary Alliance, Episcopal, Jewish, Lutheran, Methodist, Presbyterian, and Seventh Day Adventist) and from various parts of the country.

The introduction provides an overview of some of the most serious health challenges our country faces and why partnerships between health care systems and religious congregations are able to address these challenges. Clergy and lay leaders interested in seeing how a health program can complement existing ministries and programs will find an outstanding example in chapter 1, where we report on a congregational health program that has been going strong for more than 13 years. This program, coordinated entirely by volunteers, also illustrates how an effective and vibrant congregational health ministry can be run at virtually no expense to the church.

Health care professionals and religious leaders who have questions—and perhaps even some doubts—about the amount of interest in congregational health programs among parishioners and the types of program they believe are needed will find answers to many of these questions in the survey results reported in chapter 2. Elsewhere in that chapter we present a brief summary of the basic principles and methods of preventive medicine and illustrate how they can be incorporated into congregational programs. Chapter 3 provides an overview of the strategies that congregations can employ to link people with valuable health information and resources through proactive health education programs.

Part II focuses on specific chronic diseases and medical topics. Assisted by a panel of distinguished medical experts from the Johns Hopkins Medical Institutions, we provide, in a concise format designed specifically for individuals with little or no background in health care, the latest information about the most common diseases and the treatments for them. Each chapter includes suggestions for congregational programs and examples of such programs, and at the end of each chapter we provide information on additional resources.

In this section we also present strategies and resources that individuals can use to reduce their risk of illness and injury, effectively manage their medical conditions and health care, and maintain functional independence. Topics covered include lifestyle modifications, medication management, home safety, and advance directives. A chapter on communicating with health care providers includes a section on the concept of a patient advocacy or health partners program. This program trains individuals within a

congregation to assist members with chronic illnesses who may not have relatives or close friends to help them navigate a complex health care system. Several of the chapters in this section include brief guides that can be reproduced and shared with interested persons. These guides are also available in PDF format on the Web site of the O'Neill Foundation for Community Health (www.oneillcommunityhealth.org) and can be downloaded and copied.

Finally, Part III provides up-to-date information on models that can be studied and resources that can be used by any individual or organization interested in developing medical-religious partnerships. Included is information on how to identify and access local agencies and organizations, along with descriptions and contact information for national organizations that offer valuable health education materials. Also included are descriptions of five different medical-religious partnership models, along with contact information for those who would like to learn more about the programs.

The programs and materials presented in this book are by no means exhaustive. Religious congregations can sponsor many other programs, and religious and medical institutions can work together in a number of different ways to enhance community health. There has never been a better time to explore innovative and collaborative efforts to minister to the health needs of communities. We are in the midst of a fundamental change in the way people are conceptualizing and organizing health care. Health care leaders are awakening to the fact that they need to reach out to the community through trusted institutions, and religious leaders are learning that they can ask for assistance and support from medical institutions. We encourage you to take the initiative to bring medical and religious communities closer together.

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We could not have written a book about community health partnerships without the assistance and goodwill of many people. First and foremost, we want to express our appreciation for the steadfast support and encouragement of the late Mr. and Mrs. William E. O'Neill. The programs we initially designed more than fifteen years ago could easily have gone no farther than the idea stage if it were not for their generosity and efforts on our behalf. Firmly convinced of the value of programs in which medical institutions and professionals worked in partnership with faith communities, they established a charitable foundation that continues to provide support for these programs. We are also indebted to their daughter, Mary O'Neill-Clement, the other members of the O'Neill family, and the individuals who have served as officers of the O'Neill Foundation for Community Health—Barbara Pearson; Bette Heins, Ph.D.; Bill Allen, J.D., M. Div.; and Lisa Ford Williams—for their continued support.

A number of health care leaders who have worked directly with us in key roles as we developed and implemented our programs deserve recognition for their contributions. These include Gail Camputaro (Volusia County Council on Aging); Tom Coleman, M.D. (Volusia County Health Department); Fran Davis (Hospice of Volusia/Flagler); Bill Griffin and Jeff Feasel (Halifax Health); Joe Johnson (Florida Hospital Fish Memorial); Mark LaRose and Mike Gentry (Florida Hospital Memorial Division); Daryl Tol (Florida Hospital DeLand); and Bob Williams (Bert Fish Medical Center). We are also grateful for the support and encouragement provided by Richard Kindred, Ph.D., and Grady Ballenger, Ph.D. (Stetson University).

We want to acknowledge the contributions of several individuals who have played important leadership roles in innovative faith-health partnerships and who offered to share their stories. Sonja Simpson, a faith com-

munity nurse and former president of the Health Ministries Association, not only wrote about her own work but also helped us identify other nurses who had similar stories to report. One of these individuals, Fran Zoske, wrote about many of the programs offered by hospitals affiliated with Ascension Health and contacted other faith community nurses who in turn shared their stories. We also greatly appreciate the contributions of Gary Gunderson, D. Min., who wrote about the programs he helped to develop for Methodist LeBonheur Healthcare in Memphis; Dale Young, D. Min., who shared his work developing the Congregational Health Alliance Ministry Program for Baptist Health South Florida; and Candace Huber, who reported on her work as director of Florida Hospital's Center for Community Health Ministry based in Orlando.

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The expertise they brought to this work has made for a better book, for which we are most appreciative. Finally, we thank our editor, Wendy Harris, for her encouragement and guidance.

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III

RESOURCES

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COMMUNITY RESOURCES

Many chronic conditions and serious injuries can create significant challenges for people who want to maintain their independence. If they do not have family or friends who can step in to assist them physically or handle some of the everyday tasks and responsibilities required to live independently in the community, they may find it necessary to move to another setting. Even if a person has a spouse or someone to live with, eventually he or she may face the prospect of moving to a less independent setting as a condition progresses. For individuals who are faced with these situations but prefer to stay in their own homes as long as possible, the key may be finding professionals and agencies in the community that can provide help. Because arranging such services can be a daunting challenge for individuals who are already ill or injured, members of a faith community can help in several ways.

The easiest step for a faith community is to create and regularly update a list of community resources, including a brief description of the services provided and contact information for local agencies. In addition, the congregation can sponsor seminars or health fairs at which agencies share information about their services. These programs give members of the congregation and community an opportunity to learn about community resources *before* they or family members need the services. Finally, members in some congregations, particularly those who have a background in health care or social services, may provide direct assistance to ill or injured individuals by taking on some of their everyday responsibilities or chores (e.g., transportation, shopping, etc.), perhaps organizing groups or teams that can share these responsibilities.

Developing a list of community resources can be done by telephone and on the Internet. A good way to begin is to contact the case management or social work department of your local hospital. The professionals in these departments are generally aware of the various services in the community. They should be able to provide you with a list of many of the services and programs, along with information about which services are likely to be covered by Medicare or other insurance policies and the typical eligibility requirements for coverage.

Your Area Agency on Aging can be a source of information about community services. Established by the Older Americans Act of 1965, these Area Agencies on Aging (there are 650 across the country) provide home- and community-based services to older adults, thus allowing them to remain in their home. They also provide support services for caregivers. To locate the Area Agency on Aging for your community, you can call 1-800-677-1116 or go to the Eldercare locator (www.eldercare.gov/Eldercare.NET/Public/Home.aspx).

Another good source of information about community agencies and programs is your local chapter of the United Way. Each chapter has a list of affiliates or partner agencies, many of which offer services for individuals with functional impairment. The location of your local United Way chapter can be found by going to www.unitedway.org. Many United Way chapters are involved in establishing and supporting the 2-1-1 telephone program. In communities with this program, people can call 2-1-1 to obtain information about health and human services. Services vary from community to community but often include food banks, rent assistance, utility assistance, support groups, transportation assistance, Meals on Wheels, respite care, adult day care, and homemaker services.

An additional source of information about services in many communities is the local chapter of AARP. This organization also offers materials on a number of topics individuals and families with disease- or injury-related limitations are likely to encounter. Among the topics offered are caregiving, home modification to improve safety, housing choices, legal issues, and driver safety. You can obtain these materials and information about your state and local chapters by visiting the AARP's Web site: www.aarp.org.

The consumer beneficiary Web site offered by Medicare (www.medicare.gov) has information about health-related services in your community. This site allows you to list and compare the hospitals, skilled nursing facili-

ties (nursing homes), home health agencies, health plans and Medigap policies, and suppliers of medical equipment by state, county, or even Zip code.

TRANSPORTATION

One of the problems facing many individuals who have functional limitations and are living alone is transportation. They may be unable to drive themselves to medical appointments or to do basic shopping, and their health-related limitations may prevent them from using regular public transportation. In many communities the public transportation agency is able to provide door-to-door transportation for such individuals. Members of a congregational health ministry team can contact your local transportation agency to see if this service is offered in your community and, if so, how this transportation can be arranged. This information may also be available through your local Area Agency on Aging. Additionally, some home care or personal care agencies offer transportation services. Experienced case managers also suggest contacting a dialysis center and inquiring about the transportation services their clients use.

ASSISTIVE DEVICES

People with functional limitations are often able to continue living in their homes and maintain much of their independence if they have appropriate assistive devices. These can include grab bars in the bathroom, bath and shower chairs, hand-held shower heads, raised toilet seats, transfer benches, bed grips, and lift chairs or lift cushions. Mobility aids, ranging from canes and walkers to motorized wheelchairs, can also help people maintain their functional independence. The congregational health ministry team can help individuals experiencing functional limitations by creating a list of local businesses that sell or rent this equipment. If local businesses do not carry all the items people need, there is the option of finding online businesses that have a comprehensive inventory of assistive devices. A related service that a congregation can offer is sponsoring a program at which an occupational therapist or other health professional familiar with assistive devices can demonstrate their proper usage.

HOME MODIFICATIONS

It may be necessary in some cases for individuals to modify certain features of their home if they are to continue living there. A ramp may need to be installed if they are using a wheelchair or have difficulty climbing steps, and doorways may need to be widened to accommodate a walker or wheelchair. The installation of better lighting and handrails, along with the removal of throw rugs, can reduce the risk of falls. Congregational health ministry team members can help by identifying contractors who have experience making these types of modifications. A good place to find these contractors is a local medical supply business that carries assistive devices and other durable medical equipment.

PERSONAL EMERGENCY RESPONSE SYSTEMS

A personal emergency response system, also called a medical response emergency system or medical alert system, can provide a sense of security for individuals living alone. These systems allow persons who are experiencing an emergency to summon help by simply pressing a button on a small radio transmitter carried in their pocket or worn around their neck or on their wrist. This sends a signal to a console connected to the user's telephone that automatically dials 911 or an emergency response center. With the systems that are linked to an emergency response center, the operator determines the nature of the emergency and notifies the appropriate party from a list provided by the client (e.g., neighbor, family member, ambulance). Some emergency response centers are operated by hospitals or social service agencies; others are operated by the system manufacturer. Members of a congregational health ministry team can research the options available in their community and the cost of renting or purchasing a personal emergency response system. In many communities, the Area Agency on Aging can arrange for the installation of a system or provide information about local providers. Also, businesses that sell or rent home medical equipment generally have information about these systems.

Individuals who have mobile telephones should consider creating one or more entries using the acronym ICE—In Case of Emergency—to assist paramedics or police who might need to alert a family member or friend in case of an emergency. The acronym can be placed in front of the name

of the person or persons they would want called if they are in an emergency and unable to communicate. For example, they might have ICE–wife and ICE–son or ICE–1 and ICE–2. This would allow the paramedic or police to quickly notify the appropriate family member or friend.

MEAL PROGRAMS

Meals on Wheels is a nation-wide program that provides meals for homebound individuals unable to prepare their own meals. Information about local programs can be obtained from the Web site of Meals on Wheels Association of America (www.mowaa.org) or from your Area Agency on Aging. Many communities also offer congregate dining programs for older adults who have a need for improved nutrition and socialization. Your Area Agency (or Council) on Aging should be able to provide information about these congregate dining sites.

PERSONAL CARE OR HOMEMAKER SERVICES

In most communities there are businesses or organizations that provide nonmedical care for individuals who need assistance with some of their everyday responsibilities and activities. These services enable individuals to remain in their own homes and continue with many of their routines and activities. Among the services offered by these organizations are meal preparation and cleanup, light housekeeping, laundry and ironing, changing linens, medication reminders, mailing bills and letters, assisting with pet care, grocery shopping, incidental transportation, and escorting to appointments, meetings, and religious services. In addition to compiling a list of these organizations in your community, congregations can sponsor programs at which representatives of these organizations discuss the services they offer.

HOME HEALTH CARE

Individuals who need certain types of health care but are homebound or normally unable to leave home unassisted may need the services of a home health agency. Home health agencies provide and help coordinate the care ordered by a physician. These organizations offer a range of skilled

care services, including nursing care, physical and occupational therapy, speech-language therapy, and medical social services. Information about the home health agencies in your community and eligibility for Medicare coverage of these services is available at www.medicare.gov.

SUPPORT GROUPS

The challenges of living with the limitations and uncertainties of a chronic illness can leave the affected individuals, and sometime their caregivers, feeling overwhelmed, emotionally drained, and deeply discouraged about their long-term prospects. Support groups, in which people facing similar health concerns and challenges gather on a regular basis, give individuals an opportunity to share their feelings and learn how to cope with the most difficult aspects of their situation. Members often receive assistance with the practical as well as emotional aspects of their illnesses, learning new problem-solving strategies and discovering additional community resources.

Identifying the various support groups in most communities can be challenging. Although some hospitals and community agencies maintain a list of support groups, in many communities there is no comprehensive list. A good place to start your research into this matter is to visit the Web site of your local hospital or contact the hospital's case management or social work department to see if they have a list of support groups. If they do not have a list, you will need to use your telephone and the Internet to compile a list. You can start by visiting the Web sites of national organizations associated with specific conditions (e.g., Alzheimer's Association, American Stroke Association, American Cancer Society, Mental Health America). Many of these include contact information about support groups throughout the country or links to local chapters that have information about support groups. Another strategy is to call physicians' offices. For example, neurologists may be aware of support groups for those who have had a stroke or have Parkinson's disease, and oncologists may have information about cancer support groups.

FINANCIAL COUNSELING AND ASSISTANCE

For some individuals who have debilitating chronic illnesses, handling basic finances can be a problem. Although they may have adequate resources, they find it difficult to handle certain financial responsibilities. In some communities the Area Agency on Aging or another community agency can arrange for a financial care manager to assume these responsibilities—making deposits, writing checks to pay the client's bills, and balancing checkbooks and bank statements. Clients can still maintain the responsibility for directing which bills should be paid and signing the checks. Another option in many communities is to arrange for a bank to electronically pay bills from the customer's account. The customer or a family member can monitor the account via the bank's online service—checking account activity and balances, viewing statements online, viewing images of paid checks, and transferring funds between accounts. The congregational health ministry team can explore various options and publish a list of organizations that provide these services.

LEGAL ASSISTANCE

Affected individuals or their families may need to obtain legal assistance for a number of illness-related challenges. These include Medicare claims and appeals, disability claims and appeals, guardianships, and disability planning, including the use of durable power of attorney, living wills, and other means of delegating management and decision making in the case of incapacity. As with many issues, the best time to learn about these is well in advance of a crisis. It is helpful for a congregational health ministry team to identify local attorneys who have experience in these areas of law and invite them to speak at a seminar.

RESPITE CARE AND ADULT DAY CARE

For many individuals, their ability to remain in their own home depends largely on having a spouse or other family member live with them and provide much of their care. This arrangement often works well, but it can place considerable stress on caregivers, who may find they do not have enough time to take care of their own responsibilities or that the strain of

caregiving is jeopardizing their own physical or mental health. When this occurs, caregivers can consider several options to relieve some of the stress. For those who are capable of providing most of the care for a loved one but need some time away to tend to their own responsibilities and needs, respite care can be a good option. Some respite care programs provide an in-home companion, while others have a facility where the person in need of care can stay for a few hours. In some communities, organizations serving older adults have partnered with religious congregations to offer respite programs. When family caregivers need to go out of town for a few days or require medical treatment that will temporarily prevent them from providing care, skilled nursing facilities may be able to provide respite care. When individuals with a debilitating chronic illness cannot be left alone but the family caregiver has full-time work responsibilities, adult day care centers that offer a protective and supportive setting may be the best alternative.

The congregational health ministry team can provide a valuable service by exploring respite care and adult day care services in the community. Your research can start by contacting the Area Agency on Aging or the case management or social work department of your local hospital, but it can also include visiting programs to evaluate their facilities and services. Some congregations may want to explore offering their facilities and providing volunteers for a respite care program one or two days a week; if so, it is advisable to work closely with experienced professionals (e.g., hospital administrators, Area Agency on Aging staff) to ensure that the facilities meet any applicable regulatory and licensing requirements, the environment is safe, and volunteers are properly trained and supervised.

CARE MANAGEMENT

For some individuals with chronic illnesses, the extent of their impairment and the services they require to live independently are not readily apparent. In such cases, the services of a care manager may be helpful. Geriatric care managers are health or human services professionals who can assess an individual's medical and human service needs and then assist in making arrangements for the provision of the required services. Care managers also can make regular visits to monitor the care and status of their client, determining if any new challenges have arisen and additional

services should be considered. Should the time come that the client is no longer able to live independently, the care manager can assist in finding the most appropriate living arrangement. The services of a care manager can be especially helpful when the family members who have assumed responsibility for the care of a loved one live in a distant community. To identify geriatric care managers in your community, you can contact your local Area Agency on Aging or visit the Web site for the National Association of Professional Geriatric Care Managers (www.napgcm.org).

LONG-TERM CARE RESOURCES

There may come a time when individuals find that they are no longer able to live independently or that their quality of life will be better if they move to a community or facility that can provide more comprehensive care and greater security. A congregational health ministry team can assist these individuals and their families by compiling a list of the various housing options in the community and providing information about their services, costs, and eligibility requirements. Four long-term care options are available in most communities.

Continuing Care Retirement Community (CCRC) or Life Care Community. These communities combine independent living, assisted living, and skilled nursing care in one setting. Individuals can start off living independently in their own apartment, townhouse, or cottage and then add services (e.g., meals, housekeeping, and transportation) or transfer to an on-site assisted living or skilled nursing care facility as their needs change. Many of these communities offer primary and preventive health care services. Residents generally pay an entry fee and then monthly maintenance fees. Entry fees, policies on refunds of entry fees, monthly maintenance fees, and fees for additional services and amenities vary widely.

Assisted Living Facility (ALF) or Adult Congregate Living Care. These facilities are generally appropriate for individuals who need assistance with activities of daily living but do not require skilled nursing care. The types of service and levels of care can vary, but assisted living facilities typically provide assistance with bathing, dressing, eating, and monitoring of medications. Meals, laundry, and housekeeping are also provided, and some facilities arrange for transportation and offer regular social programs and

activities. Residents generally pay a monthly rental fee that covers most of the basic services. Additional fees may be required for certain services.

Skilled Nursing Facility or Nursing Home. These facilities are appropriate for individuals who require skilled medical care. Although some may need to be in this setting only on a temporary basis while rehabilitating from an illness or injury, others may spend the rest of their lives in this setting due to physical, cognitive, or emotional conditions that require ongoing medical and personal care. Skilled nursing facilities provide a room (private or shared), all meals, 24-hour nursing supervision, access to needed medical services, personal care, and generally some social activities. A physician supervises the medical care of residents. Some nursing homes provide additional services for a fee.

Hospice. Hospice care is appropriate when the goal of an individual with a terminal illness has shifted from cure or life-prolonging treatment to palliative care (i.e., care aimed at relieving pain and controlling symptoms). Most hospices accept patients who have a life expectancy of six months or less if their disease runs its normal course (the requirement for Medicare reimbursement), although some are able to accept patients with a longer life expectancy. Hospice care is provided by a team that includes doctors, nurses, social workers, chaplains, pharmacists, home health aides, and volunteers, and this care can be provided in a person's home, in a nursing home, or in a residential care center.

Hospice services continue to be underused, with many eligible individuals never using hospice care and others electing it only in their final few days or weeks of life. At least some of this under-use is the result of misunderstandings about hospice care. Some people believe it is only for individuals who have cancer or AIDS, and others assume it is appropriate only when death is imminent. Hospice is often appropriate for individuals who have conditions such as advanced emphysema, heart failure, or dementia. Congregational health ministry teams can perform an important service by educating their congregations and communities about the nature of hospice care, the medical conditions for which it might be appropriate, and the point at which individuals and families may want to consider electing hospice care.

EXAMPLE OF A CONGREGATIONAL PROGRAM

An example of how representatives of faith communities can work with medical institutions and professionals to help individuals identify and access community resources is the ElderCare Project, a care transition program provided to patients by volunteer parish nurses associated with the Sacred Heart Health System (a part of Ascension Health in Pensacola, Florida). Much of the program's structure was taken from the "nurse coach" model developed through the work of Dr. Eric Coleman of the University of Colorado. The ElderCare program is funded by donations from the Escambia County Medical Society, with additional funds and in-kind services provided by a number of civic groups, health care services, and private individuals.

The mission of the ElderCare Project is to link at-risk seniors who do not have a capable caregiver living with them to appropriate health and social services, thus allowing them to live independently in their own homes. Usually two nurses make the initial home visit and do an in-depth assessment of the patient's health status and needs. Once the assessment is completed, identified needs are conveyed to a case manager at the Council on Aging or to a community agency that may be able to assist. If the nurses find a medical issue that needs to be addressed before the patient's next medical appointment, they contact (with the patient's approval) the physician or the on-call nurse practitioner who volunteers with the ElderCare project. Medication issues are managed in a number of different ways, including consulting with volunteer pharmacists from a local Veterans Administration (VA) clinic. After the initial face-to-face visit, the nurses arrange for follow-up phone calls with the patient to ensure that health and social service needs are being met.

Cheryl Pilling, M.A., B.S.N., the coordinator for Community Wellness Outreach and ElderCare Health at Sacred Heart Health System, offers the following case as an illustration of how the program operates.

A woman in her late seventies had been placed on a new blood pressure medication by her primary care physician during her hospitalization. Because of her ongoing weakness and memory problems, she was directed not to drive. Up to several months before her hospitalization, she had been essentially self-sufficient. Now she had to depend on her two children, one who lived about

twenty miles away and the other who was legally blind, to assist her. Two parish nurses, acting as ElderCare nurse coaches, made their home visit and discovered that this patient needed home-delivered meals because she had difficulty standing to cook, had missed her follow-up doctor's appointment, was out of the new blood pressure medication, and did not know what to do.

Thanks to the parish nurses' interventions, the physician's office sent a physician's assistant to the patient's home, who brought more medication, determined that she needed more assistance, and ordered home care. She was also able to obtain meals delivered to her home, a service that reduced her anxiety over not being able to get out and purchase groceries and cook for herself. And having the physician's assistant make home visits meant that she would not miss any more doctor's appointments.

INFORMATION RESOURCES

Information and advice on housing options and links to additional resources can be found at www.aoa.dhhs.gov/eldfam/Housing/Housing.asp (the Web site for the Administration on Aging). The AARP Web site (www.aarp.org) also provides information on housing options.

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INNOVATIVE MEDICAL-RELIGIOUS PARTNERSHIPS

The health needs and concerns that can be addressed by medical-religious partnerships vary from community to community. This chapter presents five different programs. Our own report on a program serving Daytona Beach and surrounding communities is followed by a report on a program in Memphis (prepared by Gary Gunderson), information on several programs offered in communities served by Ascension Health (prepared by Fran Zoske), a description of a program based in south Florida (prepared by Dale Young), and a report on a program serving the greater Orlando area (prepared by Candace Huber).

THE O'NEILL FOUNDATION FOR COMMUNITY HEALTH

The O'Neill Foundation for Community Health, a tax-exempt, nonprofit organization, works with religious congregations, health care organizations, social service agencies, and educational institutions throughout the United States to provide the resources people need to maintain their own health and to care for sick or disabled individuals. The foundation's goals are:

- To provide training programs and ongoing support for clergy and members of religious congregations who are interested in developing health ministries
- To produce educational materials and other resources that clergy,

parish/faith community nurses, and volunteer health ministry coordinators can use to address the health needs of their congregations and communities
- To facilitate collaboration between religious institutions and medical organizations

The O'Neill Foundation traces its roots back to 1992, when the authors collaborated in the development of a curriculum used to train volunteers from faith communities to coordinate health programs. Volunteers were taught how to organize programs on a wide range of conditions and medical issues, including Alzheimer's disease, heart disease, hypertension, cancer, depression, diabetes, managing medications, advance directives, and preventing accidents. Hospitals and medical professionals participated, collaborating with volunteers to conduct health education programs, screenings, and preventive interventions in their congregations. Building on the success of these programs and in response to needs of many of the older adults with whom we worked, we subsequently developed a program to train volunteers to serve as patient advocates or health partners for individuals who do not have a relative or friend to accompany them to doctor visits or help coordinate various aspects of their care.

Interest in these programs exceeded our initial expectations. The workshops attracted volunteers eager to learn more about important medical issues and how they could organize health programs for their congregations and, in many cases, for the community at large. As word of the programs spread, more congregations became involved, and so did more hospitals and health care professionals. It was clear that these programs were meeting an important need.

Critical to the success of these programs was the support of Mr. and Mrs. William E. O'Neill, of Daytona Beach, Florida. Longtime supporters of religious, medical, and educational institutions, they recognized the potential of programs that harnessed the energy of committed members of faith communities and coupled it with information and resources provided by health care professionals. In 2003 the O'Neills offered to establish a charitable foundation to provide ongoing support for this effort.

The O'Neill Foundation is headquartered in Volusia County, Florida, which serves as an ideal "field laboratory" for developing and evaluating new programs because the county has a sizable population of older adults.

In fact, the proportion of the population age 65 or older—20 percent—is the same as that projected for the entire United States by 2030.

One of the first steps the O'Neill Foundation took as part of an effort to develop an innovative faith-health initiative was to compile a list of all religious congregations in the county. We found nearly five hundred faith communities in this county of approximately 500,000 people. A letter introducing the foundation and its plans was sent to each of these congregations, and those that were not interested in receiving further information could opt to have their name removed from the mailing list. Only five congregations asked that we do this.

The foundation then contacted each of the seven hospitals in the county (Bert Fish Medical Center in New Smyrna Beach, Florida Hospital DeLand, Florida Hospital Fish Memorial in Orange City, Florida Hospital Oceanside in Daytona Beach, Florida Hospital Ormond Memorial in Ormond Beach, Halifax Health Medical Center in Daytona Beach, and Halifax Health Port Orange) to invite them to serve as partners with the foundation. All seven accepted the invitation and offered financial support and assistance in planning and promoting health education programs. Also joining as partners were the Volusia County Health Department, the Council on Aging, the Hospice of Volusia/Flagler, Stetson University, and Bethune-Cookman University.

Each year the foundation, in consultation with its partners, selects several timely health topics to serve as the focus of a Congregational and Community Health Initiative. As part of this initiative, the foundation produces materials, including taped interviews with medical experts from the Johns Hopkins Medical Institutions designed specifically for faith communities. The format of these materials is such that they can be used to organize special congregational programs, presented during regularly scheduled congregational gatherings or taken home and viewed by individual members. Topics include Alzheimer's disease, depression, diabetes, cancer, heart disease, palliative care, chronic disease in African Americans, and making the most of a medical visit.

As part of its annual Congregational and Community Health Initiative, the foundation and its partners sponsor one or more major conferences on medical topics that have been found to be of concern to the community. Although the conferences are open to the entire community, special invitations are sent to all religious congregations, and speakers include in their

presentations suggestions for how congregations can address some of the needs associated with the medical issues being discussed. The foundation also tapes the presentations and makes these available on DVD at no charge to individuals who are unable to attend and to those who do attend and wish to share the information with other individuals or groups.

An example of the foundation's multifaceted community health initiatives is one that focused on Alzheimer's disease in the fall of 2007. The centerpiece of this program consisted of two presentations (one on each side of the county) on "Alzheimer's Disease: Challenges for Professionals and Caregivers" by Dr. Peter Rabins, a geriatric psychiatrist on the faculty at the Johns Hopkins University School of Medicine and co-author of the best-selling book, *The 36-Hour Day: A Family Guide to Caring for People with Alzheimer Disease, Other Dementias, and Memory Loss in Later Life.* The hospitals and other organizations that serve as the O'Neill Foundation's partners co-sponsored the event, with each organization sharing information about its services and programs. But these presentations were only part of a comprehensive initiative to reach out into the community. The first part of this initiative had come a month earlier when the foundation mailed to each of the congregations on its mailing list not only an invitation to send representatives to attend one of Dr. Rabins's presentations but also a copy of his book that could be placed in the congregation's office or library for use by anyone who needed information on Alzheimer's disease.

The third part of the foundation's initiative involved videotaping one of Dr. Rabins's presentations and then making copies of the DVD available at no charge to anyone who believed that he or she knew other individuals or groups who would benefit from the information. Of the more than 700 people who attended this conference, 250 requested a copy of the DVD. Individuals requesting a copy were asked to estimate the number of people who would view the tape over the next twelve months; the estimates totaled more than 9,000.

A similar community health initiative, this one focusing on "Recognizing and Responding to Depression" and again featuring Dr. Peter Rabins as the guest speaker, was organized by the foundation in the spring of 2008. This time the foundation mailed to all religious congregations in the county an invitation to hear Dr. Rabins and a 24-page booklet on depression prepared by the National Institute of Mental Health. The foundation also arranged to have one of Dr. Rabins's presentations videotaped and copies of

the presentation made available to individuals who heard the presentation and knew of others who would benefit from the information. Of the more than 600 people who attended one of Dr. Rabins's presentations, 210 requested a copy, and their estimates of the number of people who would see the video over the next twelve months totaled almost 5,000.

In addition to these major, high-visibility initiatives, the foundation cosponsors with individual hospitals a number of smaller programs targeting congregations near each hospital. Among the topics covered in these programs are accident and fall prevention, advance directives, modifying risk factors for cardiovascular disease and diabetes, stress management, and hospice and palliative care. The foundation stays in touch with local congregations by mailing newsletters and maintaining a Web site, with both providing information about timely health topics and local health resources. Bulletin inserts with information about health programs and services are also mailed to congregations.

The foundation conducts workshops for clergy and laypersons interested in establishing health ministries or expanding existing programs. No medical experience or background is required to enroll in these workshops, just a strong interest in serving others and good organizational skills. The workshops are often co-sponsored by religious, medical, or educational institutions.

The O'Neill Foundation offers consultation services and workshops for health care organizations interested in developing partnerships with or educational programs for faith communities. More information about programs and materials can be obtained by contacting the foundation or visiting its Web site: O'Neill Foundation for Community Health, P.O. Box 1529, DeLand, FL 32721-1529; (386) 748-3775; www.oneillcommunityhealth.org.

THE CONGREGATIONAL HEALTH NETWORK OF MEMPHIS, TENNESSEE

Memphis is a tough town with a bitter legacy of health disparities that appear to many to be intractable. Some of the downtown neighborhoods have infant mortality rates comparable to those in Zimbabwe, while rates of poorly managed and early-onset chronic disease are epidemic. One might expect faith-based health projects to be modest, perhaps focused on

devising pilot approaches that could be scaled up later. But this is the ground where the dream of Dr. King's "beloved community" continues to thrive forty years after its dreamer was killed. It is a city where dreams don't die.

The Congregational Health Network (CHN) is a young but significant network of 105 churches and Methodist LeBonheur Healthcare that have entered into a covenant with each other to share the ministry of improving the health of members and neighbors. The covenant is focused on helping people navigate their journey of life, which will probably, from time to time, involve some aspect of the medical system, even a hospital. Hospital research indicates that 70 percent of emergency room patients in Memphis have been in a house of worship within the last 30 days, indicating that the congregation is the critical care network of the majority of patients before they enter into a medical care environment. As Gary Shorb, the CEO of Methodist LeBonheur Healthcare, says, "We want to connect the faith-based treatment system (us) with the faith-based health system (the congregations)." The current 105 congregations signed up within the first nine months of the program. Expectations are that, within a couple of years, 20 percent of the more than 2,000 congregations within an hour or so of downtown—roughly 400—will enter the covenant.

The covenant provides the logic of the infrastructure that is emerging in the shared space between hospital and congregation. Both already have extensive infrastructure; only the web of relationship between them is new. That scaffolding includes a full-time "navigator" at each hospital whose primary job is to know and build the caring capacity of the congregations closest to that facility. Each pastor appoints at least one "liaison" whose job is to build the caring pathway with the navigator. Thinking of it as scaffolding emphasizes that it is under construction, because the pathway differs depending on the nature, size, capacity, and demographics of each congregation. The navigators are trained to appreciate the strengths the congregations already have and then to follow the intelligence of its clergy and laypeople about where best to extend those strengths.

The hospital does not prescribe any particular program: some of the congregations have Stephen Ministers (laypersons trained to provide one-to-one Christian care; see www.stephenministries.org for more information); others have parish nurses or lay health workers; some are just now organizing a health committee. The hospital offers specific training related to spiritual care visitation that is designed to build the confidence and com-

petence of laity and clergy to share the spiritual care of their members and neighbors when in the hospital. The seven-week classes are limited to 40 participants and tend to fill up months in advance. About half of the graduates volunteer to share the care of the general inpatient population beyond their own members.

The evidence base on which the Congregational Health Network rests is not programmatic, but social. This reflects the often-overlooked work of Ellen Idler of Rutgers University, which strongly suggests that the positive effect of congregational participation on peoples' lifespan is achieved at low levels of technical sophistication. The "intervention" is the whole thing: the complex, unpredictably relevant social support and engagement that happens in a congregation. CHN focuses on the existing social network of the congregation and its neighborhood, not on any particular added program. The health programs of various sorts add powerfully to the underlying social strengths a congregation already expresses without ever noticing that it is doing "health ministry." This perspective reflects the eight congregational strengths of *Deeply Woven Roots* (Gunderson 1997), but those strengths would exist regardless of the book.

The work in Memphis adapts the work of the African Religious Health Assets Programme (ARHAP) based at the University of Cape Town, South Africa. Using a blend of geographical information system mapping, participatory appreciative inquiry, and qualitative social science, ARHAP has shown how to see what is on the ground in Memphis that contributes to the health of the city. Although the hospital has hundreds of millions of dollars and most congregations do not, the most powerful health assets lie in the congregations, even the tiny ones led by clergy who have no formal seminary training. The art and, Idler would say, science, is in how to align the health assets of all sectors so that the journey of life reflects what God has in mind. That alignment begins with a covenant built on shared humility that is just as curious about what the hospital knows about congregational vitality as it is about what the congregation knows about health.

This humility is visible in the heart of the covenant, a document that emerged from a mixture of clergy and health system intelligence.

> Methodist Le Bonheur Healthcare (Hospital System) agrees to:
> *Extend to partnering clergy the following benefits already extended to United Methodist clergy:*

- Admission to clergy wellness events and programs
- Up to a 60 percent discount off the total Methodist LeBonheur Healthcare charges (not to exceed the balance after payment by your insurance)
- Tuition waiver to Methodist LeBonheur Healthcare clinical pastoral education
- Health-related training experiences, made available and affordable to partner clergy through work with local and national academic partners

To share in the work of aligning the mutual strengths of congregation and health system, we will:

- Provide a dedicated hospital navigator assigned to work with partner congregations to coordinate and help train members on the partnership activities with the congregation
- Work with expert partners such as the Church Health Center and Memphis Theological Seminary to help assess, plan, and build the education, prevention, intervention, treatment, and aftercare support that will be appropriate to the partnership congregations
- Provide ongoing support, training, and appropriate resources for the partnership with the partner clergy
- Partner to monitor, review, and expand the Congregational Health Network (CHN)

Clergy agree to:

- Attend quarterly clergy partnership gatherings for mutual training, awareness, and encouragement
- Provide ongoing leadership to monitor, review, and expand the CHN
- Use the clergy role to articulate and mirror the values and practices of a healthy lifestyle
- Extend an opportunity for members/neighbors to be informed of the program and benefits and to become active participants
- Provide leadership training for an active health ministry in the congregation. This group will be involved in education/prevention for members and neighbors. They will also have a role in intervention/aftercare if a member or neighbor is hospitalized.
- Assign a congregational liaison to facilitate the program
- Seek ways to help other clergy, health system staff, and congregations pursue healthy lifestyles and common goals

- Continue to support the partnership in prayer and worship to become God's instruments for health and wholeness in our community

Congregational Health Network is not owned by the hospital or by any one of the congregations. It is emerging through a kind of co-creation that in itself is healthy and builds the confidence and strength of all the partners. The future will emerge through the continued work of paying close attention to the real journeys the members and neighbors are taking. It offers individual members the opportunity to register through their congregation so that they have an ID card and are entered into the Methodist LeBonheur Healthcare's electronic medical record system. This allows CHN to activate the congregational support network just as with other parts of the care technology environment. The system also enables CHN to engage in "back-end data capture" to track health outcomes by comparing CHN members' health status (e.g., average length of stay) to those of non-CHN peers over time. CHN members' health status, ultimately, may demonstrate the capacity and vitality of CHN webs of trust to move Memphis toward the Beloved Community envisioned by Dr. King more than forty years ago.

For more information on the Congregational Health Network of Memphis, contact Teresa Cutts, Director of Research and Praxis, Center of Excellence in Faith and Health, Methodist LeBonheur Healthcare, 1211 Union Avenue, Memphis, Tennessee 38104, cutts02@gmail.com.

ASCENSION HEALTH

Ascension Health was founded in 1999 and today is the largest Catholic and largest nonprofit health system in the United States. It was formed through the merger of two health care systems, the Daughters of Charity Health System and the Congregation of the Sisters of St. Joseph's. The Daughters of Charity National Health System included nearly 80 facilities in 15 states, and the Sisters of St. Joseph Health System had four regional systems operating more than 30 hospitals, nursing homes, and outpatient clinics throughout lower Michigan. In 2002 the Sisters of St. Joseph of Carondelet joined, adding 13 more health care institutions to the Ascension system. Since that time, Ascension Health has achieved recognition as a model of leadership and clinical excellence in U.S. health care.

The Ascension Health ministry is dedicated to spiritually centered, holistic care that sustains and improves the health of individuals and communities. It is not surprising, then, that faith community nursing (also known as parish nursing) has long been a part not only of Ascension Health but also of the founding organizations. The values and goals of this system—service to the poor, reverence, and integrity—provide the spiritual foundation for Ascension Health's faith community nurses. The faith community nurses view themselves as advocates for a compassionate and just society.

The faith community nursing movement within Ascension Health can be traced back through its founding organizations, with the first programs beginning in 1986 at Seton Health of Troy, New York (a Daughters of Charity–sponsored health system), and in 1989 at St. John Health of Warren, Michigan (a Sisters of St. Joseph's–sponsored health system). Today more than a thousand nurses function in the role of faith community nurse within Ascension Health, making this the largest cohort of faith community nurses in one national health care system.

The Ascension Health Faith Community Nurse Leadership Network was founded in 2004 with the acknowledgment by Ascension Health of the importance of this growing nursing specialty. A Web site was instrumental in breaking down the barriers brought on by distance. The Ascension Exchange Faith Community Nurses Web site allowed individual members to seek out common endeavors, identify best practices, and address on a national level specific health issues common to all. One significant event solidified this group: this new network provided important feedback to the Health Ministries Association and the American Nurses Association in the revision of *Faith Community Nursing: Scope and Standards of Practice* (2005). In 2006, Ascension Health gave financial support to the University of Albany to conduct a survey of this network that would become the first enumeration study of faith community nurses in the United States. The current network includes faith community nursing leaders representing 22 health systems within Ascension Health.

The strategic priorities of Ascension Health's faith community nurses can be found at the local and national levels. Some initiatives are best addressed by local leaders within the context of the community needs; others require collaborative engagement as a national ministry. Their stories illustrate the many ways in which these faith community nurses have

facilitated and/or improved clinical excellence and safety; created innovative, patient-centered environments; and expanded access to care for uninsured and underserved individuals.

At Borgess Health in Kalamazoo, Michigan, faith community nurses reach out to their community with emphasis on spiritual beliefs and practices. Individuals identified by parish staff or by self-referral receive home visits by the faith community nurse and pastor that allow for an assessment of individual needs, resources currently being used, and additional resources that are needed. These visits include prayer; information gathering; problem solving; and referrals to appropriate parish, community, and health care resources. The faith community nurse and pastor then determine the type of follow-up needed and coordinate their contacts with the individual.

The Borgess Health nurses collect, analyze, prioritize, and document comprehensive data pertinent to the holistic health of individuals in the community. Faith community nurses, in collaboration with health cabinets and pastoral staff, conduct a health survey of the congregation within the first year of ministry and periodically thereafter. Results are aggregated, analyzed, reported to congregational leadership, and used in planning health ministry activities. They also recruit, train, and support volunteers and identify strengths that enhance the health and spiritual well-being of others.

Faith community nurses at Borgess Health identified a lack of support for pregnant, non-English-speaking Hispanic women. The Mother-Friend program was developed through a collaborative relationship among community agencies, area churches, and OB professionals to provide bilingual volunteers to mentor and support women in need through the pregnancy and the baby's first year of life. Mother-Friends are given an orientation to their role and information about prenatal care routines; current labor, delivery, and infant care practices; and postnatal care needs. They are offered ongoing in-service education and support through a Mother-Friend program at a local agency as they mentor young mothers.

At Seton Health, in Troy, New York, faith community nurses reaching out to diverse communities used evidence-based practices and assessment techniques to address adolescent obesity within an African American community. Recognizing the effect obesity was having on the children within their community, faith community nurses at Bethel Baptist Church, an African American church in Troy, obtained a local grant to develop an aerobic

exercise program for teens. The program, Pray Hard and Move Your Feet, was held on a weekly basis, led by a certified aerobic instructor using hip hop music. As the children were dancing, parents were invited to attend a cooking lesson given by a diabetes educator with the purpose of teaching healthier eating choices.

Reyut's Faith Community Nursing Program, a committee of the Women's Network of Congregation Agudat Achim (a Jewish synagogue in Schenectady, New York, and a member of the Seton Health Faith Community Nursing Network), supports members of their congregation through life's transitions while they grow spiritually and remain an integral part of the Jewish community. Reyut (a Hebrew word meaning "friendship") is working to create a caring congregation and is composed of volunteers who provide transportation to the synagogue, the doctor's office, or other activities. The volunteers also visit homebound members, hospitalized members, and members residing in nursing homes. Educational presentations focusing on health promotion, illness prevention, and caregivers' issues are offered on a monthly basis.

M.O.S.T. (Men of St. Timothy's Lutheran Church in East Greenbush, NY) began when the faith community nurse identified numerous health concerns voiced by male members of the church on the health needs survey. Using the services of a men's health consultant, a focus group was held with male members of the congregation. The men requested an ongoing support and spiritual group. The group, using the Carpenters Bible, was able to identify and address various physical, emotional, and spiritual concerns of male members and went on to hold yearly father-son breakfasts on Father's Day, bringing in guest speakers to discuss these issues.

In 2002–2003, at St. Agnes of Baltimore, Maryland, faith community nurses obtained a grant from Kaiser Permanente for the Faith Community Diabetes Self-Management Project. Training was provided to congregational health ministry leaders who facilitated monthly meetings for groups of ten members diagnosed with diabetes, using American Diabetes Association guidelines. Data were collected on seven diabetes education outcome areas. Participants reported a 10–20 percent increase in all data points: knowledge, skills, and confidence.

At Genesys Health System, of Grand Blanc, Michigan, faith community nurses strengthen and enhance health and spiritual well-being through advocacy. A faith community nurse worked with a mother of a severely

disabled 12-year-old, advocating for resources that would allow the child to remain in her home under her mother's care. The nurse helped reaffirm the mother's strengths, and this assistance has helped to keep the family together.

The Genesys nurses also serve as referral agents. During a blood pressure screening, a man became faint and pale and had a low blood pressure reading. The parish nurse provided him with a copy of the reading and encouraged him to call his physician. He made an appointment with the physician for follow-up and further exploration of signs and symptoms.

At Lourdes Hospital, in Binghamton, New York, faith community nurses reached out to the larger community by providing blood pressure screenings at the local soup kitchen and health fairs in various counties of the Southern Tier area of New York. They also addressed the needs of uninsured and underinsured individuals by bringing resources to area faith communities during Access to Care month. Individuals in need of insurance could speak to local insurance companies as well as to Child Health Plus representatives and sign up for health insurance.

At St. Vincent Medical Center in Bridgeport, Connecticut, the faith community nursing program is a valuable health information resource center. It provides weekly health talks in parishes, health tips in Sunday bulletins, a caregivers resource and nursing home placement guide, a speakers bureau guide to various community agencies, and a guide on medications with information on potential side effects and possible interactions with over-the-counter medicines.

For more information on Ascension Health, contact Fran Zoske, M.S., R.N., FCN, Director, Health Promotion and Wellness, CDPHP, 500 Patroon Creek Blvd., Albany, NY 12206-1057, fzoske@cdphp.com.

CONGREGATIONAL HEALTH ALLIANCE MINISTRY PROGRAM

In 1986, after evaluating the changes and impact of managed care on health, Baptist Health South Florida, the region's largest not-for-profit health care organization, formed an advisory board to create a partnership between the health system and area faith communities. The advisory board, made up of professionals in the health system as well as clergy and volunteers from the community, modified the "parish nurse model" of the Mid-

west to suit the social-economic-cultural context of the Miami area. This new model, the Congregational Health Alliance Ministry Program (CHAMP), trains volunteer community health promoters to develop congregation-based health ministries.

Three trends in health care created the contextual situation that the CHAMP model addressed:

1. Numerous research studies showed that patients who receive religious support and are connected to their faith or their religious community experience better health outcomes than patients who are not connected to their faith or their religious community. Doctors, nurses, social workers, and, most important, health care administrators paid attention to the research and began asking for more spiritual/religious support for hospitalized patients.
2. Managed care resulted in a significant reduction in the number of days patients stayed in the hospital and an increase in the number of outpatient surgeries. This meant that patients would be receiving less spiritual support in the hospital and would have a greater need for support by the faith communities following discharge. The change in context required a shift from providing institution-based spiritual support toward congregation-based support.
3. The tourist and agricultural-based economy of south Florida tends to create jobs that do not provide health insurance. Some 600,000 area residents lack health insurance. Additionally, new immigrants, especially if undocumented, tend to be marginalized with respect to health care delivery systems. The poor, the uninsured, new immigrants, and part-time workers have two things in common: they lack preventive care measures such as health education and screenings, and they have less access to health care.

The need for health promotion in the community became increasingly evident. CHAMP began to build capacity in the faith community to respond to these changing trends.

The CHAMP mission is to develop and strengthen a network of health ministries in faith communities. CHAMP promotes congregation-based programs of health education, health screenings, home visitation of sick people, bereavement support, care teams, and practical/spiritual support to

individuals with health challenges. CHAMP has trained, assisted, and supported more than 85 area congregations that currently network to promote health in the community.

The CHAMP model envisioned a two-prong strategy to meet the contemporary challenges: health promotion and support of the sick.

In the first part of the strategy, building capacity in the faith communities took the form of health education, health promotion, and health screenings based on specific "congregational health profiles." Each congregation in the CHAMP network designed its own health promotion program based on the results of a congregational health profile. Programs developed in this strategy include: health education events, health fairs, health screenings, and health support groups. In 2007, CHAMP offered free health screenings (e.g., blood sugar, cholesterol, osteoporosis, etc.) at 26 congregational health fairs. Since 1999, more than 22,700 free health screenings have been done through the CHAMP network.

The second part of the strategy focuses on support of those who have health challenges and are at home. There are three components to this facet of the CHAMP model: faith-based health support groups, care teams, and bereavement support.

Faith-Based Health Support Groups

Faith-based health support groups function within the life of the partnering congregations and focus on specific health issues (cancer, diabetes, depression, Alzheimer's disease, etc.). Through these peer support health promotion groups, congregations are becoming agents of healing and wholeness. CHAMP has established working partnerships with health promotion organizations such as the American Heart Association, the American Diabetes Association, the local chapter of the National Alliance on Mental Illness, the Alzheimer's Association of South Florida, and the Alliance for Aging. For example, when CHAMP trains leaders for health support groups with a healthy heart focus, it invites the American Heart Association to participate in the training and the follow-up support, using the materials that AHA developed for use in faith communities.

Congregation-Based Care Teams

Congregation-based care teams are designed to meet the challenges of patients recovering at home following hospitalization. Before designing the care teams model, CHAMP conducted a focus group of seniors to learn about the gaps in services they experienced after a period of hospitalization. Even among those who had good health insurance, there were many gaps in care and many needs that health care providers and community organizations were not able to meet: transportation to the doctor for follow-up visits, transportation to purchase prescriptions and food, meal preparation, light housekeeping, errands, companioning, caregiver relief, and spiritual support. CHAMP designed the care teams model to fill the gaps identified by the seniors.

To successfully implement the care teams model, CHAMP developed a curriculum to train volunteers to do holistic assessments and to organize and administer a care teams program in their respective congregations. A training course was developed to build capacity within partnering congregations and to train, enable, and support congregation-based care team programs. "Post-Hospitalization Spiritual Care" is a 32-hour curriculum that includes holistic patient assessment, spiritual assessment, self-care, active listening, infection control, advance directives, confidentiality, organizational model, and administration of a care teams program. While doing this work, CHAMP learned that the staff needed to focus on the spirituality of aging and the spiritual challenges implicit in facing end-of-life decisions. Those and other emerging issues were incorporated into the training course. CHAMP also learned that volunteers who served on care teams found it a meaningful activity. One of the volunteers stated, "If I could do this full time, I'd quit my regular job and do this every day."

Once a team from a congregation is trained, they organize care teams and set the parameters of the program in their respective congregation. To solidify the link between the hospitals and the faith community care teams, CHAMP established a procedure to make referrals from the hospital. CHAMP consulted with chaplains, social workers, and discharge planners before creating a guide that would facilitate the referral of patients to the faith-based care teams. Using this referral guide, discharge planners, social workers, and chaplains may easily refer a patient to an appropriate care

team. Congregational membership, language, culture, and location are factors in making referrals.

Eleven congregations have implemented the care team model and currently receive referrals from the chaplains and social workers of the Baptist Health system. By mid-2007 the CHAMP care teams had provided spiritual and practical support to more than 2,500 individuals. More than 200 congregational volunteers are involved in this ministry.

Services offered by partnering care teams include:

Meals delivered to the home
Transportation to medical appointments
Errands such as picking up medications and groceries
Home visitation and companioning
Caregiver relief
Light housekeeping
Spiritual support
Keep-in-touch phone contact

Bereavement Support

The CHAMP bereavement program received one of seven nation-wide grants from the Open Society Institute's Death in America Project in 2000. The objective of the grant was to establish a multicultural and cross-denominational grief support program in the faith community of Miami-Dade. There were three concerns in developing that program: (1) the desire to integrate spirituality into the bereavement support process; (2) the concern to integrate the wisdom and inherent cultural skills of Miami's diverse faith and cultural traditions; and (3) the goal to equip faith communities with professionally endorsed understanding of grief, empowering indigenous leadership to provide culturally appropriate peer group grief support. To date, CHAMP has trained more than 180 facilitators of bereavement support in Miami-Dade and the Upper Keys. CHAMP was invited to introduce this program in India and Sri Lanka following the Christmas Day 2005 Tsunami. In 2006 and 2007, more than 70 peer group grief support leaders in Sri Lanka and India were trained in the CHAMP bereavement support model.

The story of Susan illustrates how the CHAMP program works:

Susan came to Miami from New York to take care of her sister, Maryann, who was dying of cancer. Maryann was the caregiver of their brother, Michael, who had cerebral palsy. After Maryann died, Susan and Michael sought out one of the CHAMP bereavement programs, the network of peer group grief support programs in faith communities. They still attend after five years. Now, having worked through their own grief issues, they go to support others with their grief.

A few months ago, Susan had intestinal surgery and was hospitalized five days. She was discharged and that same evening was back in the ER with a blockage that required additional surgery. This time she stayed 14 days in the hospital. Once discharged, she had no one to help her. Her brother, who is on disability, cannot cook, cannot drive, and is basically dependent on Susan, who was in bed recovering. A friend went grocery shopping for her but then had to go out of town, and Susan was left with no help. She needed to go to five different doctors, needed medications, and could not even get out of bed.

Then she remembered about the CHAMP care teams program, so she called her church and got the number for the CHAMP office. Two churches in her Zip code had care team programs. A lady from the first church took her to the doctor, but Susan needed more support than that church could provide, so a second church got the referral. This church has more than 80 volunteers in the care teams program, and they went into action. The leader of the transportation team helped Susan organize her doctor visits and provided rides to her appointments, followed by trips to the pharmacy. They ran errands such as picking up prescriptions at the pharmacy and purchasing ready-to-eat meals and groceries. When Susan had a doctor's appointment, they would call the day before and also before picking her up, just to remind her. They provided care for a month and half.

When Susan was well enough to function on her own, the leader of the phone follow-up team would call once a week to see how she was doing. One month later, Susan became very sick. She called the doctor, and he prescribed medicine, but Susan had no way to pick up the medicine. She was desperate; she had no one she could call. Just then, there was a knock on the door and it was a lady from the CHAMP care team who had shown up just to see how she

was doing. "It was like an angel had appeared," Susan said. She explained her predicament, and the visitor went to the pharmacy for her medicine.

Susan now tells everyone who will listen how wonderful are the ladies from the care teams and how she couldn't have made it without their support. Her own church is now organizing a care teams ministry, and Susan cannot wait to volunteer.

For more information about the CHAMP faith/health partnership, call 786-573-6087 or visit the Web site, www.baptisthealth.net/champ.

FLORIDA HOSPITAL'S PARISH NURSE INSTITUTE AND CENTER FOR COMMUNITY HEALTH MINISTRY

Florida Hospital is a not-for-profit, acute care health system with facilities in seven locations in the greater Orlando area. With more than 1,900 beds, it is the largest health system in the region. Florida Hospital is part of a comprehensive network of 17 hospitals of the Adventist Health System–Florida Division.

For nearly one hundred years, the stated mission of Florida Hospital has been "to extend the healing ministry of Jesus Christ." Adventist hospitals, inspired by the strong Adventist heritage of health ministry, work toward this goal through a commitment to patients' physical, mental, emotional, and spiritual well-being. This means that, in addition to treating illnesses, an important part of Florida Hospital's mission is to provide the support and education people need to prevent diseases and to live life to the fullest extent possible. The commitment to whole-person health is illustrated by CREATION Health, an acronym for the eight essentials of optimal health: **C**hoice, **R**est, **E**nvironment, **A**ctivity, **T**rust in divine power, **I**nterpersonal relationships, **O**utlook, **N**utrition. This commitment has inspired joint endeavors between the hospital and like-minded community resources.

Florida Hospital's Parish Nurse Institute was established in 1994. The following year, working in association with Stetson University, the hospital began offering the Lay Health Education Class developed by the authors, Drs. Hale and Bennett. In 2001, Florida Hospital became an educational partner with the International Parish Nurse Resource Center and adopted the standardized curriculum for parish nurse preparation. At this point, the approach to congregational instruction was revised, and the Health Minis-

try Team Building Course was developed. This eight-hour course focuses on health as a congregational ministry and emphasizes the importance of engaging clergy and lay leaders in support of health and wholeness as part of the mission of the congregation. Course participants also receive instruction in the development of an inclusive health ministry team along with strategies for effective health promotion and lifestyle behavior change. More than 350 congregations in central Florida have sent representatives to participate in the health ministry training, and more than 400 nurses from 26 states and Puerto Rico have been educated in the practice of parish/faith community nursing. Health ministry leaders and parish nurse coordinators throughout the United States and as far away as Russia, Australia, and South Africa have used the materials developed by Florida Hospital.

Faith Community Nursing: Scope and Standards of Practice, a document developed by the American Nurses Association with the cooperation and support of the Health Ministries Association, defines faith community nursing as "the specialized practice of professional nursing that focuses on the intentional care of the spirit as part of the process of promoting wholistic health and preventing or minimizing illness in a faith community." It goes on to state, "With an intentional focus on spiritual health, the faith community nurse uses the interventions of education, counseling, advocacy, referral, utilizing resources available to the faith community, and training and supervising volunteers from the faith community" (Health Ministries Association and American Nurses Association 2005).

The document sets forth fifteen standards of faith community nursing practice. The standard of health teaching and health promotion (5B) often presents challenges for nurses coming out of strictly medical settings. Many have had little experience in the field of health science that focuses on the promotion of healthy lifestyles and health behavior change necessary to both manage and reduce the risk of disease. This work includes facilitating presentations that inform congregations on certain health topics. However, to effectively change behavior, efforts must extend beyond health events or presentations. There must be time assigned to identify health risks, followed by the explanation and the meaning of the results. This needs to be accompanied by related health information that can lower the disease risk, individualized and realistic goal setting, and group support for successful health behavior change. An important part of the training

program is attention to the standard for collaboration (11) and the standard for research (13).

Recently the Parish Nurse Institute and the Center for Community Health Ministry had an opportunity to study the effect of congregational health education and health promotion activities. With a grant from Winter Park Memorial Hospital, one of the seven Florida Hospital facilities in the greater Orlando area, a three-year project, Project HOPE (Healthy Outcomes through Personal Empowerment) was implemented. This was a demonstration project to measure improvement in health through the work of the congregational health ministry team and the parish nurse in cooperation with the hospital partner. As part of the process, the hospital provided funds to support the part-time salary of the parish nurse and provided health science support for an annual health risk appraisal (including laboratory blood tests, biometrics, and a comprehensive lifestyle questionnaire) and record-keeping to determine baseline health risks and measure participants' health behavior change. Each congregation's health ministry team received an executive summary report indicating prioritized percentages of participants' health needs for the purposes of planning a yearly health initiative. A variety of health and lifestyle change programs were implemented (e.g., nutrition, fitness, weight loss, grief recovery) as well as "train-the-trainer" programs for congregational leaders. The parish nurse's role included developing a health ministry team and responding to expressed health needs for individuals and groups according to the roles of parish/faith community nursing.

Of the 10,732 possible adult participants, 947 chose to participate, with 221 involved for three consecutive years. Eighty were male (75% over the age of 50), and 141 were female (71% over the age of 50). All participants completed a standardized health assessment instrument. The greatest health risks identified were cancer risk (87%), poor nutrition (64%), needing improved fitness (61%), needing weight management (60%), coronary risk (48%), needing cholesterol level management (39%), and needing high blood pressure management (23%).

The outcomes achieved by the end of three years indicated the greatest improvements or risk reductions were in the areas of cholesterol management and nutrition. Other encouraging changes noted were cancer risk reduction and improvement in blood pressure management, weight management, and fitness. Two of the three congregations, convinced of the

value of a health ministry, increased the hours of the parish nurse to full-time status and assumed the greater part of the salary by the fourth year—an encouraging sign for the sustainability of the effort.

Interestingly, spiritual health questions were also a part of the measurement process. As one might expect from congregational participants, 99 percent responded affirmatively when asked if their belief in a "higher power" was a source of direction. A series of questions were asked relating to the influence faith has on the participants' meaning and purpose, joy and harmony, comfort during crises, strength to deal with problems, reason to help others, and social contact. Where these questions were concerned, responses such as "yes, very much" and "yes, very often" were in the range of 86–93 percent. The one item that scored lower and indicated a larger potential for improvement was "My faith influences my life as a support and motivation for a healthy lifestyle." Initially, only 69 percent responded "yes, very much" or "yes, very often." By the close of the third year, this percentage had climbed to 79 percent.

Clergy may ask an important question about parish nursing and health ministry: How does health ministry build the kingdom of God, which is the work of the church? The story one Project HOPE participant shared at the time of her second-year health risk appraisal may help answer this question:

> "I can hardly wait for this year's measurement results."
>
> "Why," I asked. "What happened to you?"
>
> She replied, "Last year, I found out that I was at risk, and so I have begun to work on my health. I took a class called Fitness for Life, held here at the church. I learned how to make simple changes—it's not just my diet. It's about a healthier lifestyle. Now my husband and I get up and walk every morning at 5:30. I have lost weight, and I feel great."
>
> Then she added excitedly, "And I am attending church three times a week."
>
> Surprised by this last comment, I asked how often she had attended church before this.
>
> "About once a month," she replied.

Through the work of health ministry and parish nursing, this participant was made aware of certain health risks that, if left unattended, would

eventually contribute to poor health or disease. She began facing her situation by acknowledging her personal risk and began to alter her behavior. She attended a class offered by the church, made some simple changes in her lifestyle, altered her diet, and began a reasonable and simple exercise program. She lost weight and noticed that she had more energy, and she proclaimed that she was feeling "great." This participant was affected in positive ways by becoming more engaged in her own health, and she was an influence in her family (her husband joined her in walking). Her newfound "energy" led her to change one other area in her life—participating in her church more. She desired to become more involved in her congregation and had the energy to act on her decision. She wanted to share her experience with someone else: "Let me tell you my story, and it happened here at church."

Also of interest in this work is a "control" congregation that did not have a parish nurse or a health ministry team. This congregation was similar to the others in most respects and open to having a presentation to explain Project HOPE to its leadership and members. In a church of 480 members, 20 participated the first year for baseline data. Each participant was given a personal report. The offer for follow-up health programs was made, but the church did not request any programs or seek further contact with Project HOPE during the year following the initial assessments. When approached to schedule the second year's measurement, there was no response to multiple inquiries and thus no further assessments or programs were arranged. This congregation had dedicated and friendly members, yet without a team of people or a parish nurse to work with the pastor to develop health ministry, the connection between faith and health could not gain traction.

For more information on Project HOPE or to learn more about the Florida Hospital's Parish Nurse Institute and Center for Community Health Ministry, contact Candace Huber, director, at Candace.Huber@flhosp.org, or visit the Web site, www.parishnursing.net.

18

NATIONAL ORGANIZATIONS AND RESOURCES

There are numerous organizations that have excellent materials and other resources that can be used in planning congregational and community health programs. In this chapter we offer information about some of the ones we have found particularly helpful.

HEALTH MINISTRIES ASSOCIATION

The Health Ministries Association (HMA) is a nonprofit membership organization open to individuals, faith communities, institutions, and organizations. Founded in 1989 as a resource to support faith community nurses (formerly called parish nurses), it has expanded to include program coordinators, lay health ministers, clergy/chaplains, health educators, faculty, and other professionals. The stated purpose of this organization is to encourage and support its members in the development of programs that integrate care of the body, mind, and spirit. The HMA embraces people of diverse faiths, backgrounds, and interests, and currently has more than 1,300 members.

The HMA provides a number of benefits and resources for its members, including an annual conference, online continuing education opportunities, consultation and support, a newsletter, a regularly updated Web site, toolkits and guides, book reviews, discounts on HMA and other conferences, discounts on selected publications, and opportunities for networking.

In addition to participating in the activities and events offered by the national organization, members can join and participate in activities and events offered by regional chapters and HMA networks (e.g., faith community nurses, lay health ministers, clergy/chaplains, etc.). The HMA Web site, open to both members and nonmembers, provides links to faith groups and other organizations that have programs and materials appropriate for congregational health ministries. For more information about the HMA, including how to become a member, you can visit their Web site (www.hmassoc.org) or call 800-280-9919.

Nurses who are interested in learning more about faith community nursing and other individuals who would like more information about health ministries will find the thoughts of Sonja Simpson, a recent president of the HMA, enlightening and inspiring.

I have been involved with health ministry and have been a faith community nurse (FCN) since 1999. It has been the highlight of an interesting and diverse nursing career. Despite my many "mountaintop" experiences in national and state arenas of influence, nothing can take the place of my personal and rich experiences within the arena of health ministry.

Health ministry is a wonderful opportunity for nurses to practice the science and art of nursing. The art of nursing has been greatly diminished by the technology of health care and medical science. Despite the life-saving mechanics of that technology, the art of "holding a hand and fluffing a pillow" has almost disappeared. I believe that true healing is enhanced by a relationship experience—when there is a human connection between the healer and the client. Faith community nursing provides the unique experience for that relationship to occur.

My initial experience with faith community nursing was in Arizona where I lived in a rural area south of Flagstaff and near the beautiful and scenic area of Sedona. I was a volunteer faith community nurse for a small Presbyterian church but soon became the "nurse of the community." I had many referrals from community agencies that heard about and/or experienced, however vicariously, the benefits of a faith community nursing intervention. Most of what I did was case management. Many of my clients were elderly people (upper 70s to 90s) living alone, with family scattered across the country. My ministrations focused on education about their plan of care, nutrition education, "sorting

out" medication, and physician visits with the client. Many of the folks did not know how to advocate for their care or what questions to ask or how to tell the physician that they could not afford the medication ordered.

Many of the clients could not be maintained in their home environment, so my job became one of "connecting the dots" for transfer to another level of care. This is a complex process of evaluation of the current situation, financial concerns, and quality of life, and then the appropriate and caring transfer to another level of living. It always involved contacting next of kin and assisting them in the decision-making process of where Mom or Grandma or whoever should go. The mechanics of this care management were always interwoven with concern for the spiritual and "core sense" of the person. Faith community nurses are uniquely prepared and skilled in weaving this complex tapestry of care management.

I was successful in obtaining a small amount of grant funds through the Arizona Community Foundation, which supported my travel and communication needs. By writing the grant, others became aware of the uniqueness of a health ministry program. Within two years, five other churches in the northern part of Arizona developed similar programs.

In 2001, I moved to Grand Island, Nebraska, a medium-sized Midwestern community. I began to pick up the threads of health ministry within my new community and at the same time became networked within the health ministry community on a statewide basis.

I am currently working with a traditional ELCA Lutheran church in developing a health ministry program. The demographics of the congregation indicate that they are largely farmers and families who have been raised generation after generation within that particular church. Women play a very traditional role and seldom exert leadership in marital or family matters.

Several women had questions related to their bodies, aging, nutrition, and exercise. I developed a weekly exercise program for any woman who was interested. It was a joy to teach and to watch individuals improve their balance and agility. The class focused on toning, stretching, breathing, and balance. The ages of the women ranged from the late 50s to the early 80s, with a fourth of the class being in their early 80s. Many women felt that exercise might be too strenuous or that they were not agile enough to do the moves or that they were too self-conscious to exercise with others. I assured them that everyone would work at their own level and that there was no pressure to perform.

As time went on, the women became more engaged and delighted in making

progress. I ended the class about a year ago for reasons not related to the program. After about six months the women asked me to return to teaching because they noticed that their balance and agility had declined without the class. So I reinstituted the class, and I enjoy seeing how much they improve each week. I have incorporated stretch bands and small balls in the class to work on range of motion and body strengthening. The women often lingered after class to ask questions related to their health, and it now has evolved into a post-class coffee and conversation time. I do informal teaching over coffee, which encourages questions. I was amazed at how many did not really understand how their bodies worked and were frustrated with physicians who sometimes seemed to dismiss their concerns—"Oh, you are getting older . . . It is just a part of aging." What I do is give them tips and tools that empower them to do self-care and make subtle changes in their lifestyle and routine.

I also take monthly blood pressures at this church, which is often like a mini-clinic where the individuals have trust in my listening and advising skills and ask some great questions. Additionally, I teach a monthly interactive class on topics of interest to the group. We laugh and have a good time in the process. Holy friendships occur!

My first exposure to the "big picture" of health ministries came through the Interfaith Health Program, a program funded by a grant from the Centers for Disease Control and Prevention and administered by the School of Public Health at Emory University. It brought together teams from around the country to look at how faith groups can collaborate with community assets such as health systems and public health organizations to improve the overall health of individuals.

I was graced with the opportunity to lead a rural team from Nebraska to participate in the initial training session in 2001. Ten teams from around the country were selected to participate in this new endeavor. It became obvious that both faith communities and health communities are valuable reservoirs of vision, strength, and hope, so it would be natural for them to work together. Individuals who have health issues and emotional concerns often turn to their faith community as their "first avenue of help."

In subsequent years I had the opportunity to lead a national nursing organization focusing on holistic health and to participate in national summits on the connection between faith and health—how healing occurs and how to make health care more humanistic. At the same time, the research on the impact of spirituality on health was becoming more intense and visible, with

studies consistently showing that those who have a sense of spiritual identification have a more successful outcome with their health issues.

During this time, the Health Ministries Association (HMA) was becoming more visible as an organization with a focus on developing the team concept to enhance holistic approaches to care. HMA led the movement to obtain recognition from the American Nurses Association that faith community nursing was a valued and legitimate specialty nursing practice with recognized standards of performance and practice. HMA has become a cherished home for faith community nurses as well as for chaplains, lay health ministers, and others who focus on intentional care of the spirit as part of their work with individuals and groups facing health challenges. They help clients and other members of the faith community make connections among themselves and with other resources in the community. As I learned from the Interfaith Health Program training, the work of others in the Health Ministries Association, and my own experience, the health ministry team weaves a web of relationships, structures, and entities to build a healthier community. If a healthy community is a fabric, then the health ministers and faith community nurses are like the needle to the thread, guiding it back and forth, making it whole.

INTERNET RESOURCES

The Internet is the gateway to endless amounts of information. It's easy to use, accessible, and finds what you are looking for in a matter of seconds. With this in mind, it is no surprise that more and more people are tossing aside books and using the Internet as their main source of information.

There are more than 100,000 health-related Web sites. Keep in mind, however, that since the Internet is a public domain source, anyone can create a site regardless of their credibility. We recommend that you:

- Use reputable sources. Start with MedlinePlus (medlineplus.gov). MedlinePlus has information that is reliable, current, accurate, multilingual, and written by health professionals. It's free and accessible from any Internet connection.
- Beware of commercial sites. Sites with ".com" at the end of their address are commercial sites whose primary goal is to make a profit, and not necessarily to provide reliable information.

- Check to see if the information is current and accurate. Be sure the information you obtain is written by a health care professional. Look for credentials (i.e., M.D., Ph.D., CRNP, D.D.S., R.N.). Check all information for a date. Information more than five years old is considered outdated.

MedlinePlus (http://medline.gov/)

MedlinePlus is a service of the U.S. National Library of Medicine and the National Institutes of Health. It offers information on more than 700 health topics. These topics are organized both alphabetically and by categories (e.g., Body Location/Systems, Disorders and Conditions, Diagnosis and Therapy, Demographic Groups, and Health and Wellness). For each topic, an overview, the latest news, and links to the Web sites of other federal agencies and health-related organizations are provided. This Web site also has a medical dictionary, an illustrated medical encyclopedia, interactive tutorials, and information on drugs and supplements. Information is provided in Spanish as well as in English. MedlinePlus contains both copyrighted and noncopyrighted material. Noncopyrighted material (e.g., government information at National Library of Medicine Web sites) can be reproduced and copied without permission, but reproductions should contain proper acknowledgment of the source.

Healthfinder.gov (www.healthfinder.gov/)

Healthfinder.gov was developed by the U.S. Department of Health and Human Services together with other federal agencies and is coordinated by the Office of Disease Prevention and Health Promotion and its National Health Information Center. It links to information and Web sites from more than 1,500 health-related organizations. Visitors to this Web site will find a wide range of prevention and wellness topics, a drug interaction checker, and various health-related consumer guides (e.g., Health Insurance, Hospice, Hospitals, Long-term Care, Nursing Homes, Patient Privacy, Public Health Clinics, and Support Groups). Information is provided in Spanish as well as in English.

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National Institutes of Health (www.nih.gov/)

The National Institutes of Health's Web site offers information on hundreds of consumer health topics. For each topic, it provides links to Web sites that provide information and allow you to download information sheets or brochures that may be reproduced and copied without permission. For example, selecting "Depression" will take you to the Web site for the National Institute of Mental Health, where you will find a 28-page booklet, *Depression,* that can be downloaded and copied. Selecting "Diabetes" will link you to the Web site for National Diabetes Information Clearinghouse (NDIC), a service of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), where you will find a 68-page booklet, *Your Guide to Diabetes: Type 1 and Type 2,* that can be downloaded and copied. This Web site also groups topics under several headings: Men's Health, Minority Health, Seniors' Health, Wellness and Lifestyle, and Women's Health. Many of the Web sites and publications are in Spanish as well as in English.

The National Institutes of Health also has a Web site designed specifically for older adults seeking age-related health information (www.nihseniorhealth.gov). Features of this Web site include a "talking" function that reads the text aloud and special buttons to enlarge the text or turn on high contrast to make the text easy to read.

National Institute on Aging (www.nia.nih.gov/)

The National Institute on Aging (NIA) produces a variety of informational materials on age-related topics for the general public. NIA's AGE PAGES are brief, easy-to-read information sheets (4–8 pages) on topics of interest to older adults or those who live or work with them (e.g., Aging and Your Eyes, Arthritis Advice, Considering Surgery, Diabetes in Older People). NIA also produces lengthier publications on age-related topics (e.g., *Alzheimer's Disease: Unraveling the Mystery, Talking with Your Doctor: A Guide for Older People*) for individuals wanting more extensive information. Both

types of publications may be downloaded and copied. NIA also has produced a number of videos that can be purchased for a nominal fee. These can be ordered through the Web site. Many of the informational materials are available in Spanish as well as in English.

Centers for Disease Control and Prevention (www.cdc.gov/)

The Centers for Disease Control and Prevention (CDC), a part of the U.S. Department of Health and Human Services, has as one of its major goals ensuring that people are healthy in every stage of life. As part of its strategy to meet this goal, the CDC provides on its Web site fact sheets and brochures on a number of preventive care measures that can be downloaded and copied (e.g., What YOU Can Do to Prevent Falls, Check for Home Safety: A Home Fall Prevention Checklist for Older Adults, Influenza Vaccine: What You Need to Know). Many of the CDC materials are available in Spanish as well as in English.

National Health Information Center (www.health.gov/nhic/)

The National Health Information Center (NHIC) is a health information referral service established by the Office of Disease Prevention and Health Promotion within the U.S. Department of Health and Human Services. The NHIC Web site provides links to numerous governmental and private health-related organizations. Also available on the NHIC Web site is a comprehensive list of national health observances (e.g., American Stroke Month, National Suicide Prevention Week, National Mammography Day) and an extensive list of toll-free numbers for organizations that provide health-related information, education, and support. Included on this list are organizations that provide crisis intervention (e.g., National Youth Crisis Hotline) and organizations that provide information about rare disorders—disorders that affect less than 1 percent of the population at any given time (e.g., Multiple Sclerosis Association of America).

U.S. Food and Drug Administration (www.fda.gov/)

The Food and Drug Administration (FDA) Web site provides information on medicines (brand-name, generic, and nonprescription), medical

devices and procedures (e.g., LASIK eye surgery, mammography, CT scans), food and nutrition, and a number of other health-related topics. Much of the information on the FDA Web site is available in Spanish as well as in English. The information on the FDA Web site is not copyrighted, unless otherwise noted, and it is not necessary to obtain permission from the FDA to republish or reprint noncopyrighted materials. Crediting the FDA as the source of the information is appreciated but not required.

Familydoctor.org (http://familydoctor.org/online/famdocen/home.html)

Familydoctor.org is a health information Web site sponsored by the American Academy of Family Physicians (AAFP). Topics are organized alphabetically and by a number of categories, including Healthy Living (e.g., Flu Shots, Food and Nutrition), Women (e.g., Breast Cancer, Osteoporosis), Men (e.g., Prostate Cancer, Testicular Cancer), Over-the-Counter Guide (e.g., Pain Relievers, Risks for Special Groups), Smart Patient Guide (e.g., Talking to Your Doctor, Advance Directives), and Seniors (e.g., Arthritis, Memory Loss). The information on this Web site is available in Spanish as well as in English. The content of this site is copyrighted, but information from the site may be printed and distributed if used for nonprofit, educational purposes only. This information should be properly attributed to the AAFP and include a notice of copyright.

AGS Foundation for Health in Aging (www.healthinaging.org/)

The AGS Foundation for Health in Aging (FHA) is a national nonprofit organization established by the American Geriatrics Society. The AGS Foundation serves as a bridge between researchers in aging, geriatricians, and the public. Topics are organized into three categories: How We Age (e.g., The Aging Process, Trends in the Elderly Population), Health Care Decisions and Issues (e.g., Talking to Your Healthcare Providers, Ethical and Legal Issues), and Elder Health at Your Fingertips (e.g., Problems with Joints, Muscles, and Bones; Vision Loss and Other Eye Diseases). Available on this Web site are a number of tip sheets (e.g., Avoiding Overmedication and Harmful Drug Reactions, Cognitive Vitality, Tips for Avoiding Caregiver Burnout) that may be downloaded, copied, and distributed at no charge.

The only stipulation is that they not be altered in any way. Also offered on the FHA Web site is *Eldercare at Home: A Comprehensive Online Guide for Family Caregivers.* This free, 27-chapter guide is authored by more than thirty experts in geriatric care.

My Personal Health Record (www.myphr.com)

My Personal Health Record is provided as a free public service by the American Health Information Management Association, a national nonprofit professional association dedicated to the effective management of the personal health information needed to deliver quality health care. The site contains helpful forms that can be downloaded and a step-by-step guide for creating a personal health record. Also on the site is information about how to access your medical records, your privacy rights, and common privacy myths.

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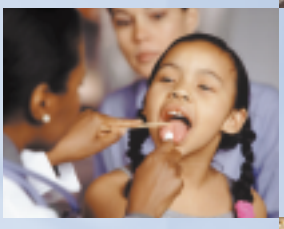
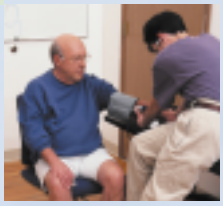


Sharing a Legacy of Caring

Partnerships between Health Care and Faith-Based Organizations



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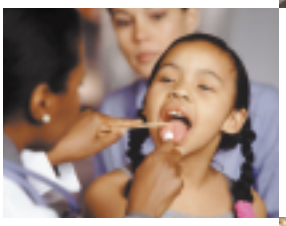
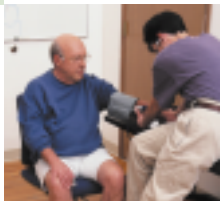


Sharing a Legacy of Caring

Partnerships between Health Care and Faith-Based Organizations



DEVELOPED BY:
National Center for Cultural Competence
Georgetown University Child Development Center
Department of Pediatrics
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IN COLLABORATION WITH:
Faith Partnership Initiative
Office of Minority and Women's Health
Center for Communities in Action
Bureau of Primary Health Care
Health Resources and Services Administration
U.S. Department of Health and Human Services

WINTER 2001

ON THE HORIZON OF THE 21ST CENTURY, healthcare professionals are being called upon to revisit the concept of "community" to effect change across America's landscape. There are many compelling health crises and social ills that beg us to do no less than join together to build the bridges necessary to better address the needs of the vulnerable and underserved.

Cooperative partnerships between health care and faith-based organizations are a revolutionary concept. Faith-based organizations are trusted entities within many communities. They provide spiritual refuge and renewal and have served as powerful vehicles for social, economic and political change. In the same vein, health care organizations that are community-based deliver high-quality, patient-sensitive medical care along with a host of other enabling services to diverse, needy populations. While these institutions share many commonalties, collaborations between the two have evolved slowly. The Faith Monograph developed by the National Center for Cultural Competence for the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC) and its Faith Partnership Initiative addresses the various issues that surround partnership and collaboration between these two cultures.

There are approximately 43 million individuals in this country who are without health insurance and many more that are without access to comprehensive, continuous, and culturally competent primary health care. There are persistent disparities in health outcomes between our poor and non-poor, our minorities and non-minorities. The BPHC is committed to 100% access to quality health care and 0 disparities for this nation. This is a bodacious goal and sustainable partnerships are necessary. Traditionally, our nation's public health safety net providers have shouldered the responsibility of caring for these individuals and helping to meet their health and medical needs. They have demonstrated remarkable ingenuity in eliminating many of the cultural, linguistic and geographic barriers to access that routinely prevent the underserved from seeking care or understanding how to navigate the intricacies of the health system. Safety net providers are dynamic in that they have embraced an inclusive definition of health that recognizes it as a state of complete physical, mental, and social wellbeing, and not merely the absence of disease. These providers recognize that their success is dependent on their ability to ensure that all health, psychosocial, cultural, and educational needs are met in the context the community. They are forging new partnerships with non-traditional stakeholders and sharing resources in order to achieve community health goals. We, at the BPHC, applaud their tireless efforts.

Increasingly, we are seeing spiritual mores incorporated into the holistic model of disease prevention and health and wellness promotion. We know that faith-based organizations are vital to the communities in which they are located and that now more than ever, they should be engaged as partners in the movement for *100% Access and 0 Health Disparities.* Historically, these institutions have served alongside the safety net as providers of health and social services for many, particularly the disadvantaged and indigent.

This legacy of caring, shared between safety net providers and faith-based organizations, is the premise of this Monograph. It is offered as a guide to developing successful, substantive and mutually beneficial partnerships that will lead to improved health outcomes for individuals and communities. The challenges to effective collaboration are at times daunting, but there is much work to be done and we cannot do it alone.

Henry Ford once said, "Coming together is a beginning, staying together is a process, and working together is success." The health of an individual, and the subsequent community, is impacted by many non-biological variables—environmental, social, mental and spiritual. Partnerships between health care and faith-based organizations are important because by working together we can better address the broad spectrum of human need. These alliances will require us to be respectful of our diverse experiences and cognizant of new skills and roles, necessary for teaching and learning community building. There are many invaluable lessons to be learned at all stages of partnership development. These opportunities should be encouraged and embraced for their immeasurable potential. This publication is an insightful exploration of the dynamics of such organizational relationships.

I extend my sincerest thanks to the National Center for Cultural Competence, and to the panel of experts that comprised the Faith Monograph Workgroup. The work they have done is tremendous!

Marilyn Hughes Gaston, MD
Assistant Surgeon General, Public Health Service
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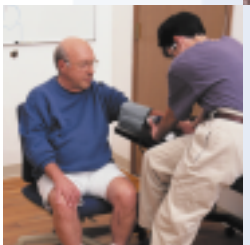


Definition of Terms

It is difficult to find universally accepted and recognized definitions for some of the terms used in this monograph. The following terms are thus defined for the purposes of this document:

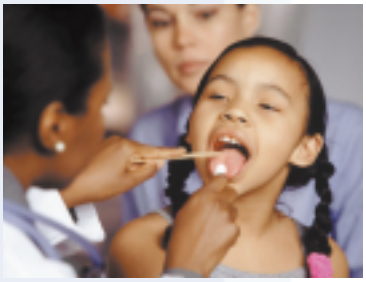
- **cultural competence**—there is no one definition of cultural competence. Definitions of cultural competence have evolved from diverse perspectives, interests, needs and are incorporated in state legislation, federal statutes and programs, private sector organizations and academic settings. The NCCC embraces a definition of cultural competence (Cross, T., et.al., 1989) that subscribes to the following beliefs:
  - there is a defined set of values, principles, structures, attitudes and practices inherent in a culturally competent system of care;
  - cultural competence at both the organizational and individual levels is an ongoing developmental process; and
  - cultural competence must be systematically incorporated at every level of an organization, including policy making, administrative, practice/service deliver and consumer/family levels.
- **faith-based organization**—any group/organization created by or for a religious or spiritual group including, but not limited to, individual places of worship, groups of community or tribal elders/spiritual leaders, intra- or interdenominational community coalitions, faith connected health and human service agencies, denominational hierarchies/governance bodies, religious orders and schools of divinity.
- **health**—complete state of physical, mental, spiritual and social wellbeing and not merely an absence of disease (World Health Organization).
- **health care organizations**—any entity with the main purpose of addressing delivery of health and medical services including, but not limited to individual health care practitioners, group practices, community-based health centers, home health agencies, free clinics, state and local public health programs, private clinics, hospitals, vertically integrated health care systems, managed care organizations, professional associations and university medical, dental, nursing and other health professional schools.
- **linguistic competence**—the capacity of an organization and its personnel to effectively communicate with persons of limited English proficiency, those who are illiterate or have low literacy skills, and individuals with disabilities. This capacity may include, but is not limited to, bilingual/bicultural staff, telecommunications systems, sign or foreign language interpretations services, alternative formats for materials, and translation of legally binding documents, signage and health education materials (Goode, et.al., 2000).
- **religion**—a set of beliefs and practices related to the issue of what exists beyond the visible world, generally including the idea of the existence of a being, group of beings, an external principle or a transcendent spiritual entity (Adapted from Random House Dictionary of the English Language, 1967).
- **safety net**—the safety net, as defined by the Bureau of Primary Health Care, is a national network of providers of primary health care to underserved and vulnerable populations, including non-traditional partners. Activities that support the maintenance of the safety net include enhancing quality, improving cultural and linguistic competence and providing enabling services.
- **spirituality**—the experience or expression of the sacred (Adapted from Random House Dictionary of the English Language, 1967).

I. Purpose of the Monograph

THIS MONOGRAPH IS INTENDED TO HELP HEALTH CARE POLICY makers, administrators, governing and advisory boards and providers explore the potential for developing partnerships with faith-based organizations. It is also intended for leaders in faith-based organizations who seek to develop partnerships around health issues to help them understand the interests, potential concerns and successful models from the health care organization's perspective.

The monograph showcases the types of partnerships that can support community and individual health by strengthening the community safety net. It clarifies concerns and misconceptions about the appropriateness of collaborations between health care organizations that receive government funding and faith-based organizations. Finally, the monograph introduces the challenges and benefits that arise when two organizations, each with its own distinct purpose and culture, forge new relationships for a common goal.

Although a growing body of literature supports the benefits of a holistic approach to health and the inclusion of spirituality in patient care, this topic is not within the scope of this monograph. The resource section of the monograph provides information for those interested in pursuing this topic. The monograph is not meant to be a step-by-step blueprint for developing partnerships between health care organizations and faith-based organizations. This topic will be addressed by other publications of the Faith Partnership Initiative.



II. A National Initiative to Eliminate Racial and Ethnic Disparities in Health

DESPITE RECENT PROGRESS IN OVERALL HEALTH STATUS OF THE nation, all segments of the U.S. population have not equally benefited. A long-standing and well-documented pattern of disparity continues to plague racially and ethnically diverse populations in this nation as it relates to the incidence of illness, disease and death. This pattern of disparity is evident in both health care outcomes and utilization (Goode and Harrison, 2000). The Initiative to Eliminate Racial and Ethnic Disparities in Health was launched in 1998 under the auspices of the Department of Health and Human Services (DHHS) to address this critical problem. It targets six areas of health disparity including cancer screening and management, cardiovascular disease, diabetes, infant mortality, HIV/AIDS and child and adult immunizations.

The initiative to eliminate health disparities has been significantly strengthened by the establishment of public health policy and dedication of resources. Healthy People 2010, the new set of goals and objectives, was designed by the DHHS to help the nation achieve the vision of Healthy People in Healthy Communities. The elimination of health disparities is one of two overarching goals. The Health Resources and Services Administration (HRSA) took leadership in responding to these goals with an initiative, referred to as *100% Access and 0 Health Disparities,* to challenge the nation's public health systems to create new approaches, including non-traditional partnerships to eliminate health disparities.

As articulated in Healthy People 2010:

> *"Over the years, it has become clear that individual health is closely linked to community health...Likewise, community health is profoundly affected by the collective behaviors, attitudes and beliefs of everyone who lives in the community...Partnerships, particularly when they reach out to non-traditional partners, can be among the most effective tools for improving health in communities"*
>
> U.S. Department of Health and Human Services, 2000

The elimination of health disparities among this nation's racial and ethnic groups is an exigent goal that the health care community cannot accomplish in isolation. Since many of the determinants of wellbeing span the boundaries of health care and medicine, eliminating health disparities call for new and non-traditional partnerships across diverse sectors of the community (Goode and Harrison, 2000). The formation of community-based partnerships is a viable strategy to address the inherent challenges and opportunities to achieve the goal of *100% Access and 0 Health Disparities.*

III. Leadership and Innovation: Making 100% Access and 0 Health Disparities a Reality

THE BUREAU OF PRIMARY HEALTH CARE (BPHC), WITHIN THE Health Resources and Services Administration of DHHS, plays a significant role in the initiative to eliminate health disparities. Consistent with its mission, the BPHC is a national leader in delivering care to underserved groups including Medicaid beneficiaries, uninsured and vulnerable populations such as migrant and seasonal farmworkers, individuals who are homeless and those living in public housing. The BPHC funds a comprehensive network comprised of more than 3,000 non-profit health centers and 4,000 clinicians that provide care to more than 12 million people throughout the U.S. and its territories. Despite the scope of this health care safety net, it only reaches approximately 20% of those without access. Given that an estimated 43 million people in the United States do not have access to regular health care, it is not possible for the BPHC to meet the enormity of need for every individual and every community with federal resources alone.

Therefore, in February 1999, the BPHC launched the Faith Partnership Initiative, an innovative effort to increase the capacity of underserved communities to develop new partnerships to expand the safety net of care. The BPHC's Center for Communities In Action is spearheading this program, which builds upon strategies identified in the Healthy People 2010 goals for the elimination of racial and ethnic disparities in health. **Figure 1** (see page 4) depicts a rich array of potential partners that have a vested interest in improving community health, including the faith community.

"Our vision is that every person, in every underserved community will have access to primary and preventive care and through improving the delivery of care and patient self-management of disease, there will be no disparities in health status due to race, ethnicity and income."

MARILYN GASTON, M.D.
Assistant Surgeon General
Public Health Service
Associate Administrator, Bureau of Primary Health Care
HRSA/DHHS

SOURCE: BULURAN, 1999.

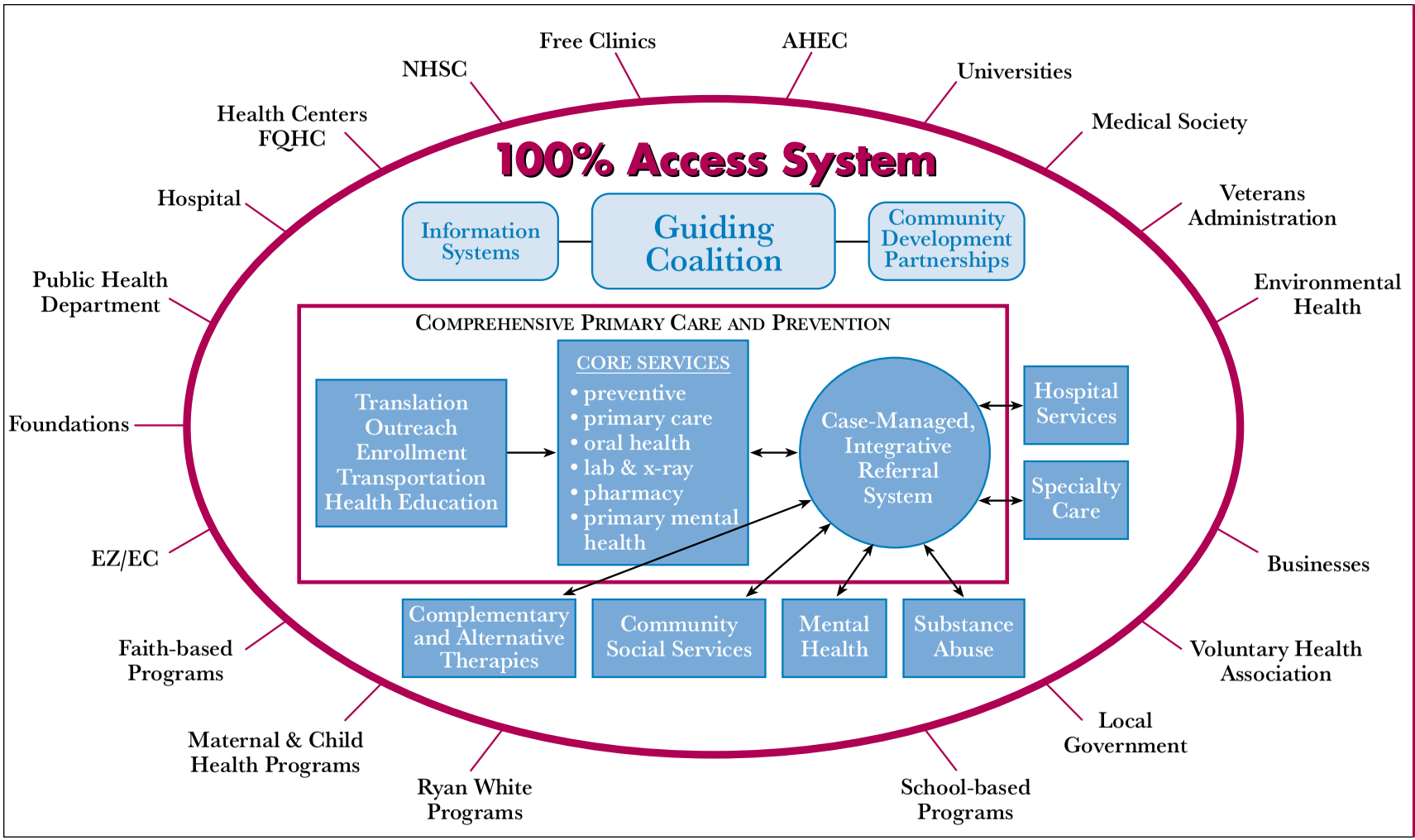


FIGURE 1 INTEGRATED PRIMARY CARE COMMUNITY-BASED HEALTH SYSTEM

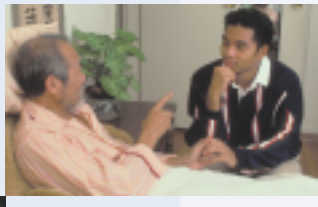
IV. A Shared Legacy of Caring

THE FAITH PARTNERSHIP INITIATIVE IS DESIGNED TO PROMOTE collaboration between health care and faith-based organizations to encourage alignment of health, fiscal and other assets. Faith-based organizations are a natural choice: they have a legacy of providing safety net services in many communities, but have not traditionally been viewed or enlisted as partners to improve community health, and they represent an enormous resource with thousands of health and educational organizations and more than 365,000 congregations that span the nation.

The Faith Partnership Initiative seeks to enlist these organizations to support the *100% Access and 0 Health Disparities* campaign by creating a partnership for health that strengthens the safety net in every community. The Faith Partnership Initiative's goals are to:

- resonate the role of faith institutions as major new partners in the care-giving process;
- stimulate and build partnership networks with faith-based organizations that desire to have an impact upon and that are dedicated to improving health and social well-being;
- provide access to tools and techniques that foster collaboration between faith-based organizations and BPHC-supported health centers; and
- create opportunities for faith-based institutions to engage in productive dialog with public and private sector stakeholders.

The Faith Partnership Initiative supports the development of key community partnerships needed to strengthen the safety net and extend it to the large number of people without access to health care.



V. Why Reach Out to the Faith Community?

IT IS QUITE NATURAL THAT THE BPHC WOULD IDENTIFY THE FAITH community as potential partners in addressing the issues of access and health disparities. BPHC funded health centers and faith-based organizations share a ***common legacy of caring*** for some of the most underserved and vulnerable members of society. They also share a common legacy of working to improve their own communities. Driven by a mission to serve all, regardless of ability to pay, health centers have filled the gap in health services to poor and medically underserved individuals. They serve as the entry point to the health care system for millions of Medicaid beneficiaries, the uninsured and people throughout the U.S. and its territories.

Historically, faith-based organizations have also served as an important gateway to services and care-giving for those living in poverty and in social exclusion. They have taken strong leadership roles in communities and provided job training, housing, economic development, educational support, meals and spiritual support to those in need. Just as health centers have addressed the gaps in health care, faith-based organizations have filled the gaps in the delivery of supportive services commensurate with the World Health Organization's broad definition of health including physical, mental, spiritual and social wellbeing. Faith-based organizations can bring needed resources, expertise and a shared legacy of caring for these most vulnerable members of society to assist in achieving the goal of *100% Access and 0 Health Disparities* for the nation.

BPHC's vision, as articulated by Dr. Marilyn Gaston (Buluran, 1999) delineates three specific approaches to achieve *100% Access and 0 Health Disparities.* These three approaches are to:

A. increase access to primary and preventive care;

B. improve delivery and quality of care; and

C. improve patient self-management of disease.

Partnerships with faith-based organizations provide health care organizations with a new set of opportunities and supports for addressing each of these approaches. This monograph provides examples of how successful partnerships between health care organizations and faith-based organizations can address one or more of the approaches that are needed to achieve *100% Access and 0 Health Disparities.*

A. Increasing Access to Primary and Preventive Care

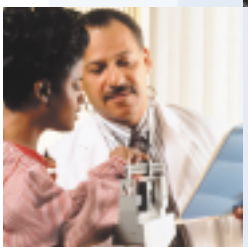
Access to health care is a complicated issue with many contributing factors. While the financing of services often receives the focus in discussions of access to care, it is only one of many issues that must be addressed to increase access to primary and preventive health care. The following aspects of access must also be addressed:

- ***availability of the services***—access is limited when providers and services do not exist within a community.
- ***geographic location***—access is limited if services are located too far from patients or in places that are not easily reached by available means of transportation.
- ***times and logistics of services***—access is limited when services are only offered during the normal business day or at other times when patients have work, family or other commitments.
- ***cultural competence***—access is limited when services are provided in settings that are not welcoming and acceptable in terms of culture, race and/or ethnicity.
- ***linguistic competence***—access is limited if patients cannot communicate in the language in which they are proficient.

Partnering with faith-based organizations can help health care organizations and their communities expand access through addressing any or all of these five aspects of access.

Availability of Services

Many underserved areas do not have enough providers and resources to ensure 100% access to health care. Faith-based organizations can help expand the base of services in a given community in a number of ways. First, they frequently have well-established volunteer networks that bring both person power and infrastructure to the task of improving individual and community health. These volunteers may include retired health care and social service providers who can expand the pool of providers with little additional cost. These volunteer networks also often serve as extended social support to members of the community. Partnering with support networks can help extend limited health resources by increasing capacity to provide time-consuming and resource intense services needed to successfully manage chronic health conditions. For example, such partnerships can support ongoing and aftercare services for patients with substance abuse and behavioral health problems and medication, diet and weight management for patients with diabetes.



Partnerships with faith-based organizations have particular application in rural areas, where access problems are often related to lack of providers and services. While 25% of the population of the United States lives in rural areas (places with fewer than 2,500 residents), only 9% of the nation's doctors practice in these areas. Yet the needs are tremendous. Injury-related death rates are 40% higher among rural populations; heart disease, cancer and diabetes rates exceed those for urban areas; and timely access to emergency care and availability of specialty care are problematic (U.S. Department of Health and Human Services, 2000). Faith-based organizations have been able to augment the capacity of health care systems through programs such as parish nursing and the provision of other home health care and support services such as transportation or meals that allow people to manage their health needs at home.

More Hands to Help

Health care organizations in Montana have a challenge in providing services to a population that is spread out geographically. In this frontier state, 80% of communities have less than 3,000 inhabitants and nine counties have no physician. Love, In the Name of Christ (Love, INC) in Bozeman, MT, consists of 18 churches and as many denominations with a combined volunteer force of 900 individuals. Its mission is to meet the needs of the people of Bozeman. These volunteers help address health and related needs in ways that are very difficult for local providers and health clinics. They provide transportation to health care and home health care for those returning from the hospital to these very remote areas, a volunteer effort that enhances access by increasing service availability.

Geographic Location

Faith-based organizations may be located within the neighborhoods in need of more geographically accessible services. They may offer use of physical facilities at no or low cost to health care organizations for expansion of services including health promotion and screening. While many health care organizations cannot afford to expand to multiple sites on their own, partnerships with community faith-based organizations may offer opportunities to bring services closer to patients and the neighborhoods in which they live.

Times and Logistics of Services

For many patients, particularly those employed in jobs with limited or no paid leave time, accessing health services means choosing between addressing the medical needs of their families or themselves and providing income necessary to support their families or themselves. Volunteers from faith-based organizations may be engaged to extend the times services can be offered including evenings and weekends.

Cultural Competence

The demographic makeup of the United States is constantly changing as a result of immigration and population increases among racially, ethnically, culturally and linguistically diverse groups. In 1999, a total of 26.4 million residents, or approximately 10% of the population, were born outside of the United States (Brittingham, 1999). This diversity creates an impetus for health care organizations to become culturally competent in order to address the wide range of health beliefs, practices and access issues. Sometimes the availability of services is less of an issue than their acceptability to segments of the community. In some communities, culturally diverse groups have been disengaged from or distrustful of health care organizations. When there is such a history, issues of cultural competence and trust must be addressed.

Faith-based organizations can bring important expertise and resources to partnerships with health care organizations. In fact, those that serve particular racial, ethnic and cultural communities can take the role of cultural brokers, helping health care organizations learn about and make connections within these diverse communities. In this way, partnering with a faith-based organization can lead to health care organizations engendering greater trust and providing more culturally competent services.

Reestablishing Trust

A local health clinic serving a Native American population began to use mammography services on site. At first this new service seemed well accepted, as many of the women in the tribe came to be screened. As a result of the mammography and follow-up care, a few women were subsequently diagnosed with lesions or breast cancer. Soon after, the clinic staff noticed that the women stopped coming for mammograms. The staff learned that those diagnosed with breast cancer believed that the machine had caused the cancer, creating fear among their peers. The clinic staff used health education materials to dispel these beliefs and reassure the women. When their efforts were unsuccessful, clinic staff discussed the situation with the tribal spiritual leader, who then performed a ceremony to rid the machine of spirits that could negatively impact the women. The spiritual leader and other tribal leaders also urged the women to return for exams. Female tribal leaders led the way by getting mammograms themselves. With this message coming from trusted and safe sources, the women in the community once again felt comfortable using this important health screening technology.

Linguistic Competence

According to the 1990 Census, 32 million people in the United States, or 13.8% of the population, speak a language other than English at home. Of this group, nearly 45% indicate they have trouble speaking English. Most current Census data indicate that there are over 300 languages spoken in the United States and this trend is expected to continue (Brittingham, 1999).

Access is severely limited when patients receive services in a language they do not understand. This concern is exacerbated as the number of people in need of health care services who have limited English proficiency has risen in the last decade. Individuals with limited English proficiency are both over represented and underserved in the nation's health care system.

Many health care organizations are struggling to respond to these challenges. Faith-based organizations can help in this effort, by recruiting individuals within the community who speak the language(s) of diverse patients. These recruits can then be trained to be effective medical interpreters and translators who can work side-by-side with health care providers to enhance access to individuals with limited English proficiency.

Meeting the Needs of New Refugees

Since the 1980's, a growing wave of Jewish immigrants from the former Soviet Union has been arriving in major U.S. cities, such as Chicago. Among this population is a large number of older people with significant health problems and who also face linguistic challenges as most speak Russian and Yiddish, an Eastern European Jewish language.

A program in Chicago, called the ARK, provides a culturally and linguistically competent venue for these newcomers to address their health and other needs. The ARK grew from a partnership between a rabbi and the director of a local health clinic to better serve the poor and elderly in the Albany Park neighborhood of Chicago. Services include a medical clinic with volunteers; a partnership with Mount Sinai hospital so any ARK patient without insurance may have procedures performed free of charge; a home visiting program; a dental clinic; an eye clinic; and a pharmacy where medications are free to those who need them and cannot afford them.

ARK volunteers include senior citizens, many of whom speak Yiddish and whose families immigrated to the United States early in the century, who can relate to these newcomers' experiences. As with many immigrant groups who have experienced government persecution in their countries of origin, a government clinic or government agency may not have been acceptable to the new Russian immigrants. The ARK provides a venue to access treatment and preventive services they need without arousing the fears of government persecution and religious discrimination they have brought with them from their previous experiences.

Health, healing and holy all come from the same word.

B. Improving the Delivery and Quality of Health Care

As Dr. Gaston noted, eliminating health disparities will take more than improving access to quality health care. Services will also have to be delivered in different ways to have an impact on disparities. There are three arenas in which partnerships with faith-based organizations may help health care organizations deliver care in ways that may reduce disparities:

- Developing culturally competent and culturally specific service delivery models;
- Incorporating spirituality into the delivery of health care that supports the holistic concept of health as defined by the World Health Organization; and
- Expanding and increasing the impact of health education and prevention efforts.

Developing culturally competent and culturally specific service delivery models.

A one-size-fits-all approach does not effectively apply to health care delivery models. Researchers have discovered that the use of standard concepts, theories, instruments and procedures are often inappropriate for culturally diverse groups (Caldwell, et al., 1999). In fact, recent literature reviews reveal there is an emerging body of literature that substantiates differences among racial and ethnic groups in response to health education and other interventions (Goode and Harrison, 2000). For example, research indicates that cancer prevention and control activities targeted toward Asian and Pacific Islander Americans must consider the influence of culture, acculturation, and English and native language tobacco-related media. Studies suggest that Asian and Pacific Islander Americans respond better to intervention and education strategies that feature peer interactions with lay Asian Americans of corresponding ethnic backgrounds and that consider cultural and linguistic factors (Chen, 1998). Among African American women, it has also been demonstrated that a weight loss program designed around this group's culturally based health beliefs, values, food choices and preferred kinds of social supports can be effective when other weight loss programs are not successful (McNabb, et. al., 1997).

For many ethnic and cultural groups, "healing" is distinguished from "curing." Healing involves restoring balance to the individual within the community, while

Linking Spirituality and Health Promotion

The Lowell Community Health Center in Lowell, MA, has developed a partnership with a local Buddhist temple to provide community health education and outreach in the growing Cambodian community. For example, Cambodian health center staff have partnered with the Buddhist monks to address smoking as a health issue. The temple has been designated smoke free, except for incense. Public service announcements about smoking directed to the Cambodian population include scenes from the temple with the monks talking about tobacco related health issues. These initial collaborative efforts with the Cambodian community and the temple have led to a fuller partnership: a new health center at the Cambodian Mutual Assistance Association has received BPHC funding that will offer a monk on-site with a meditation center, mental health services and opportunities for community members to work with traditional healers.

curing is a medical approach designed to rid the body of physical disease. In many cultures, non-traditional healers and alternative therapies are a key component of the healing process, so service delivery models that do not incorporate the more holistic concept of healing and culturally appropriate healers may not be viewed as credible. It may be difficult for health care organizations to directly employ and compensate traditional healers. However, this challenge is being met by some health care organizations through partnerships with faith-based organizations that have created community models of care that incorporate spirituality and traditional healers.

Honoring Religious Beliefs: A Health Care System Responds

Dearborn, MI, is home to a large population of Arab Americans, including many recent immigrants, with a large Islamic constituency. Both ethnicity and religion create an important cultural context within which health care and support services must be designed to be effectively delivered for this Arab community. The ACCESS Community Health Center was specifically founded to address these needs by creating networks with other health care organizations and Islamic faith organizations to deliver health care services and health education approaches that are culturally and linguistically competent. One effort includes a collaboration with Oakwood Health Care System, a comprehensive regional network that serves more than 1.2 million people in southeastern Michigan and that includes one of the largest teaching hospitals in the Dearborn area. "Collaboration whenever possible" is one the health system's guiding principles.

The hospital operated by Oakwood Health Care System in Dearborn found that while a large percentage of its inpatient services were being delivered to Arab Americans, existing services did not consider the special dietary needs, linguistic issues and pastoral support needed to create an effective care delivery model for this population. Oakwood Health Care System then partnered with ACCESS, Arab American community leaders and local mosques and churches to develop a culturally competent approach to inpatient care delivery. The results: Arab language TV channels in patient rooms, availability of meals that meet Islamic dietary laws and counseling to terminally ill patients and their families that supports their Moslem faith. These two health care organizations have also partnered with other community agencies to develop a culturally specific domestic violence prevention program that includes English and Arabic language health education materials with text that incorporates Moslem religious principles and is written at literacy levels that will reach the largest number of people possible.

Incorporating spirituality into care delivery to support the holistic concept of health as defined by the World Health Organization.

For much of the world, physical health, emotional and spiritual wellbeing are inextricably intertwined. Consequently, many individuals from diverse backgrounds do not respond well to care that does not incorporate the spiritual dimension. While many U.S. health care providers are generally not comfortable with- nor skilled at- including spirituality in their practice, many are now gradually recognizing the importance of spirituality in health and healing. More than 50 U.S. medical schools now offer elective courses in spirituality and 19 have been awarded grants from the National Institute for Healthcare Research to develop curricula in spirituality and medicine (Baird, 1999). Moreover, partnerships with faith-based organizations can help health care organizations incorporate spirituality into the delivery of care, thereby achieving the World Health Organization vision of health.

Expanding and increasing the impact of health education and prevention efforts.

Clearly one approach to assist in the elimination of health disparities is through prevention and health education. Such efforts must be tailored to the specific populations and take into account culture and language. For example, the Back to Sleep campaign, targeting Sudden Infant Death Syndrome (SIDS), has been hailed by the Surgeon General as the most successful public health education initiative in recent times. Since this health education effort began in 1994, it has been credited

Caring for the Whole Person

In the 1980's, Reverend Otis Moss, pastor of the Olivet Institutional Baptist Church in Cleveland, OH, had a dream of addressing the health disparities in his primarily African-American community. He recognized that an effective approach to addressing these inequities was to promote individual, family and community health, healing and wholeness in a spiritually supportive environment. He envisioned a facility in his community that provided affordable, quality health care in a private practice setting which incorporated the spiritual dimension. Because the church had already created the Olivet Housing Corporation, a partnership between the corporation and University Hospitals of Cleveland made Rev. Moss' dream a reality.

Under this arrangement, the church provided the land for the medical center; with foundation support the University Hospitals provided resources to build the new facility. The result is the Otis Moss Jr.-University Hospitals Medical Center, which now houses the Olivet Health and Education Institute. The church leases the building to the University Hospitals, which staffs the medical center. The Medical Center Board has ensured that physicians practicing within the facility are knowledgeable about and open to including the spiritual dimension in health and healing. The Institute operates a chapel within the medical center and through counseling and education, encourages the expression of spirituality through such activities as prayer, meditation and fasting. Institute programs include: From Stress to Healing (a lifestyle wellness series); Freedom to Change (nutrition and spirituality), Understanding Prayer in Health; a breast cancer education program and education programs for men. Institute staff partner with health professionals. They conduct joint case reviews that help maintain the holistic focus of the Medical Center's philosophy of health care.

Giving a Blessing

In the Dallas, TX, area, an important prevention message was not reaching the Latino community. Despite standard public education efforts, local Latino families in the area were not using infant car seats, which can significantly reduce child injuries. Recognizing this problem, the Greater Dallas Injury Prevention Center (GDIPC) approached the Santa Clara Catholic Church for help. GDIPC learned that many Latino families perceived the car seat as a place that isolated the child from the warmth and protection of their parents. In essence, standard car seat safety messages were at odds with closely held cultural beliefs that a child should be close to parents and was safest in their arms. GDIP asked a Santa Clara parish priest for help. One Sunday, the priest held a special Mass that included the blessing of the car seats. GDIPC took about 30 car seats to distribute to families who did not own one. Families believed that the blessing ensured a measure of protection for their children. While acknowledging and respecting cultural beliefs, the blessing provided spiritual guidance to families to make the behavior change that was key to the health and safety of the children within their communities.

with a 40% reduction in the incidence of SIDS cases nationwide. However, it has not been equally successful across all segments of the U.S. population. The SIDS rates among African American and Native American populations have not decreased, and in some geographic areas have actually increased. Current studies indicate that there has not been an appreciable change in sleep positions in these communities (USCPSC, 2000). Such studies provide strong evidence that health education must address cultural and linguistic differences in order to be effective and to impact infant mortality, one of the six areas of health disparity.

In some cultural groups, health professionals may not always be authorities and key sources of information about health, child rearing practices and lifestyles. Elders, traditional healers or leaders in the faith/spiritual community may be far more credible sources of information and guidance. When health care organizations partner with faith-based organizations, they can tap the power of that credibility to deliver health messages and encourage behaviors that prevent health problems. Health care organizations can learn from those faith-based organizations to enhance their knowledge and skills in developing culturally competent approaches to health education and prevention. Finally, faith-based organizations provide settings and person power to reach out broadly in the community to conduct health education and prevention efforts, extending the reach of health care and expanding its impact.

C. Improve Patient Self-management of Disease

Many of the disparities in health care outcomes relate to the patients' self-management of their diseases. In diseases such as diabetes, heart disease and hypertension, for example, changes in diet, exercise, and life style contribute to improved outcomes. Yet these types of behavioral changes are difficult to achieve and require effective health approaches and ongoing support to be sustained. Simply providing patients with "the facts" has not proven to be an effective approach especially when such approaches do not take into account how culture affects health beliefs and practices. Many cultural groups rely on natural networks of support within their communities as a valued source of information for health related issues. Partnerships with faith-based organizations provide health care organizations with resources to create the kinds of programs, services and support networks that will improve patient self-management by:

- Promoting healthy lifestyles that reflect religious, spiritual or moral values;
- Assuring that lifestyle changes recommended are consistent with religious or spiritual beliefs and cultural practices; and
- Creating support networks to help sustain lifestyle changes.

Promoting healthy lifestyles that reflect religious, spiritual or moral values.

The faith community has traditionally played a key role in shaping lifestyle behaviors and promoting moral and healthy living. Faith-based organizations are thus important partners in bringing about changes in behaviors to enhance health in individuals and the community

Speaking Out for Health

In 1995, a shared vision for community eventually led to what is today a strong community driven collaborative effort to improve the health and social conditions of the Haddington Community in Philadelphia. That effort, called the Haddington Community Health Project Collaborative, began in 1995 as a result of discussions between Rev. Frank Lilley, pastor of Greater St. Matthew Independent Church and the president of To Our Children's Future with Health, Inc., a community organization dedicated to improving the health of the community with a special focus on children. The 45-member collaborative now consists of a number of faith-based institutions, hospitals, community health centers and health care providers, schools, community-based organizations, legislators and area housing development representatives. Recently, 13 community churches have come together as a subcommittee of the Haddington Community Health Project Collaborative, called the Faith-based Initiative, to lend their support to current and emerging issues of importance to the community residents.

This community has clearly identified the enormous power of partnerships, particularly in addressing the well-documented disparities in cancer rates among the African American community. Prostate cancer is a major concern, yet the Haddington community noted a reluctance among African American men to go for annual physicals including prostate cancer screening. As a result, one of the many health initiatives conducted by the Collaborative throughout the year, is an annual Men's Health Night Out. Held at Greater St. Matthew Independent Church, the event provides health promotion and prevention screening activities for men. These health promotion activities are embedded in a program of a live jazz band, dining and dancing with their companions. This program has been especially successful through the personal endorsement of the church's pastor, Rev. Frank Lilley. Using his position as a religious and community leader, Rev. Lilley helped overcome the reluctance of his male congregants to get screening for prostate cancer. His success is an example of how the sender of the message is vital to the level of response. Rev. Lilley's understanding of his role in promoting the health of the community and the community's respect for him as a credible voice opened doors that may not have otherwise opened. Bringing the power and respect of the pulpit to support health in a community is one key asset that can be tapped by health care organizations through partnerships with faith-based organizations.

at large. Such institutions and their leaders can teach by example (e.g. serving healthy foods at events) and can use what some religions refer to as the "power of the pulpit" to work toward behavioral change. By connecting health issues to the values and priorities of a community, a faith-based organization can help health care organizations develop effective approaches to improve patient self-management of disease that reflect religious, spiritual or moral values.

Assuring that lifestyle changes recommended are consistent with religious and spiritual beliefs.

When lifestyle changes are presented only from the medical viewpoint, they may lack relevance to the cultural and social context in which patients live. In fact, certain recommendations may appear to patients to contradict closely held cultural or religious beliefs and practices. When faith-based organizations partner with health care organizations, they can help make sure that information is presented in ways that are congruent with patient beliefs. This approach can support behaviors that may be different from traditional ways by sanctioning them within a given cultural or religious belief system.

Creating support networks to help sustain lifestyle changes.

Faith-based organizations often comprise natural networks of support for patients. These support networks can be tapped and helped to provide the kinds of ongoing and often intensive support needed to sustain behavioral changes for improved health outcomes for such issues as smoking cessation, weight loss and dietary changes and aftercare for substance abuse. Such networks can also promote health and assist in supporting behaviors that prevent or reduce the risk of disease and disability.

A Comprehensive Approach to Community Health

Pittsburgh's East End is 80% African American and is largely a low income, underserved area. Teen pregnancy, poor academic performance, high unemployment, and high percentage of children living in poverty have historically characterized the East End. In 1990, Pittsburgh Pastoral Institute, a mental health agency, and East Liberty Family Health Care Center, two agencies comprised primarily of white staff members, acknowledged a shared problem: there were significant limitations in comprehensive health care services for the growing African American population they served. These agencies came to recognize that the African American church was the one "long term, indigenous institution in the Black community that encounters and embraces individuals, families and extended families from birth to death in a holistic way", (Rogers and Ronsheim, 1998). Thus, they reached out to the faith community by inviting the director of Christian Life Skills, Inc. to discuss their concerns. Christian Life Skills, Inc., a community organization, had developed a network of churches and church-based groups in the East End community to provide mentoring, life skills training and other support services for youth and families.

These partners worked together over the next decade to create a broad and strong safety net entitled Families and Youth 2000 to improve the health of residents of Pittsburgh's East End. The collaborative partners had to work through issues of trust and control, which were manifest in such issues as employment policies and race and culture. They learned to deal with the organizational "cultures" of new partners such as university systems. The partners also learned about diverse "cultures" among families, informal networks of support and communities.

Today, this collaborative ministry provides a broad array of services to address the holistic view of health for individuals and the community in a spiritual and cultural context that resonates with the African-American community. Services include counseling, therapy, health care, mentoring, life skills, youth leadership education, training, youth development activities, job skills programs, home management training, ministry to single mothers, data management and tutoring. These services are provided by a network of agencies and churches in the community. Pittsburgh Pastoral Institute serves as the fiscal agent for the collaborative (Rogers and Ronsheim, 1998).

VI. Strengthening the Safety Net

THE PROGRAMS AND PRACTITIONERS FUNDED BY THE BPHC MAKE up the third largest primary health care system in the United States. Unlike other health care systems, the BPHC is known as a national *safety net* because its mission is to provide comprehensive preventive and primary health care to the nation's most vulnerable and underserved populations. Through the Faith Partnership Initiative, the BPHC is providing leadership, innovation and resources to expand the scope of the safety net for this nation's communities. Partnerships between faith-based organizations and health care organizations are a viable strategy to achieve the vision of "healthy individuals in healthy communities", a vision where everyone benefits.

Benefits to Those Served

Individuals and families served by partnerships between health care organizations and faith-based organizations receive these benefits:

- culturally and linguistically competent primary and preventive health care and health education services;
- improved health outcomes because services are delivered in contexts that build trust leading to consistent follow-up;
- better connections with community support networks to provide treatment and sustain healthy lifestyle changes;
- inclusion of spirituality in beliefs and practices related to health and healing;
- convenience when services are delivered closer to home and at flexible times; and
- health care providers who have an understanding of the interactions between health issues and an individual patient's constraints based on religious and spiritual beliefs, values and practices.

Benefits to Health Centers

The benefit of faith partnerships to community-based health care organizations is being able to more effectively meet their mission of providing the services and supports that lead to increased access and better health outcomes for the populations served.

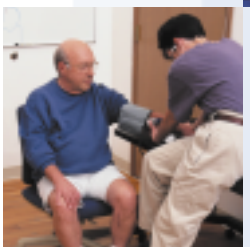
In particular, resource sharing can enhance the capacity of health care by providing:

- additional space or access points for screening, referrals, health

"...the Bureau is wise and prudent for saying let's start connecting with the faith institutions, for they are beginning to emerge as a major leader ... involved in what they refer to as a holistic approach to health with a focus on the whole person. They're concerned about education, housing, job development, economic and commercial development, and social justice issues, which all contribute to the health of an individual and a community..."

CAPTAIN JAMES GRAY
Acting Director,
Center for Communities in Action
Bureau of Primary Health Care
HRSA/DHHS

SOURCE: BAIRD, 1999.



education and promotion and follow-up services with limited additional cost;

- volunteer support to organize health promotion programs and to provide child care and transportation to partnership services;
- additional partners who have credibility in their communities to deliver health promotion and preventive health messages; and
- access to existing community networks that provide patient support during illness and aftercare.

Political benefits of partnerships with faith-based organizations include:

- new partners, hence, increased community support for health centers;
- better community awareness of health care organizations and their value to communities:
- increased ability to engage diverse stakeholders in planning processes that support improved community health; and
- new and additional collaborators to advocate for a community health agenda at the local, state and national levels.

Benefits for the Community

When faith-based organizations and health care organizations partner, the entire community benefits. These benefits include:

- improved health of citizens, including fewer persons disabled by chronic conditions that are not appropriately prevented or treated:
- a healthier workforce;
- the creation of health care related jobs and the purchase of goods and services that provide for economic reciprocity within communities; and
- a consortium of key community stakeholders who can participate in other planning and program efforts that can strengthen the community safety net.

VII. Perceived Barriers to Partnerships

GIVEN THE EFFECTIVENESS OF PARTNERSHIPS BETWEEN health care and faith-based organizations, why are they not more common? Why, in fact, is a special initiative needed to foster these relationships? There have traditionally been a number of issues that have made health care organizations hesitant to pursue such relationships. Most of these concerns, however, can be addressed with careful discussion within health care organizations and with any potential partners. Given the benefits of such partnerships, it is time to move beyond concern to action.

The following questions and answers have been provided to respond to concerns about legal, financial and resources issues associated with partnerships between health care organizations and faith-based organizations.

Q Is it permissible, based on constitutional and legal grounds, for organizations receiving government funding to partner with faith-based organization? How do such partnerships relate to separation of church and state?

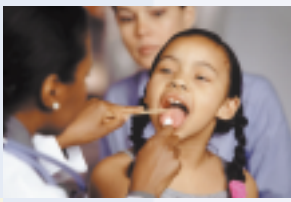
A There is a long history of partnerships between faith-based organizations and government-funded efforts. In fact, the Supreme Court has ruled that such partnerships are permissible within certain bounds. See pages 20-22 to understand the structure within which such partnerships are permissible and to learn how multiple government agencies support and enhance such partnerships.

Q Will working with any one faith-based organization be seen as an endorsement of the religion related to it, possibly alienating other groups in the community?

A If the opportunity for partnership is open to all and if the partnership clearly addresses a community need, health care organizations need not be seen as preferential.

Q Will new partnerships stretch already thin resources further?

A Any new effort may initially stretch an organization's resources and level of effort of personnel. However, partnerships with faith-based organizations can actually provide opportunities to leverage additional resources of the faith community. It is important, however, that such partnerships exploit neither partner (See pages 23 and 24).



Q Will partnerships with faith-based organizations increase liability problems for health care organizations?

A Liability issues need to be explored. There is evidence, however, that when services are delivered in culturally and linguistically competent ways, there are actually fewer liability issues (Cohen and Goode, 1999).

Q Will faith-based organizations keep the same level of accountability in terms of business standards, financial records and reporting requirements that health care organizations must maintain?

A All organizations have to be accountable for their business practices. The amount of record keeping, reporting and other related requirements will vary depending on the nature of the partner organization, and the partnerships and mandates from funders and applicable local, state or federal statutes. These are important issues that need to be addressed up front. Each partner's respective responsibilities should be clearly delineated.

The following questions and answers have been provided to respond to political concerns that may arise regarding partnerships between health care organizations and faith-based organizations.

Q Will traditional community partners frown on partnerships with faith-based organizations?

A Many concerns are allayed when health care organizations clearly articulate the goals and objectives of such partnerships and the benefits to the community as a whole.

Q Will partnerships diminish the power and influence of health care organizations?

A Carefully designed partnerships should strengthen rather diminish the power and influence of all organizations involved. Partnerships can increase the number of stakeholders that are concerned with and advocate for issues of concern within communities. These partnerships should be viewed as complementary, not competitive.

Partnerships with faith-based organizations may also challenge the attitudes and belief systems of health care organizations and their personnel. The following questions and answers have been provided to respond to such concerns that may affect the comfort zone of health care providers.

Q How does religion and spirituality relate to the scientific discipline of health care?

A Professionals can begin to understand partnerships with faith-based organizations as a way to address individual patient needs in areas in which they are neither trained nor comfortable. This issue may become less of a

concern in the future as many medical schools add courses about spirituality in medical care. Health care organization staff can learn from the growing literature on the importance of the spiritual/religious component in both healing and health promotion.

Q What if members of the faith-based organization try to proselytize patients, providers or other staff?

A Health care and faith-based organizations must establish principles upon which they agree. These principles form the basis for policy that specifies how each organization and its employees and constituency groups will conduct business. These types of issues should be discussed openly between the partners until they agree on principles and establish a comfort zone. Based on current statues and regulations, proselytizing is clearly prohibited when government funding is involved in joint activities.

Q What if the religious tenets of the partner seem to inhibit the delivery of health messages to patients that the health care organization deems important?

A Health care organizations must avoid making assumptions about what faith-based organizations will or will not support. For example, a recent survey of interdenominational African American clergy found that 76% had discussed HIV/AIDS with their congregations and were supportive of schools or other institutions addressing issues of sexuality that the clergy did not directly address (Coyne-Beaslye and Schoenback, 2000). Frank discussions must occur during the initial meetings and negotiations. The partnership should have structures to assure a venue for continued discussions of this nature. Health professionals need to be able to articulate the underlying goal of health messages and then collaborate with the faith community to find an acceptable way to promote messages to meet that goal. If an understanding cannot be reached on a particular issue, it may be necessary for health care organizations to find other partners in the community who can help deliver that message.

Does the Constitution Allow Partnerships Between Faith-based Organizations and Government-funded Health Care Organizations?

"Congress shall make no law respecting an establishment of religion or prohibiting free exercise thereof..."
First Amendment, Constitution of the United States of America

Government-funded agencies and programs must always give thought as to whether partnerships with faith-based organizations create legal problems based on the Constitution. The Constitution's First Amendment contains the well-known establishment clause. While this clause firmly establishes the separation of church it does not prohibit government and religion from interacting. The interaction between government and faith organizations is hardly a new issue. The Supreme Court, in decisions going back almost 30 years, has addressed this issue in numerous cases. There is only the requirement that in any such relationships the government remain neutral.

The Supreme Court has developed a series of three tests, all of which must be met, to allow a relationship between government and religious/faith-based organizations:

- First, the action undertaken in the relationship must be secular in nature.
- Second, the primary effect of the action must neither advance nor inhibit religion.
- Third, the action must not foster excessive government entanglement with religion.

Within these guidelines, federal departments and agencies have developed policy and guidelines that govern their relationships with faith-based organizations. Numerous programs have been created between faith-based organizations and agencies or programs receiving public funds. For example, the federal government has long funded denominational colleges and universities with the requirement that those funds not be used for religious purposes.

PUBLIC SCHOOLS

PUBLIC SCHOOLS HAVE OFTEN PARTNERED WITH FAITH-BASED ORGANIZATIONS IN THEIR communities around issues such as crisis counseling, mentoring programs, and "safe havens" for children while going to and from school. In December, 1999, the Department of Education distributed a new set of guidelines developed jointly by the American Jewish Congress, the Christian Legal Society and the First Amendment Center that suggest how religious organizations and public schools can work together without violating the First Amendment of the Constitution.

This document provides greater detail to the three guiding principles set forth by the Supreme Court, noting that cooperative programs are permissible only if:

- participation in cooperative programs is not limited to religious groups—any responsible community organization may participate;
- a student's grade, class ranking or participation in school programs will not be affected by his/her willingness to participate or not participate in such a cooperative program; and
- student participation in a cooperative program cannot require membership in any religious group or acceptance of any religious belief or participation in any religious activity.

In addition, when cooperative programs are operated in facilities of religious institutions, those programs cannot allow any actual opportunity for proselytizing during the time of that joint program.

WELFARE REFORM

FEDERAL WELFARE REFORM HAS LOOKED TO THE FAITH COMMUNITY FOR POTENTIAL partners in carrying out the new approaches to serving those receiving welfare benefits. Section 104, the "charitable choice" provision of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, encourages states to partner with independent organizations to provide welfare services and forbids the exclusion of faith-based providers. In fact, if the state involves any independent organizations, then it must not discriminate against faith-based providers. Section 104 requires states to protect the autonomy and religious character of such participating providers. These rules apply to the federal welfare block grant funds. If a state's constitution prohibits funds from being awarded to religious organizations, then the state must keep its funds separate, while assuring that federal funds are used in compliance with Section 104. The law secures the following rights to participating faith-based organizations:

- control of religious mission—they retain the right to keep, change and express their religious convictions;
- control of employment policy—they retain the right to use religious criteria in hiring, firing and disciplining employees;
- maintenance of religious atmosphere—they retain the right to keep religious art, symbols, icons, etc. in their service location;
- control of governing boards—they retain the right to constitute such boards in the way they judge best and may not be compelled to create them to meet ethnic, gender or cultural diversity criteria;
- control of internal governance—they may not be required to form a separate 501c3 corporation to provide welfare services;
- independence—they retain their legal status as independent organizations;
- limited audits—they can keep federal funds in a separate account to confine audits to those funds; and
- legal remedies—they can bring civil suits in state courts to order alleged violators of their rights to comply with Section 104.

Section 104 also specifies that religious organizations that receive federal funds directly, not via vouchers, may not use them for sectarian worship, instruction or proselytizing (Carlson-Thies, 1996).

CENTERS FOR DISEASE CONTROL AND PREVENTION

IN 1997, THE FEDERAL CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) sponsored an educational forum called "Engaging Faith Communities as Partners in Improving Community Health." The CDC now funds an initiative of community-based HIV prevention programs for African Americans that are designated for faith-based organizations. The community-based HIV Prevention Services program awards four Cooperative Agreements with faith, spiritual and religious-based community organizations to create effective community-based HIV prevention programs for African Americans.

DEPARTMENT OF HOUSING & URBAN DEVELOPMENT

ON NOVEMBER 30, 1999, SECRETARY OF HOUSING AND URBAN DEVELOPMENT (HUD) Andrew Cuomo hosted a public forum on "The Role of Faith and Justice in Public Policy". During his keynote speech, he urged faith-based organizations to "argue for a seat at the table in the name of justice, not for crumbs in the name of kindness." "Tension over the role of religion in government is always present when governments enter into partnerships with faith-based organizations," he said, " but it's a resolvable issue."

HUD has a long history of such partnerships. More than 1,000 organizations provide housing for people with AIDS. Close to one third are faith-based organizations of which two-thirds receive funding from Housing Opportunities for Persons with AIDS. Non-profit faith-based organizations operate 40% of HUD's Section 202 housing for the elderly program. HUD awarded a total of $114 million in grants to faith-based organizations for the homeless and special needs programs (Department of Housing and Urban Development, 2000)

HUD has evolved the "true beneficiary" theory. For some time, HUD has taken the position that when services and food are provided by faith-based organizations to the homeless or other poor people, the true beneficiary is that ultimate recipient, not the religious institution. This theory allows for effective community programs and partnerships involving HUD funds and faith-based organizations. HUD guidelines include these stipulations:

- The program may not discriminate against any employee or applicant on the basis of religion or give preference in employment on the basis of religion.
- The program may not discriminate against any person applying for publicly funded services on the basis of religion.
- The program may not provide any religious instruction or counseling or conduct any religious services, engage in religious proselytizing or exert religious influence on participants in the program.

BUREAU OF PRIMARY HEALTH CARE

WHILE THE BPHC IS A RELATIVE NEWCOMER TO THE GROUP OF FEDERAL DEPARTMENTS and agencies that encourage partnerships with faith-based organizations, it supports an array of innovative activities. Most of these activities are under the auspices of the Faith Partnerships Initiative.

For example, the BPHC's Faith Partnership Initiative is funding a series of activities with faith-based organizations to address health disparities in racially and ethnically diverse communities.

- **Congress of National Black Churches, Inc.**
  The BPHC has a Cooperative Agreement with the Congress of National Black Churches, Inc. (CNBC), which represents congregations serving 19 million people. The project is designed to build an infrastructure so that CNBC affiliates will be prepared and ready partners with health care organizations.
- **Summit Health Research and Education, Inc.**
  BPHC also has a contract with Summit Health Research and Education, Inc. (SHIRE) to address one of the health disparities. The project is entitled *Managing Diabetes in Communities of Color Through Expanding Partnerships with Faith-based Organizations.* The goal of this project is to connect faith-based organizations and their community partners to the health providers linked to the BPHC-funded health centers, particularly those participating in the Diabetes Collaborative.
- **Christian Community Health Fellowship, Inc.**
  In addition, BPHC has a cooperative agreement with the Christian Community Health Fellowship, Inc. to support the development of research and evaluation tools to test "best practices" among faith-based health care organizations serving the nation's poorest urban and rural populations.

VIII. A Meeting of Cultures

ORGANIZATIONS HAVE CULTURES THAT DEVELOP OVER TIME based on their vision, mission and values, as well as the broader context within which they exist. While faith-based organizations and health care organizations may share many fundamental values and seek common goals related to strengthening the safety net, they also have very different cultures that each should respect. Faith-based organizations are driven by a religious, spiritual and moral core of beliefs. Health care organizations are rooted in using the benefits of science and technology to address the health of those they serve. Each partner must be clear with the other about what brings them to the table and how each views the path to enhancing the health of the community.

An organization's culture is impacted not only by its mission, policy and structures, but also by the diversity of its work force. A complex array of factors converge within the work force of faith-based and health care organizations including, but not limited to, race, nationality, ethnicity, culture, language, gender, age, sexual orientation, education, class and political affiliation. The challenges of developing relationships across these cultural differences may also face those trying to build partnerships. Rogers and Ronsheim (1998), in describing the experiences of developing a partnership among four African American churches, a neighborhood health center, a church-based community grassroots organization and a counseling and therapy agency note:

> "In addressing patterns—such as culture, race, trust and control—common to these divergent systems, several key factors transcend the differences and make possible effective interaction. The factors include time, good communication, relationship building, and mutual respect."

Trust is essential with any new partnership. Yet the process of establishing trust requires a commitment of time from both partners. It is important to set a tone that honors and supports all partners and their missions, as well as the cultural backgrounds of all individuals involved. The partnership must be developed within the context of fulfilling mutual goals and not simply using one another to pursue the goals of one organization while "plundering" the resources of the other. Gary Gunderson, (1999) director of the Interfaith Health Program at the Rollins School of Public Health, Emory University, provides excellent guidance to thinking about how to bring the faith and health cultures together in partnership for health goals. He suggests that there are two "right" steps to frame the early stages of such coalitions:

- Reframe health as a domain of opportunities, not problems.
- Reframe community health as a social challenge dependent on strong and enduring partnerships, not just stop-gap arrangements.

Such approaches can help organizations develop a new way of creating a community vision and infrastructure, and can set the stage for the two organizational cultures to work together.

Gunderson also suggests, however, that some questions that partners may bring to the table early in the partnership reflect a lack of respect for the other entity, and can derail trust and ultimately collaboration toward common goals. These questions are:

- How can health systems use religious groups to substitute charity for paid medical services?
- How can government transfer financial responsibility for inconveniently expensive types of people to religious groups?
- How can religious groups secure new funding streams for community ministries they find difficult to fund otherwise?

Even though faith-based organizations bring many resources to the table, they cannot be expected to replace hard funding for many types of services and activities. There needs to be a weaving together of existing resources between the two organizations in the partnership and a commitment to collaboratively seek additional resources. A recent study by the Polis Center (Farnsely, 1998) raises cautions against assuming that there are extensive monetary resources in most congregations and notes that many small churches do not provide any social services.

Bringing together two organizations with unique histories and cultures is clearly a challenge. The work group of experts that developed this monograph recommend that as health care organizations explore the possibilities of partnering with faith-based organizations, they view the process as a continuum that develops over time. The examples of successful partnerships provided within this monograph demonstrate that the effort yields important gains for the health of individuals and their communities. These successful examples, however, reflect the culmination of much time and effort spent in developing the relationships needed to create and sustain them. With time, respect and mutuality, health care organizations and faith-based organizations can partner effectively.

IX. Taking Action

THE BPHC'S FAITH PARTNERSHIP INITIATIVE PROVIDES A FRAMEWORK and support for the very important work of strengthening the safety net within communities to assure that there is 100% Access and 0 Health Disparities as our nation moves into a new century and a new millennium. This monograph, as one of the actions of the Faith Partnership Initiative, provides the vision of the great benefits of such partnerships and addresses the attitudinal and practical concerns that may have prevented health care organizations from reaching out to create these potentially productive connections. Other products developed by the Faith Partnership Initiative will provide practical guidance on how to identify potential partners and begin doing the important work of creating these new collaborations. Driven by a common legacy of caring, health care and faith-based organizations can work together to build a stronger and more effective safety net for the health of underserved individuals and communities in our nation.

X. For More Information...

About Bureau of Primary Health Care programs:

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Bethesda, MD 20814
(301) 594-4494
(301) 594-4987 FAX
Jgray@hrsa.gov
www.bphc.hrsa.gov/bphc/faith/FaithProgramInfo.htm

Office of Minority and Women's Health
Bureau of Primary Health Care
4350 East West Highway, 3rd Floor
Bethesda, MD 20814
(301) 594-4490
(301) 594-0089 FAX
www.bphc.hrsa.gov/omwh/omwh.htm

About the topic of faith/health partnerships and the role of religion and spirituality in health:

The Interfaith Health Program
Rollins School of Public Health
Emory University
750 Commerce Drive, Suite 301
Decatur, GA 30030
(404) 592-1461
lmcphee@emory.edu
www.iphnet.org

This program, originally founded in the Carter Center, provides a wide range of information about faith/health partnerships, including a database of current partnerships.

About the National Center for Cultural Competence:

The mission of the National Center for Cultural Competence (NCCC) is to increase the capacity of health care and mental health programs to design, implement and evaluate culturally and linguistically competent service delivery systems. The NCCC conducts an array of activities to fulfill its mission including: (1) training, technical assistance and consultation; (2) networking, linkages and information exchange; and (3) knowledge and product development and dissemination. Major emphasis is placed on policy development, assistance in conducting cultural competence organizational self-assessments, and strategic approaches to the systematic incorporation of culturally competent values, policy, structures and practices within organizations.

The NCCC is a component of the Georgetown University Child Development Center, Center for Child Health and Mental Health Policy, and is housed within the Department of Pediatrics of the Georgetown University Medical Center. It is funded and operates under the auspices of a five-year Cooperative Agreement (9/30/00–5/31//05) within the Maternal and Child Health Bureau.

The NCCC is a collaborative project between the Georgetown University Child Development Center and the following Federal government agencies:

Health Resources and Services Administration

Maternal and Child Health Bureau (MCHB)

- Division of Services for Children With Special Health Needs
- Sudden Infant Death Syndrome and Other Infant Death Program
- Training Branch of the Division of Research, Training and Education

Bureau of Primary Health Care (BPHC)

- Office of Minority & Women's Health
- National Health Service Corps (NHSC)
- Division of Loan and Scholarship Repayment/NHSC
- Office of Pharmacy Affairs

Other target BPHC programs include Community Health Centers, Migrant Health Centers, Health Care for Homeless grantees, Healthy Schools, Healthy Communities grantees, Health Services for Residents of Public Housing, Primary Care Associations and Offices.

Office of Minority Health

- HRSA Cultural Competence Committee

Substance Abuse and Mental Health Services Administration

Center for Mental Health Services

- Child, Adolescent and Family Branch

The National Center for Cultural Competence
3307 M Street, NW, Suite 401
Washington, DC 20007-3935
(202) 687-5387 or (800) 788-2066
(202) 687-8899 FAX
cultural@georgetown.edu
http://gucdc.georgetown.edu/nccc

About the Examples of Partnerships

Listed below is contact information for the examples of partnerships between faith-based and health care organizations highlighted in this monograph.

More Hands to Help
The national clearinghouse for information on Love, INC is through World Vision.

Myrna Key, Ministry Coordinator
World Vision Incorporated
34834 Weyerhaeuser Way S
Auburn, WA 98001
Phone: (253) 815-2255 or 1-800-777-5277
E-mail: mkey@worldvision.org
Website: http://web2.worldvision.org/worldvision/wvususfo.nsf/stable/loveinc

Reestablishing Trust
Theda McPheron Keel
Wind Hollow Foundation
6739 D South Clifton Road
Frederick, MD 21703
Phone: (301) 371-8759
Fax: (301) 371-8769
E-mail: windholo@windhollow.org

Meeting the Needs of New Refugees
Miriam Weinberger, Executive Director
The ARK
6450 N. California
Chicago, IL 60645
Phone: (773) 973-1000
Fax: (773) 973-4362
E-mail: ArkMiriam@aol.com
Website: http://www.arkchicago.org

Linking Spirituality and Health Promotion
Dorcas Grigg Saito, Executive Director
Lowell Community Health Center
585 Merrimack
Lowell, MA 01851
Phone: (978) 937-9700
Fax: (978) 970-0057
E-mail: dorcasgr@lchealth.org
Website: http://www.lchealth.org

Speaking Out for Health
Reverend Frank Lilley
Greater St. Matthew Independent Church
5544 Race Street
Philadelphia, PA 19139
Phone: (215) 472-6537
Fax: (215) 472-6562

Honoring Religious Beliefs: A Health Care System Responds
Dr. Adnan Hammad
Health and Medical Director
Arab Community Center for Economic and Social Services
2601 Saulino Court
Dearborn, MI 48120
Phone: (313) 843-2844
Fax: (313) 843-0097
E-mail: ahammad@accesscommunity.org
Website:
http://www.comnet.org/local/orgs/access

Caring for the Whole Person
The Reverend Dr. Otis Moss
Pastor, Chairman
The Olivet Health and Education Institute
8819 Quincey Avenue
Cleveland, OH 44106
Phone: (216) 721-2850
Fax: (216) 721-2858

Giving a Blessing
Martha Stowe, Director
Greater Dallas Injury Prevention Center (GDIPC)
5000 Harry Hines Blvd, Suite 101
Dallas, TX 75235
Phone: (214) 590-4455
Fax: (214) 590-4469
Website: http://www.ipcdallas.org

A Comprehensive Approach to Community Health
Barbara Rogers, Project Director
Christian Life Skills, Inc.
Families and Youth 2000
100 North Braddock Avenue
Pittsburgh, PA 15208
Phone: (412) 371-7018
Fax: (412) 371-7718

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Faith-Based Partnerships for Population Health: Challenges, Initiatives, and Prospects

Jeff Levin, PhD, MPH[a]

In 1999, former U.S. Surgeon General Dr. David Satcher stated, "Through partnership with faith organizations and the use of health promotion and disease prevention sciences, we can form a mighty alliance to build strong, healthy, and productive communities."[1] This sentiment was recently seconded by Dr. Howard Koh, Assistant Secretary for Health.[2] Despite the contentiousness surrounding establishment of the White House Office of Faith-Based and Community Initiatives (OFBCI) under President Bush, repurposed as the Office of Faith-Based and Neighborhood Partnerships (OFBNP) under President Obama, the subsequent creation of a Center for Faith-Based and Neighborhood Partnerships (the Partnership Center) within the U.S. Department of Health and Human Services (HHS) signifies that faith-health partnerships are no longer hypothetical; rather, they are an ongoing part of the national conversation on public health.

This brief overview summarizes the scope of existing efforts among faith-based and public health institutions and organizations to work in partnership to further the health of the population. These intersections between the faith-based and public health sectors are more diverse than many public health professionals may realize, and of greater longstanding than the past two presidential administrations.[3,4]

CHALLENGES

Many may recall the controversy surrounding the OFBCI, established under Executive Orders by President Bush.[5,6] Less recalled is that legislation authorizing the OFBCI, known as "charitable choice," originated during the Clinton Administration.[7] While the intention of the legislation and the OFBCI was simply to enable religious organizations to provide services "on the same basis as any other nongovernmental provider"[7]—no provision authorized federal funding for any program—and while supported by both Democrats and Republicans, these details got lost in the uproar. Concern was voiced, early on, that the OFBCI was an effort by the religious right to create a mechanism to access federal funds. In truth, much of the religious right was opposed to the OFBCI and lobbied to eliminate it.[8]

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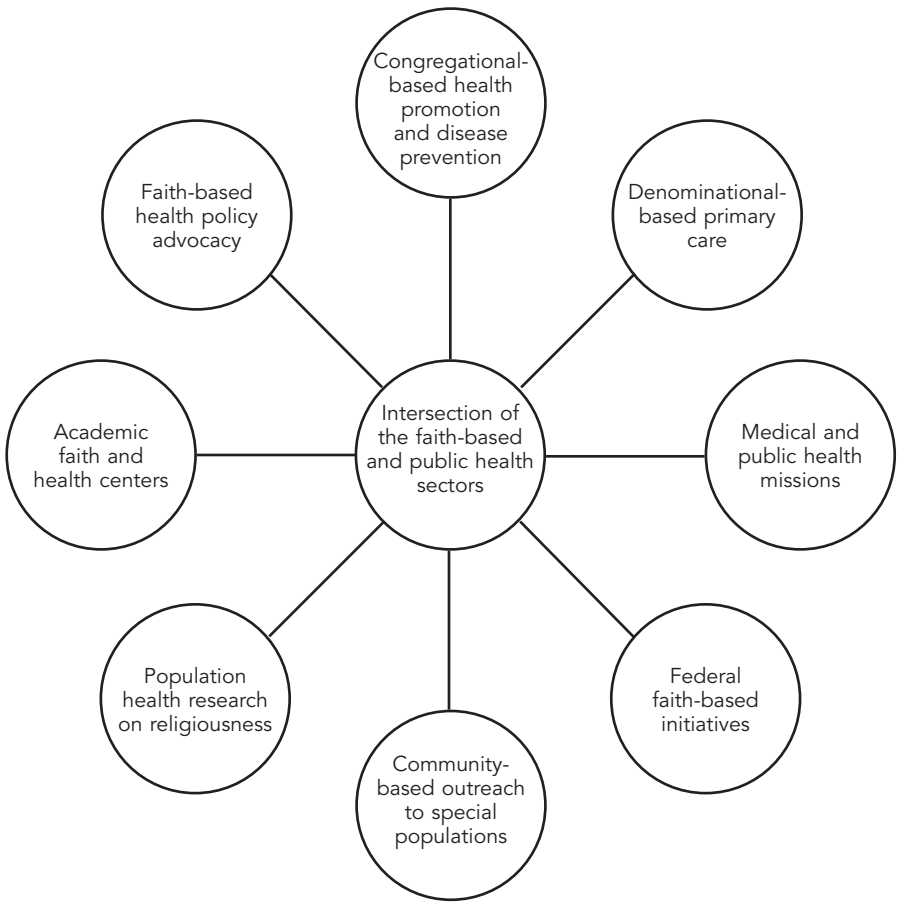
Over time, with a new director, lower profile, and track record of success, public glare faded and the OFBCI became an accepted part of the White House infrastructure. It was retained by President Obama,[9] with an advisory board containing national leaders known for progressive viewpoints. While at one time there were concerns about how the federal faith-based concept would play out, when it comes to public health initiatives, at least, the track record appears clean. Early concerns were overstated, but, to be fair, not all were due to fear mongering; the history of organized religion's forays into the public square are not entirely innocent. However, with legal and constitutional boundaries surrounding what is and is not permissible well vetted,[10] the Obama Administration and HHS recognize this model as a means to strengthen the nation's public health efforts.

More importantly, no matter how the OFBNP has evolved, two things are apparent: (*1*) faith-health partnerships are not new, and (*2*) they cover considerable ground. Collaboration between the faith-based and public health sectors in the U.S. is as old as organized efforts in public health, dating to the 19th century.[11] The challenge of meeting national and global population health priorities should not be overwhelmed by the challenge to forge creative partnerships between these sectors, no matter how daunting.[12] Religious institutions, organizations, and professionals can be, and long have been, our allies in public health, as Dr. Satcher noted.[1]

Before summarizing what is included in the Figure, what is not included is also notable; for example, groups or individuals who exploit the religious beliefs of the suffering for profit, those who espouse violence toward providers, and other unfortunate images that may come to mind at the intersection of the words "faith" and "health." This commentary is not the place to discuss the sometimes troubled history of conflicts between people and institutions of faith and those of medicine and science. There is a different narrative to unpack that merits a wider airing: the ways that the faith-based and public health sectors continue to ally in

Figure. Points of intersection between the faith-based and public health sectors



efforts to prevent disease and promote health,[13] both in the U.S. and around the world.

INITIATIVES

As shown in the Figure, the intersection of the faith-based and public health sectors contains multiple partnerships, encompassing recent initiatives and longstanding inter-sector relationships. These activities, as a whole, are representative of the fullness of what defines public health: (*1*) they entail public health research and education, delivery of primary care, and policy-making; (*2*) they target processes, impacts, and outcomes across primary, secondary, and tertiary levels of prevention; (*3*) they involve health educators, epidemiologists, biostatisticians, health administrators, public health nurses and preventive medicine physicians, environmental scientists, and others; and (*4*) they address the needs of diverse, underserved populations, especially racial/ethnic minority communities and older adults. Examples include:

- Congregational-based health promotion and disease prevention: The Health and Human Services Project of the General Baptist State Convention of North Carolina, dating to the 1970s, pioneered church-based health education to underserved communities.[14]
- Denominational-based primary care: The earliest hospitals were founded by the major faith traditions,[15] seen today in the myriad Catholic, Lutheran, Baptist, Methodist, Presbyterian, Adventist, Jewish, and other religiously branded medical centers.
- Medical and public health missions: Christian missions providing medical and surgical care and environmental health development are most familiar, but other religions have traditions of global outreach (e.g., the Tobin Health Center serving Abayudaya Jews and their Christian and Muslim neighbors in Uganda).[16]
- Federal faith-based initiatives: One of the highest-profile initiatives of both the OFBCI and OFBNP has been the President's Emergency Plan for AIDS Relief (PEPFAR),[17] a centerpiece of the nation's Global Health Initiative under the Obama Administration.
- Community-based outreach to special populations: Outreach encompasses many types of initiatives, from faith community (or parish) nurses[18] to groups such as the Shepherd's Centers of America,[19] a national network of interfaith community-based organizations serving older adults.
- Population health research on religion: Thousands of studies have identified religious correlates of morbidity, mortality, and disability, including social, epidemiologic, and community-based research on physical and mental health across all major faith traditions.[20]
- Academic faith and health centers: These centers include the Duke University Center for Spirituality, Theology, and Health;[21] the University of Florida Center for Spirituality and Health;[22] the George Washington Institute for Spirituality and Health;[23] and the Emory University Interfaith Health Program[24] and its Institute for Public Health and Faith Collaborations,[25] all of which are involved in research and education.
- Faith-based health policy advocacy: The recent health-care reform debate, for example, was informed by policy statements from the U.S. Conference of Catholic Bishops[26] and from Jewish organizations across the denominational spectrum.[27]

This summary is, by necessity, a skeleton overview. The public health literature is replete with accounts of faith-based partnerships, especially involving health promotion and disease prevention in conjunction with local health departments.[28]

PROSPECTS

Can we identify ways to broaden this intersection between the faith-based and public health sectors? Two possibilities come to mind. First, the Office of the Surgeon General could use its bully pulpit to raise awareness of social-structural determinants of population health and disease, such as poverty and inaccessible preventive care.[29] These issues have proven intractable for decades; solutions may require a broader effort than is possible drawing only on federal and state government resources. In a time of fiscal challenge, especially, religious organizations and institutions could serve as partners in meeting needs that are presently unmet. This promise is at the heart of the Bush and Obama Administrations' efforts to promote charitable choice through offices in the White House and cabinet-level agencies, including HHS.

Second, to advance such efforts, the U.S. Public Health Service could consider developing a companion document for Healthy People 2020 that comprehensively summarizes evidence from research and intervention studies involving collaboration with faith-based communities, organizations, or institutions for each of its 42 designated topic areas.[30] Besides being a practical supplement, this document would provide, for the first

time, "a complete catalog of historical and ongoing public health programs and initiatives with significant faith-based content," as well as "a useful baseline for the development of detailed goals, objectives, and implementation plans for federal faith-based efforts" related to Healthy People.[29]

The faith-based sector has much to offer public health, yet it remains underused. The potential for good is considerable, but for good to come of it, the public health establishment must set aside any intrinsic misgivings (or misunderstandings) about faith-based organizations and professionals. Stereotyped portrayals of the faith-based concept and of the motives behind partnerships involving the public health sector do not map onto the longstanding history of collaborative work between religious and public health agencies and institutions. Moreover, without the involvement of the faith-based sector and other institutions of civil society, our nation will not muster the personal and tangible resources required to fully meet national[31] and global[32] population health goals and objectives.

But the burden is not just on those of us working in public health. The faith-based sector, too, must confront its own failings that impede such partnerships. Above all, the faith traditions must reclaim their prophetic voice regarding the health of populations. They must refocus themselves away from devotion to maintaining the status quo and toward being a force that, as Dunne said, "comforts th' afflicted [and] afflicts th' comfortable."[33] They must live up to their sacred charge to act prophetically—to call citizenry and secular governments out of their complacency and neglect, in the name of justice and mercy—to address the needs of the underserved and to promote an ethic of prevention and communitarian concern for the health and well-being of all people.

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Faith and Health Collaboration Network Analysis: Capacity to Reach Vulnerable Populations

APHA Caucus Roundtable 4209.0
Mimi Kiser
November 2017
Interfaith Health Program, Rollins School of Public Health
Emory University

Presentation Objectives

1) Describe the background and accomplishments of this faith and health collaborative 10 site network
2) Explain approaches and methods for describing the unique capacities of faith based organizations to reach vulnerable and at-risk populations with prevention services
3) Describe key characteristics of a network that successfully overcomes barriers of mistrust, culture, language, income, and geography to reach hard to reach populations

PROJECT GOAL AND HISTORY: 2009-Present

To build and mobilize capacity within networks of faith-based and community organizations linked with public health to extend their reach to vulnerable, at-risk, and minority populations for improving influenza vaccination outreach and uptake

Built on:

- IHP/Emory with CDC (‘01 to ‘07) trained 78 teams of religious and public health leaders in 24 states to collaborate on eliminating health disparities

- HHS’ Center for Faith-Based and Neighborhood Partnerships work with IHP/Emory and 9 sites during 2009 H1N1

TEN UNIQUE MULTI-SECTOR SITES

- **Arkansas**
  Arkansas Department of Health
- **Chicago, IL**
  Center for Faith and Community Health Transformation (Advocate Health Care and UIC)
- **Colorado Springs, CO**
  Penrose-St. Francis Health Mission
- **Detroit, MI**
  United Health Organization
- **Los Angeles, CA**
  Buddhist Tzu Chi Foundation
- **Lowell, MA**
  Lowell Community Health Center
- **Memphis, TN**
  Methodist LeBonheur Center of Excellence in Faith and Health
- **Minnesota**
  Minnesota Immunization Networking Initiative (MINI)
- **New York City, NY**
  South Brooklyn Interfaith Coalition (NYU Lutheran Health Care)
- **Pennsylvania**
  Schuylkill County's VISION

“Network”?

or … learning community

or … community of practice

Summary of Activities and Accomplishments

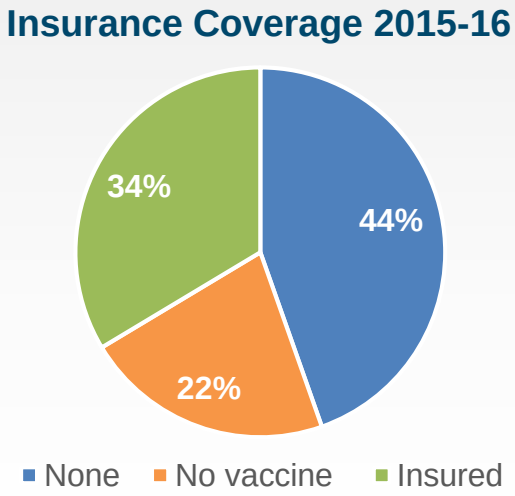
I. Capacity building
   a) Webinars, conference calls, in-person annual mtgs
II. Prevention services
   a) Influenza vaccinations
   b) Education and community outreach
III. Local ⟷ national bridging of knowledge and practice
IV. Evaluating and characterizing the distinctiveness of faith-based capacities

Cumulative Vaccination Impact

Impact	2009–10	2010–11	2011–12	2012-13	2013-14	2014-15	2015-16
Person Reach	78,708 (with partners)	13,686	15,103	16,381	19,430	13,092	15,347
		138 events	108 events	227 events	268 events	190 events	200 events

Education and Outreach 2015 – 2016 (1Yr. Example)

- Adapted evidence-based educational tools for hard to reach populations
- Incorporated CBPR findings about meaning of trust into educational and reach tools; conducted community leader interviews on emergency communication
- Used trusted networks with different mediums for information dissemination – e-newsletters to congregations, radio, family nurses, FBOs, etc.
- Reached low income, uninsured, and minority populations



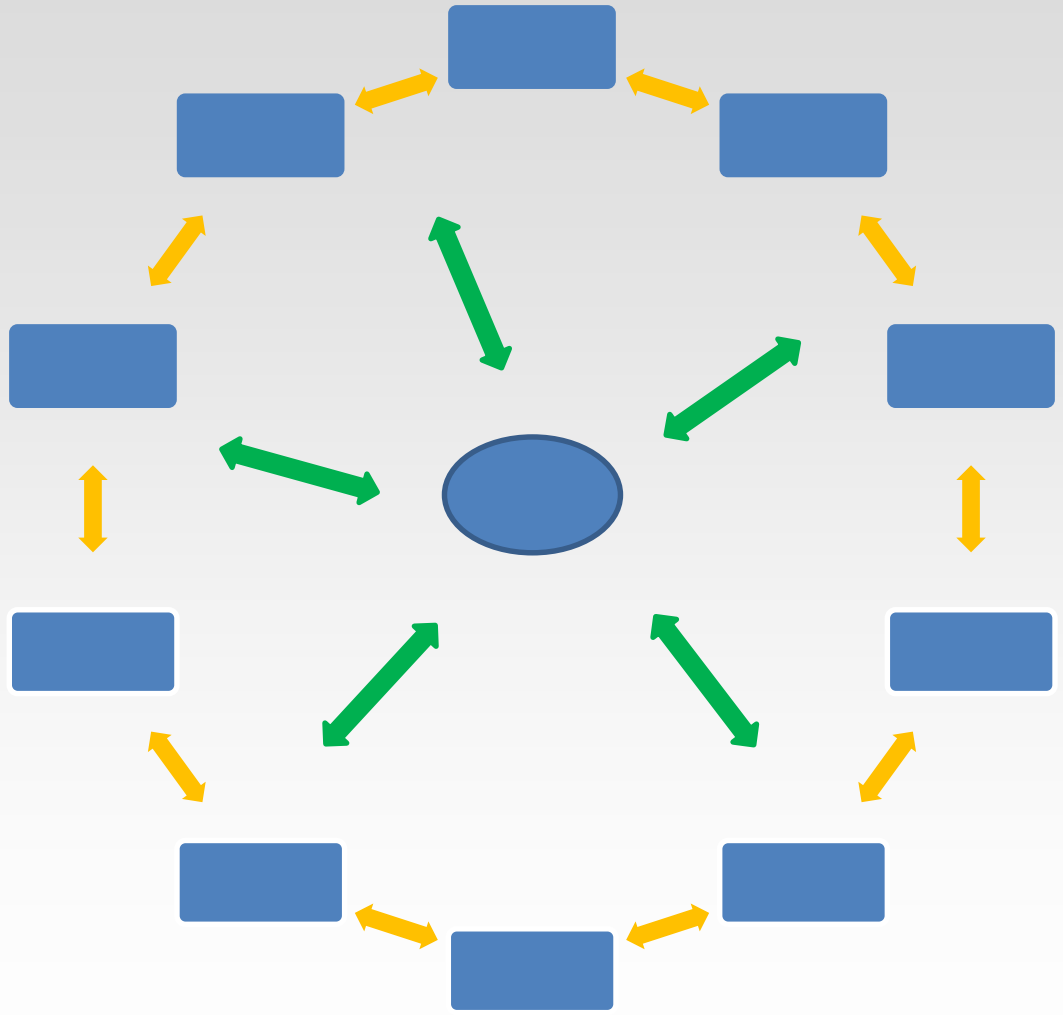
Ethnicity	Influenza Vaccinations
Asian	2278
Hispanic	2270
Black	1553
Unknown	34
Total	6135

Capacity behind the numbers ..

We maintained a commitment to evaluating and describing the work using a positive conceptual frame and methods based on:

- Appreciative inquiry
- Strengths and asset based reporting and analyzing
- Success stories

Sites Model Practices Learning Network



I. Site-based Capacity Assessments

1. Online *partnership survey* for sites and their partners
2. Ongoing *progress reports* and *annual network meetings* designed to capture capacity and accomplishments
3. Mixed methods *in-depth case study* on 2 sites to learn about local capacity/partnership building practices
4. Mixed methods *description of model practices* distinguishing faith-based capacity to reach vulnerable, at-risk, minority populations.

I. Site-based Capacity Assessments (cont'd)

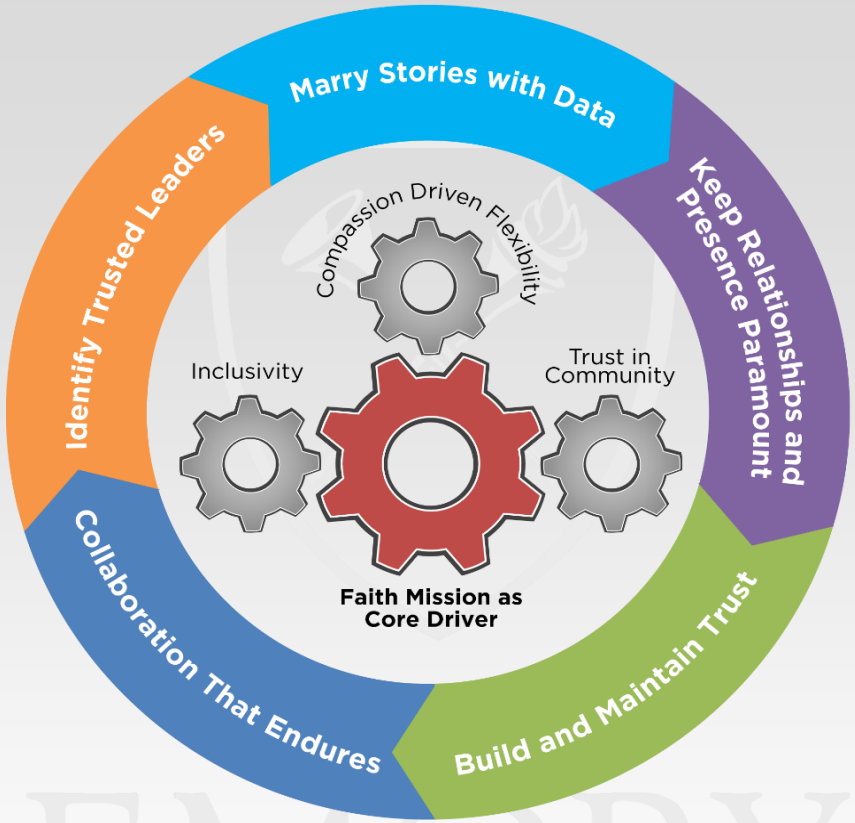
5. Mixed methods description of practices and capacity that successfully address high levels of mistrust in reaching African-American populations (3 sites)
6. Adaptation of CDC "Success Story" data collection tool for stories to post their successes on our and their websites
7. Mixed method (in-depth interviews, document review, and annual meeting structured dialogue) description of leadership, organizational, and community abilities to adapt and respond to emerging public health challenges.

Model Practice Framework Development: METHODOLOGY

A practice based discovery process using a modified Delphi technique to synthesize distinctive elements from across 10 sites.

- Document review and thematic analysis
- In-person inductive identification of key elements of practice (4 of 10 sites)
- On-line survey to validate key elements and characteristics (16 respondents across 10 sites)
- Multi-site in-person meeting to define and describe operational components of the practices

Model Practices Framework



Leadership Anchors the Work

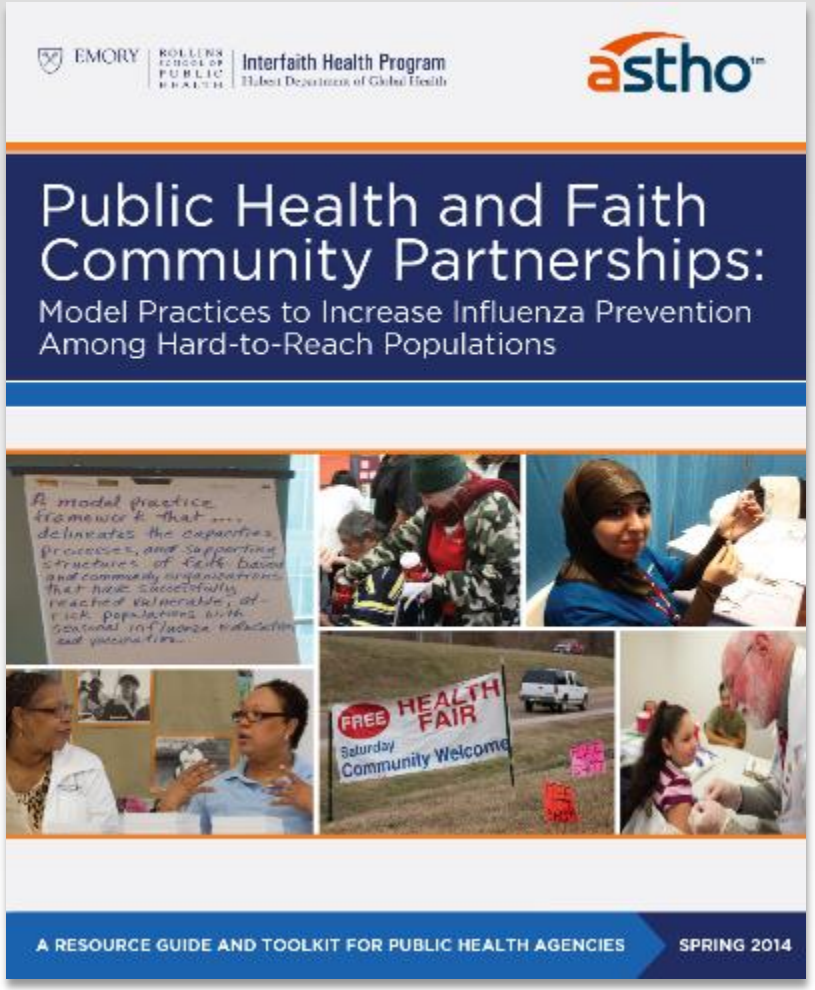
Volunteers as Groundwork

Circle of Core Partners

Network Connections

Multisectoral Collaboration

THE TOOLKIT: MODEL PRACTICES FRAMEWORK



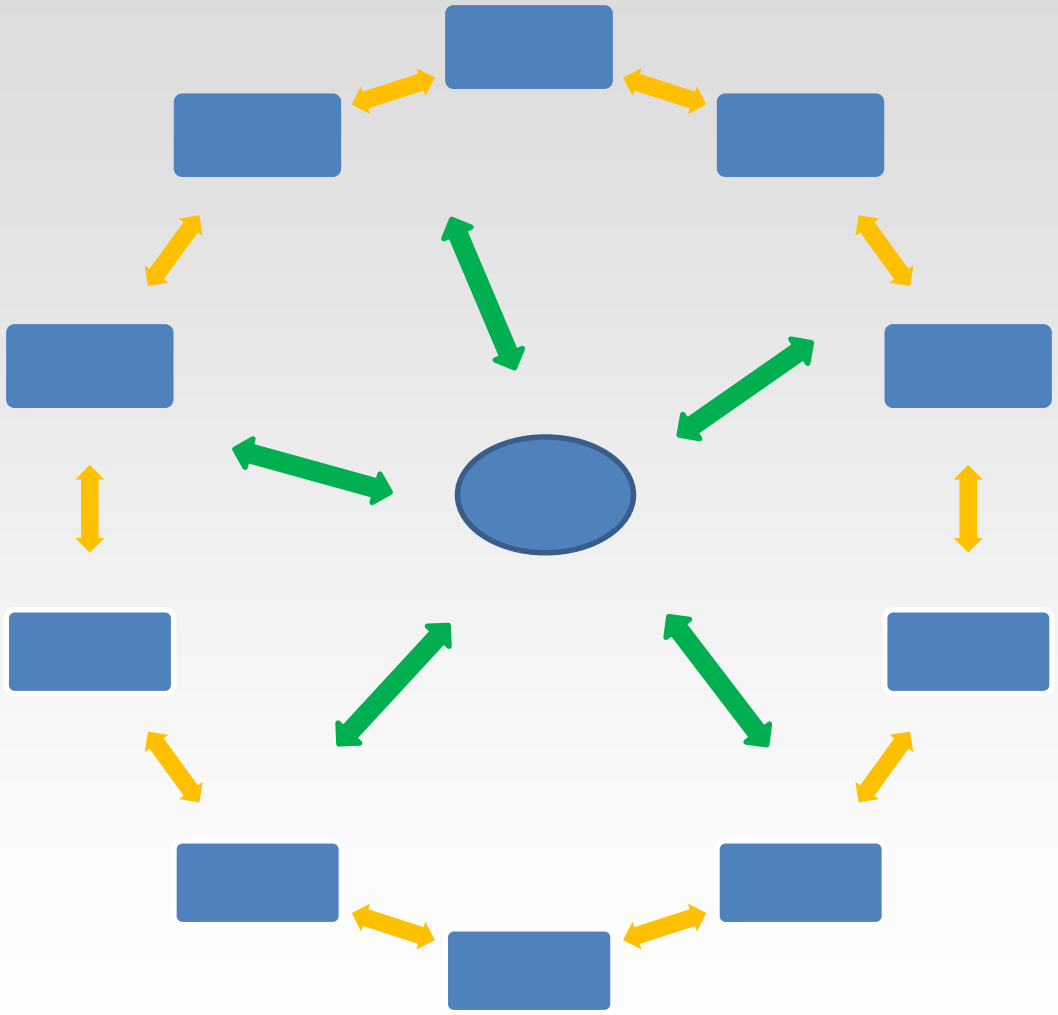
Introduction
- Purpose
- Who is the Guide For?
- How Can the Guide Be Used?

Faith-Based Organizations
- What are FBOs?
- Diversity of the U.S. Religious Landscape
- Types of Faith-Based Organizations

Faith-Based Partners
- Likely Partners in the Public Sphere
- Why FBOs as Partners?
- Government and FBO Partnerships

The Model Practices
- How Was the Model Practices Framework Developed?
- The Network
- The Fourteen Practices

Sites Model Practices Learning Network



“Network/Learning Community” Capacity Assessments

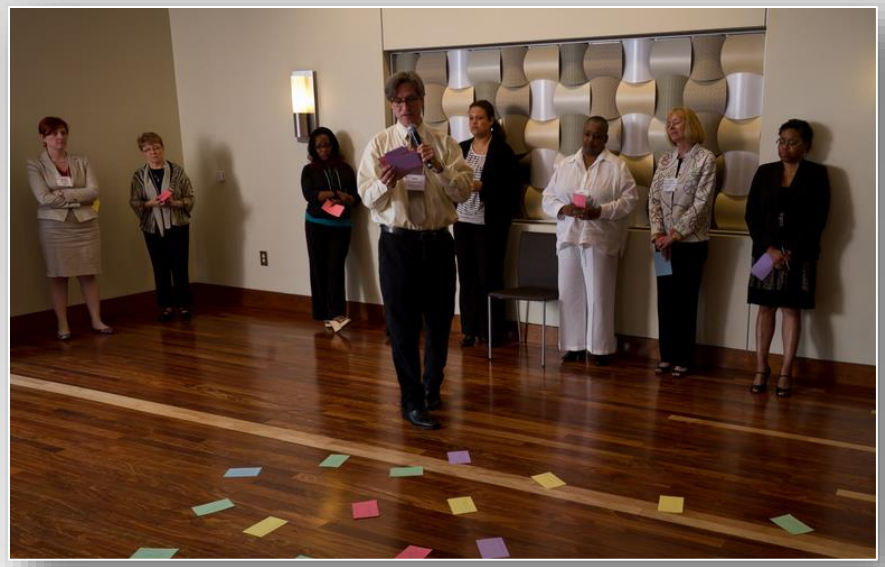
1. 10-Site Network Asset Mapping - 2012
   - Adaptation of community health asset and concept mapping technique
   - Conducted during annual meeting of 10 sites

2. 10-Site Network Analysis – 2016
   - On-line qualitative survey
   - Focus group discussions during annual meeting

1. Network Asset Mapping - 2012

Iterative three-step individual and large group participatory process:

1. Plotting the network and partners
2. Ranked most important site accomplishments
3. Ranked contributing network characteristics



Network Characteristics:

- Trust and trusted relationships
- Access to expertise (within and external to network) through collaborative learning
- Shared mission

"I think one of the most important things that has emerged for us has been the ripple effect of being part of IHP – *the network, connections, the visibility at places and times where we were previously invisible, the validation of our work and the confidence that comes with that,* our ability to truly become a portal to connect unrelated entities in our community in creative ways (especially with FBOs).

… it allowed us time to look at ourselves and do both a critical assessment and appreciative inquiry. It helped us reevaluate things we took for granted and redefine ourselves. It gave us tools to step back and actually see what we look like and lay out plans to move forward more effectively. We are a much stronger organization because of our association with the IHP [network]."

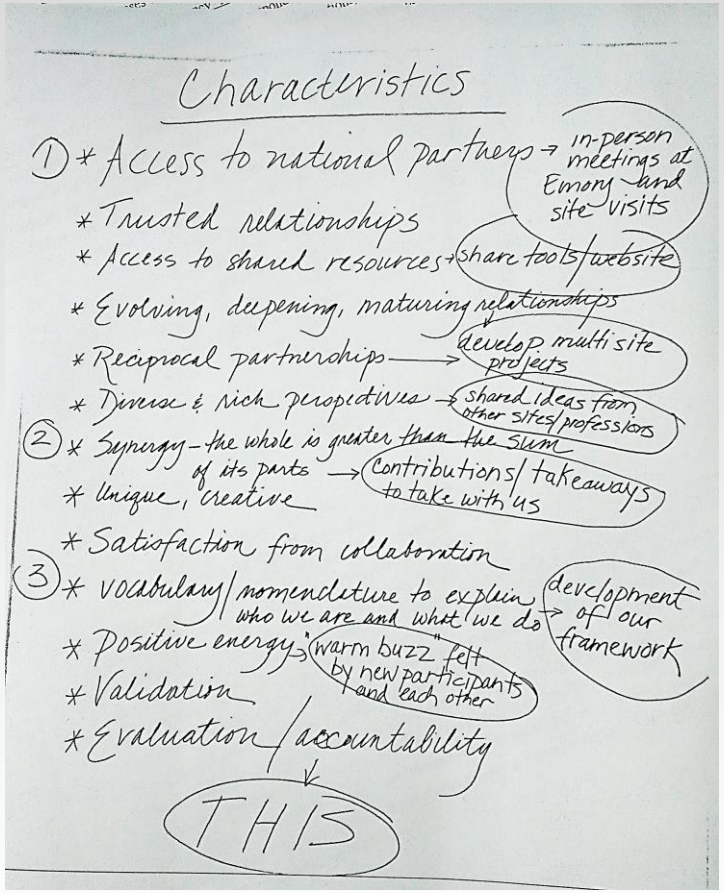
Network site participant, 2012

2. Network Analysis - 2016

Mixed methods descriptive evaluation

- On-line qualitative survey
  1. What are the unique accomplishments/outcomes of the network due to participation of the sites in the national network?
  2. What unique characteristics of the national network that have made the accomplishments above possible?

- Focus group discussions during annual meeting



2. Network Analysis - Findings

Key themes describing network characteristics:

1. Fostering of trust and an encouraging atmosphere
2. Effective communication and collaborative learning
3. Unique products as accomplishments – processes for developing a “common language and structure”
4. Diverse partners – geographic locations, religious beliefs, and expertise – provides links to information, funding, and a forum for new ways of thinking

2. Network Analysis – Participant quotes

"The Network's work and reflection on the importance of trust helped to shape our decision to focus on exploring trust in our work. The relationship building across sites has also been an important feature for the success of our projects."

"The process of developing the Model Practices Tool Kit was as important as the product itself. Being able to actually see and name the actions that had always been underlying our actions, taken for granted and never quantified gave new value to the work and directed our thinking to take what we now could identify to a new level. The exercise of dissecting the work and providing nomenclature for the parts gave us a common language and a structure upon which to build."

Summary – key points

- Key network characteristics – important capacity and an indirect "determinant" behind the "reach" numbers
  - Trust and trusted relationships
  - Access to "expertise" – processes and partners for collaborative learning
- Synergy between site and network capacity strengthening
  - "the whole is greater than the sum of its parts"
- Implications for sustaining cross-country local work and for local network capacity
- Difficulty measuring network capacity outcomes and obtaining funding support for that infrastructure

Thank you

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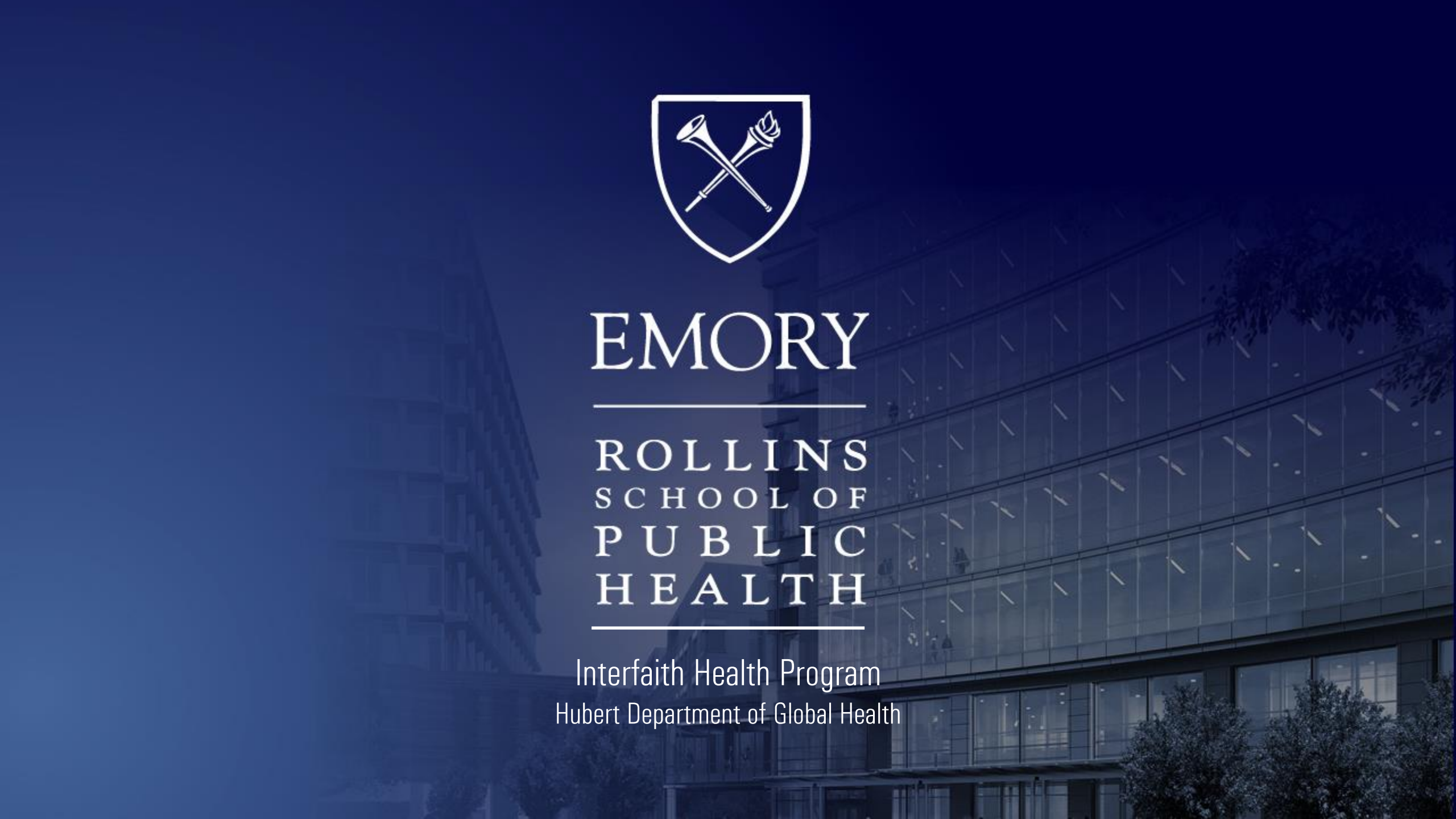
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PUBLIC
HEALTH
Interfaith Health Program
Hubert Department of Global Health

United Health Organization

Presented by Ifetayo Johnson • Velisa Perry

Core Partners

- Henry Ford Health System Faith Community Nursing Network (FCNN)
- Urban Health Resource
- Covenant Community Care
- National Association of Health Service Executives
- Detroit Medical Society

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ACCOMPLISHMENTS

Objective 1: To Increase knowledge about and access to the Model Practices Framework in Metro Detroit

- Henry Ford Health System Faith Community Nursing Network (FCNN) consists of nurses and health ministry leaders from 21 Detroit area churches. FCNN represents a potential reach of over 4500 congregants in predominantly African American communities. FCNN received training in the use of the Public Health and Faith Community: Model Practices to Increase Influenza Prevention Among Hard-to-Reach Populations website with an emphasis on the identification and development of the Trusted Leader and building Network Connections.

Objective 2: To increase health education and flu immunization outreach to at-risk populations primarily through faith-based organizations (FBO) and community based organizations (CBO) in metropolitan Detroit.

- Four flu clinics in churches vaccinating approximately 62 African American adults, the distribution of 300 Walgreen flu vaccination vouchers, six health education presentations to approximately 750 participants focused on vaccinations, Influenza, Ebola, health care enrollment and use of the Affordable Care Act and healthy lifestyle choices. Nine of the churches reported increased health activities due to partnering through network connections such as aerobics, nutrition and health education classes and other health activities.

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ACCOMPLISHMENTS (CONTINUED)

Objective 3: To increase partnership and network capacity.

Expanded our partnership capacity with:

- Black Family Development
- Black Women's Health Imperative
- Care Harbor Mobile Clinic
- Center for Urban Higher Education
- Covenant Community Care
- Detroit Medical Society, American Medical Association
- Fifth Third Bank
- First Responders 4 Fitness
- Henry Ford Health System Faith Community Nursing Network (FCNN)
- Improving Minority Wellness & Equity for Life Fellowship
- Michigan Chapter of the National Kidney Foundation
- Michigan Diabetes Prevention Network
- National Association of Health Service Executives
- Urban Health Resource
- Women of Evangelical Lutheran Church in America

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CHALLENGES

- The FCNN group went on summer hiatus before we could conduct the posttest to measure outcomes
- We chose to change our major funding activity this year to our financial detriment. This has limited some of our outreach capacity.
- One of our key staff members retired taking a wealth of organizational history and knowledge and significantly increasing the work load for the remaining staff.

CAPACITIES

- **Leadership Anchors the Network**
  - As a trusted entity in Detroit we often serve as the “glue” that binds networks together. We have been able to help bring together and lead discussions around collaboration and utilization of the Model Practices Framework.

- **Volunteers as Groundwork**
  - Our extensive network of volunteers and years of using volunteers as our core workforce help us provide insight on ways our partners could recruit, effectively use, value and show their appreciation for their volunteers. As an embedded partner, we provide gentle encouragement to the volunteers and feedback to our partners about how they are being perceived by their volunteers. This allows the partners to take corrective action where needed, prevent unnecessary dissension among the group, and provide direction and accolades resulting in higher volunteer retention.

- **Network Connections**
  - UHO has spent a large part of this year serving as the conduit for various groups in our network to connect to each other, providing support, and filling in services where needed. For example, because it was difficult to set up immunization clinics this year, vouchers from Walgreens were distributed to interested FBOs. UHO assisted churches in finding sources for immunizations in the area and several had one of the UHO partners come in to provide vaccine on site.

OPPORTUNITIES

- Serving as the trusted conduit to connect network partners to each other in a manner that facilitates easy access between organizations that can supply information and populations needing that information. This is especially important as it relates to trusting the source of emergent health issues -- becoming a trusted source for information about the Ebola “outbreak” and being a source for health screening to several churches, UHO has been able to bring in partners like the Breast and Cervical Cancer Control Program which was then able to provide Breast Cancer education to the women of the church.

- Shaping the strategy and design of the IM-WEL2 Initiative (Improving Minority Wellness & Equity for Life) Fellowship Program in Detroit that will train FBOs and CBOs to increase Medicaid enrollment and encourage the use of preventive health services and the appropriate use of health care among Medicaid enrollees.

- Developing a network of churches, health ministries and pastors to share successful health strategies, health education and emergency preparedness. The Pastors’ Council has held several local conferences that now include health as a major topic -- how health issues impact both the pastors and their congregations. The pastors then share strategies and ways to bring classes and other resources to their churches – including mini clinics, diabetes prevention, aerobic classes, nutrition classes, urban gardening, emergency preparedness, support groups and much more. UHO serves as a point of contact to connect churches with partners who can supply many of these services.

UNITED HEALTH ORGANIZATION PHOTOS

Pastor at New Calvary getting Blood pressure before flu shot

Waiting for flu shot

New Cavalry Health Fair and Flu Clinic

Flu clinic at Citadel Church

Discussion on immunizations

ACA Education

Healthy Cooking demo

Henry Ford Community Nurse Network Training

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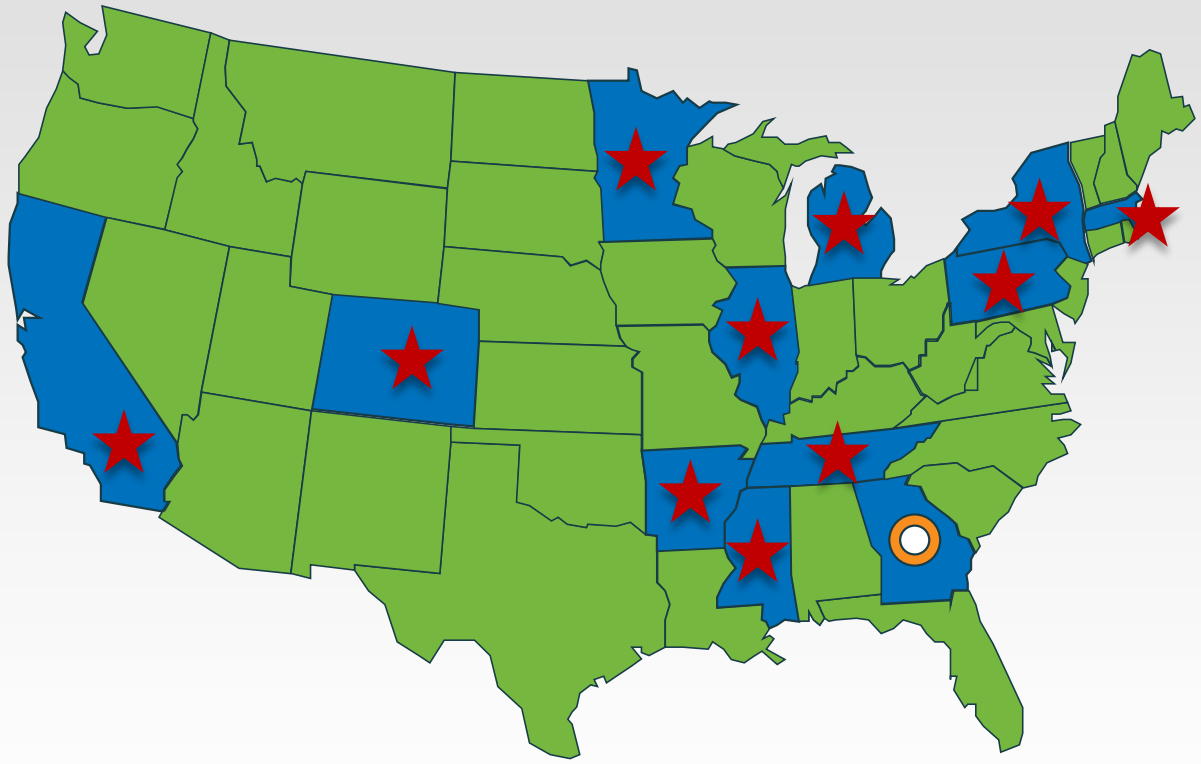
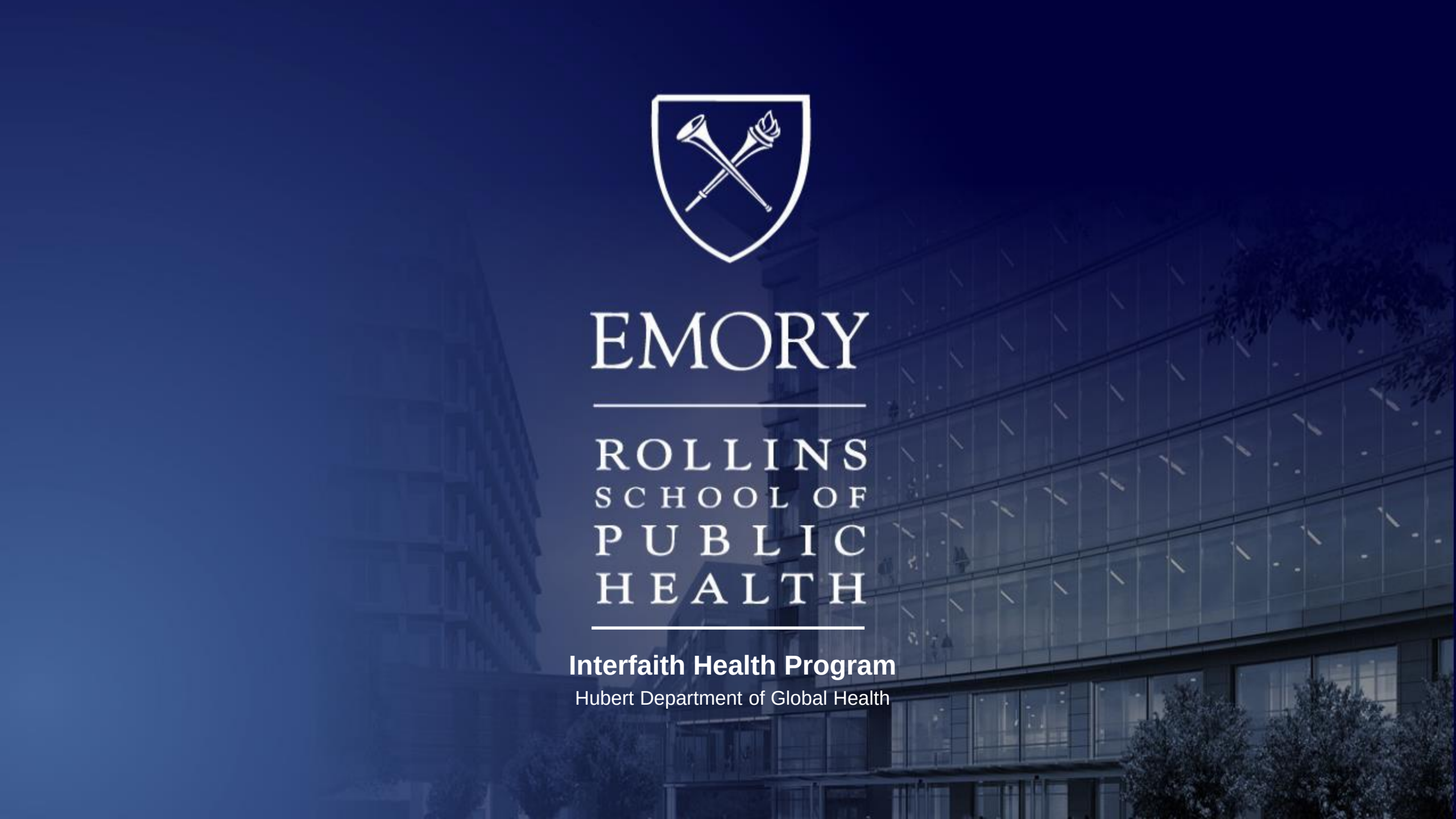
QUESTIONS FOR DISCUSSION

1. What more would you like to know about this site's work?

2. UHO, like other organizations in this network, functions as an intermediary that acts as a conduit across organizations and relationships to ensure health resources are distributed more equitably. Your organization is free standing and embedded in the community. Is this an advantage? How does public health recognize and support the UHO's in its communities?





EMORY

ROLLINS SCHOOL OF PUBLIC HEALTH

Interfaith Health Program

Hubert Department of Global Health

Faith-Based and Public Health Partnerships: Trusted Community Networks

Roundtable on Health Literacy Workshop Mimi Kiser
March 15, 2017
Emory University, Rollins School of Public Health

Presentation Objectives

1) Provide background information about a project that has demonstrated “reach” with influenza prevention services to vulnerable populations in community settings
2) Describe a “model practices” discovery methodology that was used to identify distinctive capacities of “reach”
3) Describe the characteristics of this “reach” that bridges cultural, mis-trust, low-income, and geographical barriers
   - Trusted networks and relationships
   - Flexible, adaptive organizational capacity
   - Language and cultural meaning-making

PROJECT GOAL AND HISTORY: 2009-Present

To build and mobilize capacity within networks of faith-based and community organizations linked with public health to extend their reach to vulnerable, at-risk, and minority populations for improving influenza vaccination outreach and uptake

Built on:

- IHP/Emory with CDC (‘01 to ‘07) trained 78 teams of religious and public health leaders in 24 states to collaborate on eliminating health disparities

- HHS’ Center for Faith-Based and Neighborhood Partnerships work with IHP/Emory and 9 sites during 2009 H1N1

TEN UNIQUE MULTI-SECTOR SITES

- **Arkansas**
  Arkansas Department of Health
- **Chicago, IL**
  Center for Faith and Community Health Transformation (Advocate Health Care and UIC)
- **Colorado Springs, CO**
  Penrose-St. Francis Health Mission
- **Detroit, MI**
  United Health Organization
- **Los Angeles, CA**
  Buddhist Tzu Chi Foundation
- **Lowell, MA**
  Lowell Community Health Center
- **Memphis, TN**
  Methodist LeBonheur Center of Excellence in Faith and Health
- **Minnesota**
  Minnesota Immunization Networking Initiative (MINI)
- **New York City, NY**
  South Brooklyn Interfaith Coalition (NYU Lutheran Health Care)
- **Pennsylvania**
  Schuylkill County's VISION

I. CUMMULATIVE VACCINATION IMPACT

Impact	2009–10	2010–11	2011–12	2012-13	2013-14	2014-15	2015-16
Vaccination Reach (persons)	78,708 (with partners)	13,686	15,103	16,381	19,430	13,092	15,347
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II. Education and Outreach 2015 - 2016

- Adapted evidence-based educational tools for hard to reach populations
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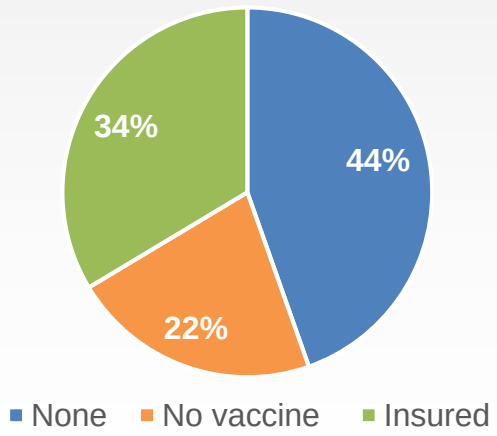
- Reached low income, uninsured, and minority populations

Insurance Coverage 2015-16



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TRENDS

Attitude and Behavior Survey: Convenience sample survey data over the past five years.
N = 1600 – 2800. The first question asks why they choose the MINI clinic and to check all that apply:

	2011-12	2012-13	2013-14	2014-15	2015-16
No health insurance	55.5%	45.2%	40.9%	30.4%	32%
No regular doctor	19.2%	15.1%	13%	13.6%	13%
Shots provided free	65.8%	51%	48%	49.6%	52%
Trusted place/setting	42.5%	28.3%	26%	24.9%	26%
Convenience	16.3%	19.6%	22.2%	46.1%	46%
Interpreters	23%	12.1%	13.6%	9.1%	12%

Trends show a decrease in those saying they are without health insurance and a marked increase in those saying they are there because it is convenient. The fact that the shots are free are still a huge draw with over 50% saying that is the reason for choosing the MINI clinic. We see a small uptick in 2015-2016 in the “No health insurance” category and in the “free shot” reason. This could be due to some new clinics this season where the largest percentage served was uninsured. — Results from MN Immunization Networking Initiative (MINI)

Model Practice Framework Development: METHODOLOGY

A practice based discovery process using a modified Delphi technique to synthesize distinctive elements from across 10 sites.

- Document review and thematic analysis
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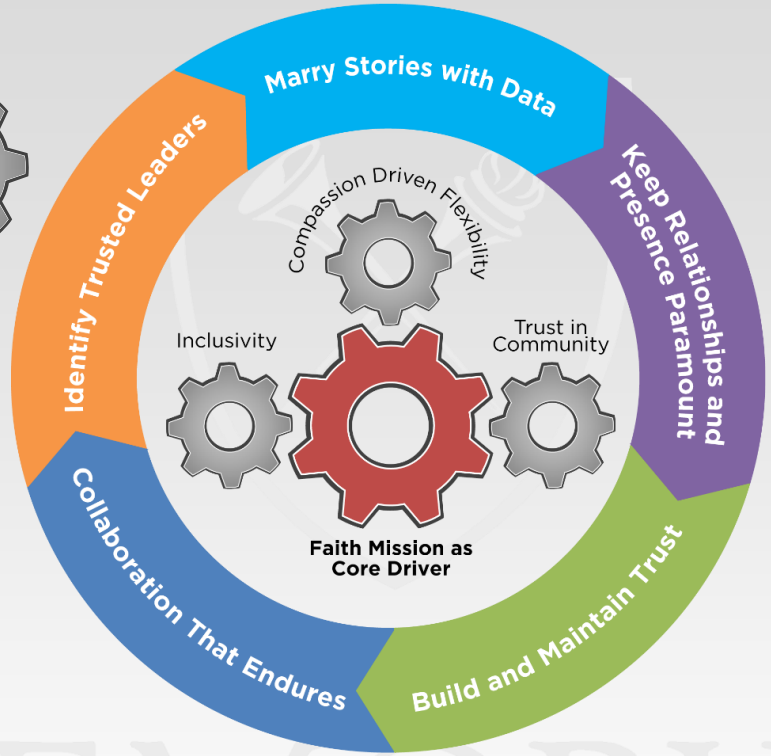
MODEL PRACTICES FRAMEWORK

Compassion Driven Flexibility

Identify Trusted Leaders



Trust in Community

Build and Maintain Trust

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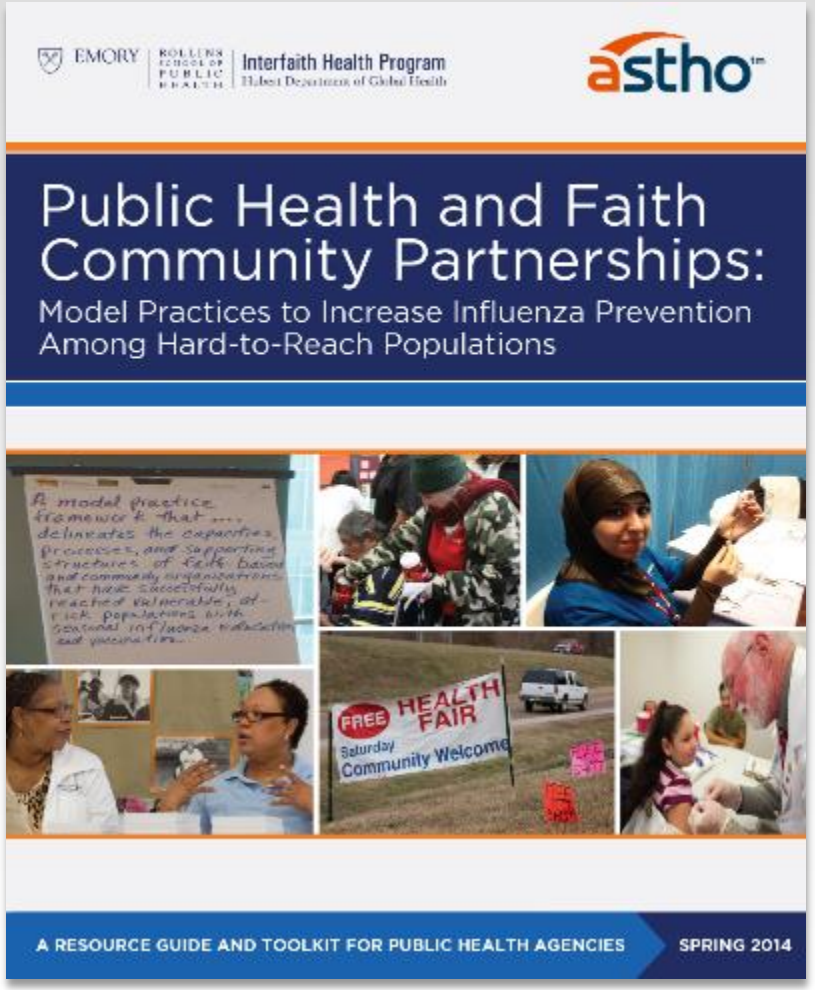
THE TOOLKIT: MODEL PRACTICES FRAMEWORK



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- The Network
- The Fourteen Practices

Buddhist Tzu Chi Medical Foundation: *Compassion Driven Flexibility*

Definition: There is an unwavering commitment to find a way to serve the community that may risk or go beyond self interest.

How does one recognize and build this?

- An enduring and imaginative creative ability to see new resources, push the boundaries of convention, and think outside the box is evident.
- There is a willingness to let go, reframe objectives, and find different solutions to new issues that arise in the face of changing policy or structural barriers.

To address the needs of hard to reach populations, Buddhist Tzu Chi Medical Foundation has built itself to be agile for work when and wherever people are best served.

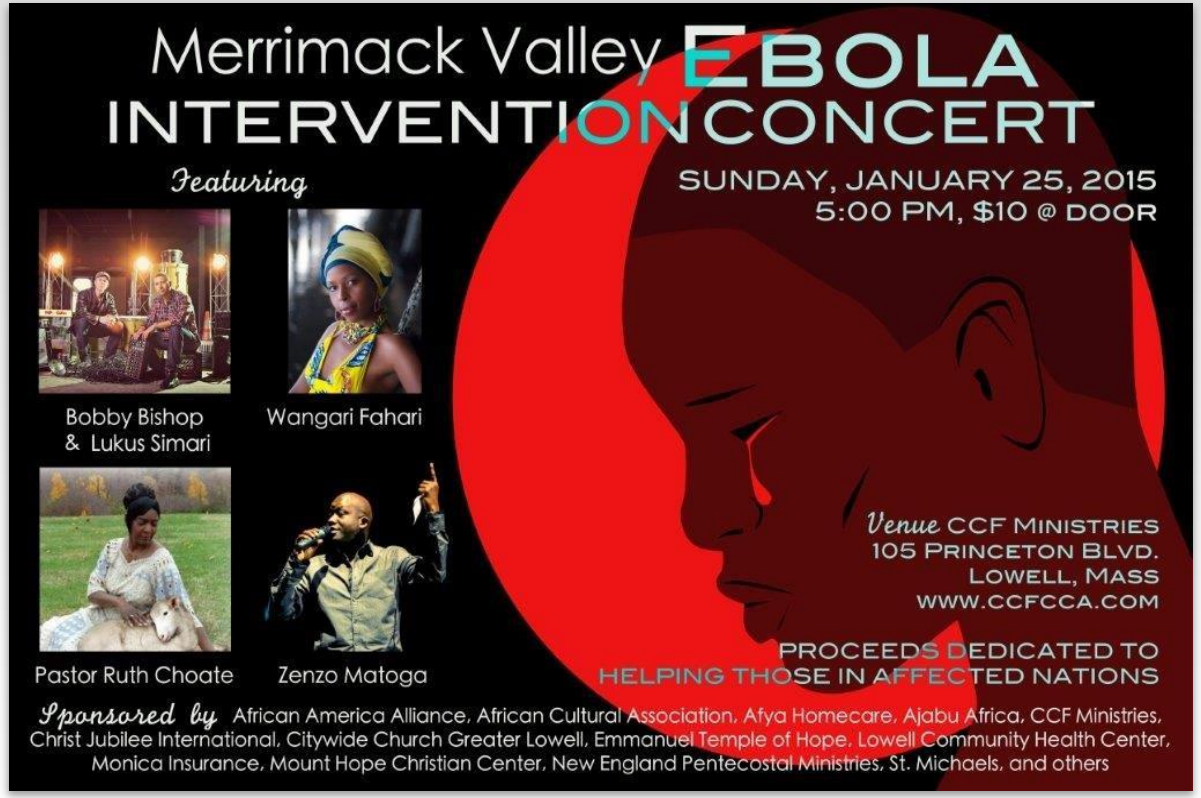
Lowell Community Health Center: *Build and Maintain Trust*

Definition: Trust is primarily relational. It is built over time when respect for differences, commitment to the good of the community, integrity, and transparency are experienced consistently in the face of challenging collaborative endeavors.

The Lowell Community Health Center has a long history of responding to the needs of immigrant communities and making institutional adjustments to respond effectively to their needs.

- Metta Health Center - a meditation room in the LCHC created in partnership with a local Buddhist Center
- A strong outreach relationship to a network of African churches
- Staff who represent the ethnicity and culture of those they serve
- A community health worker program adapted to different ethnic populations

Lowell Community Health Center



Chicago: Center for Faith and Community Health Transformation – *Identify Trusted Leaders*

Case Example:
Our strong and large partnership network has a unique communication capacity with trusted messengers and translated, accessible, whole person health information. We collaborated with one of our partners, the Council of Islamic Organizations of Greater Chicago, on the development of a flu prevention message that is framed by the commitments and theological perspectives of their faith tradition. It was distributed through their e-newsletter that has a reach of more than 9,000 readers.

FAITHFULLY PREVENT THE FLU
Purity and cleanliness is central to Islam. During each flu season, the vulnerabilities to great suffering, including potential hospitalization and death, remind us that our spiritual journeys demand attention to the messy world around us. Vast disparities in health conditions and access to health care resources result in vulnerable populations' disproportionate suffering.

Chicago: Center for Faith and Community Health Transformation – *Identify Trusted Leaders*

The Center for Faith and Community Health Transformation

Diverse Spiritual Leaders Encourage Flu Prevention

- Diverse Spiritual Leaders Encourage Flu Prevention
- Flyers, Posters and Guides
- Host a Free Flu Clinic
- National Flu Prevention Resources and Initiatives
- Regional Public Health Leaders Committed to Flu Prevention
- Resources for Faith and Values-Oriented Flu Prevention

Diverse Spiritual Leaders Encourage Flu Prevention

Spiritual leaders are trusted messengers about healthy and responsible lifestyles which minimize suffering for individuals and community. Here are examples of local leaders reaching out to their members with messages to reduce fear and encourage actions for flu prevention.

Arabic

Imam Kifah Mustapha, Mosque Foundation, Bridgeview, Illinois

Minnesota Immunization Network Initiative (MINI)

Definition: Trust is primarily relational. It is built over time when respect for differences, commitment to the good of the community, integrity, and transparency are experienced consistently in the face of challenging collaborative endeavors.

Fairview Health Services has been a partner with the MN Dept. of Health and a network of core partners who together reach diverse ethnic immigrants with partners and in settings such as – Churches, Mosques, a Hindu temple, Sikh, Buddhist Monastery and Temple, Burmese Baptist Church, Tibetan Foundation, Somali Mall, Hmong Flea Market, homeless shelters, ESL Centers, child care centers, food pantries, and the Mexican Consulate.

- Vaccinate 7 to 9,000 persons a year during an average of 100 events
- Hold clinics at the invitation of the host site
- Are well staffed with trained volunteers to “go there” on weekends, etc.
- Have extensive translation processes

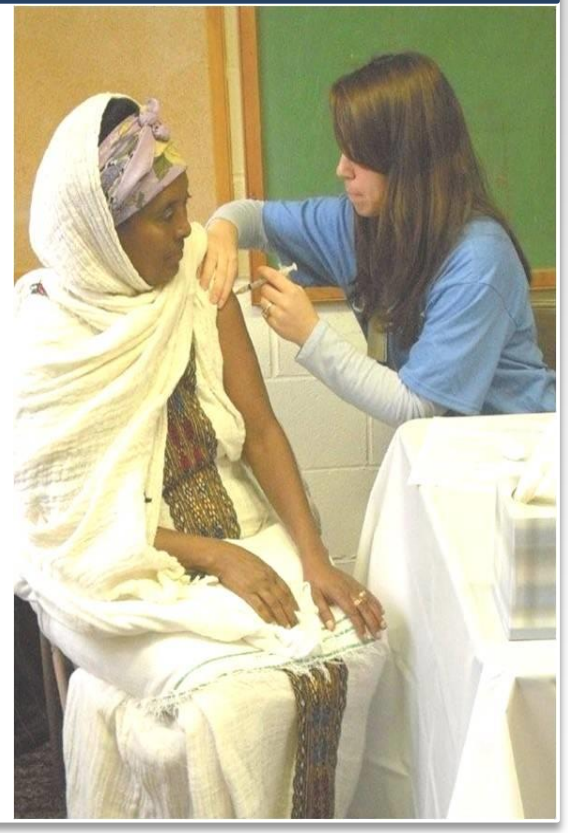
Minnesota Immunization Network Initiative (MINI)

Diverse Ethnicities

- African American
- Caucasian
- Native American
- Hispanic
- Burmese
- Vietnamese
- Cambodian
- Laotian
- Chinese
- Bosnian
- Iraqis
- Africans
- Ghanaian
- Nigerian
- Cameroonian
- Somali
- Kenyans
- South Asians

Diverse Religious Traditions

- Buddhist
- Muslim
- Hindu
- Catholic
- Lutheran
- Presbyterian
- Evangelical Free
- Christian Reformed
- Episcopal
- Baptist
- Methodist
- UCC/UUA



Summary – Key Points

Trusted and accessible messages outside of the health care system are often transmitted through ….

- Trusted networks and relationships
- Partners who have flexible, adaptive organizational capacity
- And those who deliver messages in a language and with relevant cultural meaning.

Most communities have leaders with relationships and the kinds of commitments that can leverage connections and social capital resources for the well-being and health of all.

Thank you

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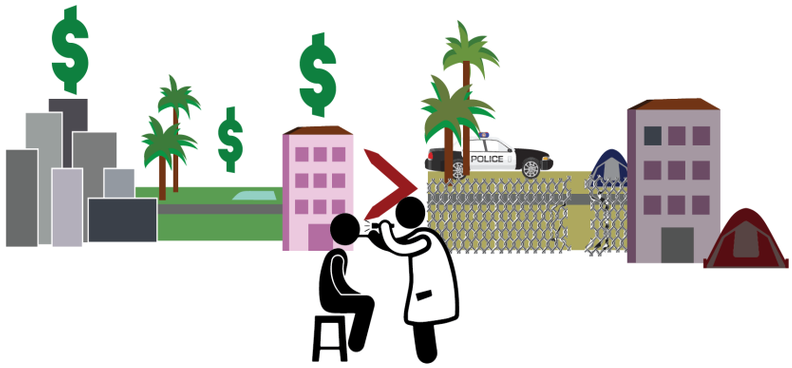

FAITH – HEALTH COLLABORATION

to advance the social determinants of health

The University Muslim Medical Association (UMMA) Community Clinic is the first Muslim - founded Federally Qualified Health Center (FQHC) in the country with a mission to provide high-quality healthcare services to those in need, regardless of their ability to pay. Their services, activities and governance are reflected by the Islamic values and moral principles which inspired the founding of the Clinic. ***These core values of service, compassion, human dignity, social justice, and ethical conduct are used to help, in partnership with the community, address the problems of caring for the overall wellness of the South Los Angeles community.***

GREAT PARTNERSHIPS = GREAT IMPACT

Opioid Addiction, Treatment and Prevention - HRSA AIMS & The Matrix Institute
Chronic Disease Management Classes -
Women's Health - Susan G. Komen Foundation & F* Cancer
Student Education - UCLA, Charles Drew University, Pacific Oaks College & USC
Behavioral Health - Weber Community Center
Resources for Mothers - Baby 2 Baby
Humanitarian Day - ILM Foundation

FEATURED PROGRAM:

Black Visions of Wellness (BVOW)

Program Start: 2012 **Participants:** 350+

It takes a village, or in our experience, a community to create robust programs with lasting impact.

With three lead organizations and 6+ additional partners, the Black Visions of Wellness (BVOW) Program provides mental and physical health services designed to encourage healthy growth and development in underserved African/ African American communities. BVOW utilizes an Afri-can-centered philosophy of treatment and education to promote wellness and rally resources in the interest of health initiatives, cultural recognition, educational reinforcement, family building and community revitalization.

Key Partners:
Weber Community Center & LA Dept. of Mental Health

Additional Community Partners:

- **Nurturing Chefs LA** - Healthy Cooking Classes
- **West Coast Sports and Fitness** – Acupuncture, Massage Therapy, Chiropractic Care, Personal Fitness
- **Westchester Wellness** – Acupuncture/ Acupressure
- **South Central Fitness Art and Dance** - Zumba
- **Extreme Boot Camp** – Tai Chi , Boot Camp Classes
- **House of Fruition** – Art Therapy
- **YMCA** - Memberships

Learn more:
www.UMMAClinic.org
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Healthcare for all, inspired by Islam

FAITH – HEALTH COLLABORATION

to advance the social determinants of health

The University Muslim Medical Association (UMMA) Community Clinic is the first Muslim - founded Federally Qualified Health Center (FQHC) in the country with a mission to provide high-quality healthcare services to those in need, regardless of their ability to pay. Their services, activities and governance are reflected by the Islamic values and moral principles which inspired the founding of the Clinic. ***These core values of service, compassion, human dignity, social justice, and ethical conduct are used to help, in partnership with the community, address the problems of caring for the overall wellness of the South Los Angeles community.***

GREAT PARTNERSHIPS = GREAT IMPACT

Opioid Addiction, Treatment and Prevention - HRSA AIMS & The Matrix Institute
Chronic Disease Management Classes -
Women's Health - Susan G. Komen Foundation & F* Cancer
Student Education - UCLA, Charles Drew University, Pacific Oaks College & USC
Behavioral Health - Weber Community Center
Resources for Mothers - Baby 2 Baby
Humanitarian Day - ILM Foundation

FEATURED PROGRAM:

Fremont Wellness Center, Community Garden & Greenhouse

Site Grand Opening: 2013

Food does not come from a box. In the food desert where roughly 1/3rd of residents suffer from diabetes, hypertension and/or obesity, we're partnering with community organizations to **make healthy lifestyles accessible to all**.

The Fremont Wellness Center and Community Garden site was created to increase accessibility to safe green space, to high-quality, culturally sensitive and affordable health-care services, and fresh fruit and vegetables. We strive to improve health outcomes, empower people of all ages, and create a healthier, safer and stronger community.

Key Partners:
Los Angeles Unified School District
Los Angeles Neighborhood Land Trust
The LA Trust for Childrens Health
Food Forward Los Angeles

Site includes:

- Wellness Center with separate community & student entrances, offering physical & behavioral health services
- Community Garden
- Orchard
- Park with picnic area
- State of the art Greenhouse
- Raised planters for student use and learning
- Biweekly Free Food Market - distributing 1600 lbs of fresh produce per market

Programs:

- **Student Health Leaders** - Local High Schoolers are trained & mentored on how to be peer health advocates.
- **Garden Apprenticeship Program** – High School students learn how to create a sustainable

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