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The role of the Chilhowee Baptist faith community in healthcare : an association-wide study of member perspectives

Lisa D. Van Camp

To the Graduate Council:

I am submitting herewith a thesis written by Lisa D. Van Camp entitled "The role of the Chilhowee Baptist faith community in healthcare : an association-wide study of member perspectives." I have examined the final electronic copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Health Promotion and Health Education.

Paula Carney, Major Professor

We have read this thesis and recommend its acceptance:

Accepted for the Council:
Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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Dr. Paula Carney, Major Professor

We have read this thesis
and recommend its acceptance:

Dr. June Gorski

Dr. Susan Smith

Accepted for the Council:

Vice Provost and Dean of
Graduate Studies

THE ROLE OF THE CHILHOWEE BAPTIST FAITH COMMUNITY IN HEALTHCARE: AN ASSOCIATION-WIDE STUDY OF MEMBER PERSPECTIVES

A Thesis
Presented for the
Master of Science Degree
The University of Tennessee, Knoxville

Lisa D. Van Camp
August 2003

DEDICATION

This thesis is dedicated to:

My husband,
Michael C. Van Camp

and

My children,
Marc and Ashley Webb

for providing me with
encouragement and support
throughout my educational career

and

In loving memory of:

My grandmother,
Mary Ella Jenkins

the most Christ-like individual I have ever known;
for openly sharing her faith and belief in Christ and
for modeling His love and compassion to all people.

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I am grateful to Kelly Campbell and Jim Snyder of the Chilhowee Baptist Association for their willingness to participate in this study. I appreciate their ongoing encouragement and support for creating a health ministry to serve members of the association and the community at large. My deepest appreciation is extended to the participating churches for completing the surveys to make this study possible.

Next, I want to recognize my nursing role model - my Aunt Wanda (Jenkins) Willett. As a child, I wanted to be just like her. I could hardly wait for her to come home so I could wear her nursing cap and pretend to be a nurse. While I will never fill her nursing shoes, I am forever thankful for her love and encouragement as I pursued my academic career goals in nursing and health education.

Finally, I want to acknowledge my family and friends who sacrificed countless hours without me while I sat in front of my computer and attended evening classes. Thank you for your support and encouragement but most of all, thank you for loving me through this long endeavor. I have missed you…it is over now; we can be a family again.

ABSTRACT

The United States has documented a strong 30-year history in regards to health promotion and health education. National health leaders recognize that individuals must accept greater responsibility for their own health before improvements in community health can be achieved. The focus on collaboration and partnering between healthcare providers and community organizations is essential for health promotion. Religion has played a role in health promotion by advocating for personal health and accepting responsibility for improving the health of others. Thus, faith-based health organizations provide an excellent venue for offering health programs. As a result of this new awareness, community leaders have initiated grassroots projects to identify local health needs. Blount County, Tennessee provides a strong faith-based organization and a public health infrastructure for community diagnosis. The Blount County Community Diagnosis Status Report of 1999 claims faith-based organizations are a valid option for addressing local health needs.

The purpose of this study was to determine the role of the Chilhowee Baptist faith community in healthcare by analyzing the member's perceptions of health issues such as: promoting better personal health, managing medical health problems, coping with family/life changes, and addressing mental health. The study was designed to examine if the size of the congregation or the member's demographic characteristics impact their perceptions regarding the level of involvement or the focus of responsibility in the four health issues.

A closed-form questionnaire was designed to elicit anonymous responses regarding the level of involvement and focus of responsibility for health issues within the Chilhowee Baptist Association. The survey instrument used for this study categorized focus areas from Healthy People 2010 into four sections: personal health, medical health problems to include acute and chronic illnesses, coping and emotional health, and finally, mental health. The survey was field-tested by members of the Knoxville and Sweetwater Baptist Associations prior to distribution to the Chilhowee Baptist Association.

The participants completed a survey designed to elicit perceptions on two health-related questions: 1) to what extent should the Baptist faith community be involved in promoting better personal health, managing medical health problems, coping with family/life changes, and addressing mental health, and 2) who should be responsible for addressing these health issues. Participants were selected by a convenience sample as pastors of the Chilhowee Baptist Association volunteered to participate in the study. A total of 500 surveys were distributed among small (<250 members) and large (≥ 251 members) churches. Either the pastor or an alternate member of the congregation administered surveys. Only adult members participated in the research and anonymity was maintained throughout the study. The overall response rate was 61.6% with small churches providing 53.9% of the returned surveys and 46.1% of the responses represent large churches. The majority (57.8%) of responses came from regular church members as opposed to pastors, teachers, deacons, or other church staff. Most (73.7%) respondents have been involved in church for over 20 years. More females (58.8%) participated than did men (38.6%). All age categories from 18 to over 65 years of age were represented in

the study; however, only 33.2% were aged 18 - 44 years while 66.2% of participants were aged 45 years and greater.

Survey responses indicated how the participants perceived the role of the Baptist faith community in healthcare based on church size, participant's age, and the number of years participant has been involved in church. There was no difference in reported level of involvement for promoting better personal health, managing medical health problems, coping with family/life changes, and addressing mental health based on church size and number of years member has been involved in church. Members of small churches indicated a significantly greater interest in shared responsibility between the individual church and the Baptist Association for managing medical health problems and addressing mental health than members of large churches. Members involved in church 21 or more years indicated a greater interest in shared responsibility for addressing mental health issues. Participants aged 18 - 44 years perceived a higher level of involvement for coping with family/life changes; yet age did not factor into the focus of responsibility. Further statistical analysis indicated a commonality among all the health issues. Most participants indicated a need to be involved in promoting better personal health, managing medical health problems, coping with family/life changes, and addressing mental health and the majority favored a shared responsibility between the individual church and Baptist association.

Results enable the Chilhowee Baptist Association to address the health issues identified through this study, particularly addressing mental health and coping with family/life changes.

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CHAPTER I

INTRODUCTION

As the United States of America continues to focus on health promotion and disease prevention, faith communities provide an ideal setting to promote health programs. The United States government has traditionally provided financial support for a variety of community health-related programs but health programs associated with religious organizations have been excluded. National health leaders now recognize that individuals must accept greater responsibility for their own health before improvements in community health can be achieved. New opportunities for faith-based programs were cultivated with President Bush's mandate for the Office on Faith-Based and Community Initiatives in January 2001. As a result of this national agenda, community leaders initiated grassroots projects to identify local health needs. Opportunities for faith-based organizations to rally round community health needs have been enhanced by the initial efforts to redefine the role of the faith community in healthcare.

The changing circumstances of health care requires a fresh look at how faith-based organizations can minister healing through affiliations with other providers. According to Princeton Religious Research Center, 43 percent of adults indicated they attend worship services at least once a week and 69 percent of adults claim church membership (Princeton Religious Research Center [Princeton], 1994). The congregational setting is an ideal place to integrate faith and health; members are receptive to both teaching and healing ministries. Ray Fur, personal fitness trainer and head of the Southern Baptist Annuity Board commented, "Christian people ought to be

leading the way in healthy living" (Jones, 2003). Because of the high degree of community trust, faith-based organizations can be very successful in reaching out to individuals and families by providing education, on-site services, and referrals to community health providers. No matter how large the organization, any community health effort is best approached at the local level. It is necessary to collaborate with people from the community to validate health concerns; to plan with, and not for, the community; and to gain support for program implementation (Smith & Maurer, 2000). A church can foster ongoing successes in the provision of holistic healthcare and health promotion by nurturing relationships with both professional and lay members of the congregation and the community. Thus, a community level religious organization provides an excellent venue to address a faith-based approach to community health needs. Blount County, Tennessee is one community that provides a strong faith-based organization and a public health infrastructure for community diagnosis.

Key leaders and community stakeholders have worked to identify and prioritize health needs within Blount County, Tennessee since the inception of a statewide community diagnosis program in 1996. The vision statement cited in the Blount County Community Diagnosis Status Report is guided by the belief that health is reflected by personal responsibilities, education, safety, accessible medical care, religious involvement, recreation opportunities, balance, and life skills (East Tennessee Regional Health Office [ETRHO], 1999). Thus, Blount County leaders recognized faith-based organizations are a valid option for addressing local health needs.

Faith and health are topics receiving increased attention within government agencies, healthcare organizations, and religious institutions as evidenced by the

numerous studies focused on the interconnectedness of health with prayer, spirituality, and faith. However, few, if any, specifically address the role of the Baptist faith community in healthcare, particularly at the local level. The remainder of this chapter will discuss the purpose of this research study, identify specific questions, basic assumptions, delimitations, limitations, and will provide a list of operational definitions used throughout the study.

Purpose of the Study

The purpose of this study was to determine the role of the Chilhowee Baptist faith community in healthcare by analyzing the member's perceptions of particular health issues. The level of responsibility between the individual church and the local Baptist association was assessed along with the extent in which member's perceived the Baptist faith community should be involved in health issues such as:

- Promoting better personal health: adolescent health, dental care, exercise, men's health, nutrition, stop smoking, weight control, and women's health
- Managing medical health problems: AIDS, arthritis, cancer, chronic illness, heart disease, high blood pressure, lung disease, managing medications, stroke, and vision
- Coping with family/life changes: aging parents, divorce, domestic violence, living wills/power of attorney, parenting, pregnancy, and unemployment
- Addressing mental health issues: anxiety, co-dependency, depression, eating disorders, grief/loss, stress, substance abuse, and suicide

The study was designed to examine if the size of the congregation or the member's demographic characteristics impact their perceptions regarding particular health issues.

Research Questions

The following research questions were developed to address the purpose of the study:

1. Is there a significant difference between large and a small church in member's perceived level of involvement in: personal health, medical health problems, family/life changes, or mental health?
2. Is there a significant difference between large and a small church in member's perceived focus of responsibility in: personal health, medical health problems, family/life changes, or mental health?
3. Is there a significant difference among age groups of member's perceived level of involvement in: personal health, medical health problems, family/life changes, or mental health?
4. Is there a significant difference among age groups of member's perceived focus of responsibility in: personal health, medical health problems, family/life changes, or mental health?
5. Does the number of years a member is involved in church affect their perceived level of involvement in: personal health, medical health problems, family/life changes, or mental health?

6. Does the number of years a member is involved in church affect their perceived focus of responsibility in: personal health, medical health problems, family/life changes, or mental health?
7. Is there a significant difference in the focus of responsibility for health issues: personal health, medical health problems, family/life changes, or mental health?

Assumptions

The basic assumptions made regarding this study were:

1. The instrument accurately measured the extent in which the Baptist faith community should be involved in healthcare according to church members affiliated with the Chilhowee Baptist Association. The instrument was valid and reliable.
2. The method used to select the sample group resulted in a representative sample of the Chilhowee Baptist Association members who regularly attend services.
3. The respondents answered the questions honestly.

Delimitations

For the purpose of this study the following delimitations were formulated.

1. This study was delimited to the population of the Chilhowee Baptist Association in the geographic area of Blount County, Tennessee.
2. This study was delimited to the Baptist faith community.

Limitations

1. The convenience sample may have limited generalizability of findings to other populations.

Definitions of Terms

This section operationally defines the terms used in this study.

1. Chilhowee Baptist Association (CBA) - an affiliation of the Tennessee Baptist Convention comprised of 84 churches located in Blount County, Tennessee. Association responsibilities include mission ministry opportunities, evangelism training, and administrative responsibilities for special programs and mission funds.
2. Blount County Community Diagnosis - a community-based, community-owned process to identify and address health needs; a health assessment and planning process involving: analyzing the health status of the community; evaluating the health resources, services, and systems of care within the community; assessing attitudes toward community health services and issues; identifying priorities, establishing goals, and determining course of action to improve the health status of the community; and establishing a baseline for measuring improvement over time.
3. Health ministry - health-related activities provided through a faith-based organization; a way for churches to promote health and wellness while serving their members.
4. Healthy People 2010 - a document of national health objectives designed to identify the most significant preventable threats to health and to establish goals to reduce the threats.

5. Large church / congregation - for the purpose of this study, the following operational definition was used: more than 250 members recorded on the Chilhowee Baptist Association Statistics Report for 2002: Sunday school average weekly attendance.
6. Small church / congregation - for the purpose of this study, the following operational definition was used: less than 251 members recorded on the Chilhowee Baptist Association Statistics Report for 2002: Sunday school average attendance.
7. Southern Baptist Convention (SBC) - an organization founded in 1845; works through local associations and state conventions sharing a common bond of basic Biblical beliefs and a commitment to proclaim the Gospel of Jesus Christ to the entire world. The priority is evangelism and is consistent with strong social ministries, including medical care, emergency famine relief, water projects and agricultural assistance.
8. Tennessee Baptist Convention (TBC) - an affiliation of the Southern Baptist Convention having administrative responsibilities for 68 associations in Tennessee.

Summary

The national focus on health and faith has spurred many new community health programs in recent years; many of them sponsored through religious organizations. Blount County, Tennessee completed the community diagnosis project in 1998, recognizing a role for faith-based involvement in health promotion and health education. Leaders within the Chilhowee Baptist Association agreed to participate in this research study to examine the role of the Baptist faith community in healthcare by analyzing member's perceptions of particular health issues. The research focused on the extent in

which the individual church or the Baptist association should be involved in health-related issues such as: promoting better personal health, managing medical health problems, coping with family/life changes, and addressing mental health.

CHAPTER II

REVIEW OF LITERATURE

Introduction

This chapter presents a review of the literature relevant to faith-based health care, health policies, and the role of the Baptist faith community in health. First, the literature review addresses the overall relationship between faith and health. It addresses faith-based health care in the United States by reviewing the history of national policy agendas for health promotion, the frameworks of Healthy People 2010 and Community Diagnosis, and the current administration's health policy agenda. These frameworks provide the rationale for the survey conducted in this research study. Finally, the literature review will examine the role of the Baptist faith community in international, national, state, and community health promotion projects.

Faith - Health Relationship

The early church was closely connected to healing but surrendered the ministry to the influence of science as time progressed. Janice Striepe, R.N., Parish Nurse and author of "Reclaiming the Church's Healing Role", gives the following historical account of how the church lost and regained the ministry of healing. As early as the fifth century, St. Augustine began impressing upon the people that healing ministries should be the exception and not the rule. During the Dark and Middle Ages (A.D. 590-1517), the church held a negative attitude toward medicine and healing was a forgotten service. The Reformation (A.D. 1517-1648) resulted in even less interest in healing. The Renaissance

movement (A.D. 1648-1789) destroyed Christian healing; while embellishing science and rational thinking, spirituality was ignored. During the 1800s, the Pentecostal churches began to reclaim healing ministries; other denominations were quick to follow. The twentieth century forged new ground, re-establishing the foundation for a relationship between faith and health (Striepe, 1993). The literature addressing health and faith or science and religion were merely non-existent in the 1970s - 80s; but a vast array of books now fill the shelves. Religious figures have articulated the interconnectedness of faith and health in a variety of ways:

- In the 1940s, William Branham, a Baptist minister, toured the United States and Europe with a healing focus (Striepe, 1993).
- In the 1960s, the Episcopal Church established a ministry of healing (Striepe, 1993).
- In 1962, Kathryn Kuhlman published a book "I Believe in Miracles" and the Vatican II opened the door to develop ministries of healing (Striepe, 1993).
- The 1970s brought wholistic health centers that were family doctors' offices in churches (Striepe, 1993).
- In the 1984, Rev. Granger Westberg created the first institutional-based, salaried, parish nurse program in conjunction with the Lutheran General Hospital (Westberg, n. d.).
- In 1997, the American Nurses Association recognized Parish Nursing as a viable specialty and set forth a Scope and Standards of Practice in 1998 (American Nurses Association [ANA], 2002).

Churches are being challenged to rediscover their commitment to health and healing. Doctors, nurses, and pastors have embraced the concept that faith does affect health; and they no longer accept the distinction between physical and spiritual care - a concept that once alienated the church from the healing ministry. Gary Gunderson, director of the Interfaith Health Program of the Rollins School of Public Health at Emory University stated, "we're seeing a new generation of health-care science...the public health priority is shifting to an emphasis on prevention" (Swanson, 2003). Gunderson also noted, "the role of the church in health ministries is not a recent concept...what has changed is the science and intentional training that goes along with that role" (Swanson, 2003).

A strong faith-based religion promotes individual responsibility for health and may even regulate behaviors that improve health. In the context of improving individual health and community health promotion, Thomas Droege, Associate Director of the Interfaith Health Program and author of Congregations as Communities of Health and Healing, stated, "This is a spiritual problem calling for changes in behavior, not a medical problem calling for scientific breakthrough" (Droege, 1995). As more people begin to embrace Droege's belief, the positive effects of faith-based health care can be celebrated.

Studies analyzing religious practice and health have affirmed the positive effect of religious belief and practice on health issues for half a century. The literature dating back to the 1980s supported the hypothesis that the church and religious leaders should deliver health behavior-change/wellness-programs to congregations and to the entire community by recognizing their motivating forces (Miller, 1987). The following

excerpts from the literature examine the association between faith and health from spiritual, physical, and intellectual perspectives.

Emotional and spiritual concerns often complicate health issues. The client and family needs typically involve issues that address difficult lifestyle changes. E. M. Pattison concluded from the 1955 National Mental Health Study that clergy were on the front line of contact with people in emotional distress. Clergy and members of the congregation are in a position to uniquely provide a number of major services relevant to both the care of the mentally ill and the promotion of mental health (Pattison, 1970, chap. 1). More recent studies addressing medical health show lower blood pressure levels have been correlated with church attendance and 80% of the psychiatric research on religion and health shows that religious belief is highly beneficial (Carson & Koenig, 2002). Research supports the relationship between faith and health; but one question asks, "should this be a faith-based ministry or left to the traditional healthcare team?"

Laurel A. Burton, Academic Dean and Professor of Pastoral Studies at The Methodist Theological School in Ohio (as cited in Carson & Koenig, 2002) acknowledged, the concept of holistic care - treating the whole person in, body, mind, and spirit is familiar to health professionals but is not a subject often taught in seminary. Despite the ever-growing research linking religion and health, very few seminaries prepare pastors for the interrelatedness of health and faith. More medical and nursing schools deal with these issues than do seminaries. Therefore, to have a health ministry program available to pastors and members of the congregation is a vital witness that body, mind, and spirit are equally important to provide the care people need on a day-to-day basis.

Granger E. Westberg, author of The Parish Nurse: Providing a Minister of Health for Your Congregation, believed that a person needed motivation in order to make behavioral changes necessary for health promotion and disease prevention. Westberg hypothesized that a person's philosophy of on life, belief system, and faith stance could provide motivation for change. He stated, "Clergy are now more open to ideas related to health and wholeness because everything they have tried to say about the value of living a healthy, balanced life is now being verified and clarified by current research in the health sciences" (Westberg, 1990). A recent Gallup survey illustrates the latest perspective of faith, health, and spirituality.

According to a 2002 Gallup poll based on telephone interviews with 1,509 adults, 77% of Americans link faith to everyday life and believe the overall health of the nation depends on the spiritual health of the nation. The poll also found 76% of Christians agreed that all people, regardless of race, creed or wealth are loved by God and therefore they should love all - but only 44% said the notion that 'God calls me to be involved in the lives of the poor and suffering' applies to them (Banks, 2002). A joint research effort between the Gallup Organization and the Center for Research on Religion & Urban Civil Society resulted in a new national "spiritual index". The index has two components; one measures people's connection with God, and one looks at how they live out their commitment through service to others. George Gallup, Director of the International Institute said the index will "measure of faith as a change agent" (Banks, 2002). The researchers hope to announce the spiritual index annually as a gauge for America.

There are numerous models of faith-based health programs in the literature. The focus on collaboration and/or partnering between healthcare providers and community

organizations is essential for the success of faith-based health programs. Healthcare providers who want to make a difference in today's healthcare environment support the idea of collaboration - bringing the appropriate people together to develop visions and strategies (Princeton, 1994). The following programs show the diversity of involvement from government, healthcare, and religious institutions:

- The Bureau of Primary Health Care's (BPHC) Faith Partnership Initiative is a collaborative effort between federally funded community health centers and faith-based organizations to increase access to quality health care. The Bureau is actively pursuing relationships with new faith institutions to stimulate and build partnership networks with faith-based organizations. The following programs are examples of BPHC faith-based initiatives:
  - Health Care for the Homeless is a faith-based community health model that provides quality health care to homeless people each year. They often collaborate with other agencies to provide for substantial needs such as: food, emergency shelter, and transportation (BPHC, 2002).
  - Heart, Body, and Soul, Inc. is a partnership between clergy from over 250 area churches and the Johns Hopkins University Center for Health Promotion. They provide primary health care, health education, referral and case management services at churches, community centers, schools, clinics, shelters, in homes, and on the street (BPHC, 2002).
  - Health and Social Services Councils is a faith-based health care provider model and a network of black, faith-based organizations and community service institutions working together to address issues affecting access to

health care and social services. This project is a collaborative effort between Health and Social Services Council, Bureau of Primary Health Care, and the Congress of National Black Churches (BPHC, 2002).

- The Center for Congregational Health Ministry is a service provided by the Via Christi Health System in Wichita, Kansas. The Center has partnerships with many agencies and organizations and serves as a resource center to assist any congregation or faith community interested in providing a health/wellness ministry (Via Christi Health System [VCHS], 2002).
- Clinic and Parish (CAP) Nurse Project is a single organization managing parish nurses for multiple sites. This project began in 1992 with a pastor and a physician's vision to provide healthcare to the medically underserved in their community. Nurses work 14 hours per week in the clinic and 10 hours per week in their assigned parish. Funding for this program comes from individual donations, grants, and volunteer hours - over 1000 hours per year are donated by volunteer workers (Augustson, 2002).
- Inner City Health Center (ICHC) is listed as a "Best Practice" through the Christian Community Health Fellowship (CCHF). This initiative began in 1983 when two Family Practice physicians shared a vision of serving low-income and uninsured patients by volunteering 20 hours per week to the inner city practice. This ministry serves African-American, Hispanic, and the working poor in the Denver, Colorado area. Collaborative efforts with local churches, hospitals, and university student programs are instrumental in recruiting volunteers and student workers (Burleson & Williams, 2002).

Nurses are the glue that holds many of these programs together. Reverend Granger Westberg, a Lutheran minister, hospital chaplain, and medical school professor, believes nurses have the skills needed to bridge the gap between religion and health (McGee, 1998). The latest movement toward parish nursing within the United States is credited to the work of Rev. Westberg and now serves as the international model for parish nurse programs. Estimates of more than 3000 parish nurses are providing care in the United States (Trofino, Hughes, Obrien, & Marrinan, 2000). Parish nursing is health promotion and disease prevention with spiritual care as its hallmark (McDermott, Solari-Twadell &, Matheus, 1998). Each program is uniquely designed to meet the needs of the members it serves. The following examples demonstrate how parish nurses are engaging faith and health:

- Primary Care Parish Nursing Program is a collaborative effort between St. Joseph Hospital Medical Center, Seton Hall University faculty, and St. Agnes parish. The program utilizes master's prepared nurses for primary care and case management for congregation members in Paterson, New Jersey (Trofino et al., 2000; Hughes, Trofino, O'Brien, Mack &, Marrinan, 2001).
- Carondolet Parish Nurse Program branched into two separate programs in 1996 - Community-based Nurse Case Management and Community Health Centers. This wellness model of health promotion and illness identification serves the medically underserved of Tucson, Arizona. Three bi-lingual registered nurses and a family nurse practitioner provide primary care and case management services. The nurse case management works with high-risk clients who have multiple medical problems and frequent hospitalizations; they do not provide

skilled care. The parish nurse program originally began as the Community Health Center - developed to meet the needs of moderate-risk clients with multiple illnesses, but able to participate in community-based programs (Huggins, 1998).

- Immanuel St. Joseph Mayo Health System Parish Nurse Program was implemented to encourage registered nurses, as church members, to more intentionally help elderly parishioners in the South-Central, Minnesota area. "Nurses who have invested energy in efforts such as this are making it clear that community-based nursing has an invaluable contribution to make to the health care system of the future" (Rydholm, 1997).
- Christian Nurses Preventive Health Project (CNPHP), sponsored by Mt. Zion Missionary Baptist Church, was implemented in Peoria, Illinois to provide health promotion services to predominately African-American church congregations. Realizing health concerns are very personal and not freely discussed, African-American registered nurses were put in the position of parish nurse in an effort to promote greater trust and acceptance (Armmer & Humbles, 1995).

Organizing a faith-based community health program is not a simple task; it requires vision, dedication, and commitment. Having the support of national health leaders is of the utmost importance for policy development and enforcement. Leaders within the United States government have recognized the benefits of health promotion for over three decades but a more recent emphasis on the relationship of spirituality, faith, and health have surfaced on a national level.

Faith-based Healthcare in the United States

History of National Policy Agendas

As early as 1973, the United States government recognized the importance of health education, health promotion, and wellness. The creation of the President's Committee on Health Education was an important event to promote a nationwide emphasis on health education and to expand the government's role in developing, financing, and implementing health programs. The 1979 Surgeon General's report on health promotion entitled Healthy People and the 1980 report entitled Promoting Health, Preventing Disease: Objectives for the Nation significantly influenced health promotion in the United States. In 1980 the U. S. Government created a separate Department of Education within the Department of Health and Human Services to be responsible for health education and health promotion. In 1981, Objective for the Nation in Disease Prevention and Health Promotion was adopted as policy in the United States. Certification and credentialing standards were implemented in 1990. The Healthy People 2000: National Health Promotion and Disease Prevention Objectives along with Healthy Communities 2000: Model Standards were published in 1991 (Breckon, 1997). The United States has documented a strong 30-year history in regards to health promotion and health education. The policy's referenced here are the foundation for the prevailing community health objectives found in the frameworks of Healthy People 2010 and Community Diagnosis.

Frameworks

The latest prevention agenda for the United States is built on initiatives started over 20 years ago. The 28 focus areas of Healthy People 2010 were developed by leading Federal agencies in alliance with more than 350 national member organizations and 250 state health, mental health, substance abuse and environmental health agencies. Healthy People 2010 goals are: 1) to increase quality and years of healthy life, and 2) eliminate health disparities (Office of Disease Prevention and Health Promotion [ODPHP], 2001).

Individuals, groups, and organizations have been encouraged to integrate Healthy People 2010 in current programs. Tennessee, like many other states, has developed its own version of Healthy People 2010 objectives and goals. An on-line survey and progress report for the participating states is available on the CDC web site at: <wonder.cdc.gov> (ODPHP, 2001). The state of Tennessee Department of Health conducted a Community Diagnosis project in 1997 as one attempt to further identify local health concerns. Blount County, Tennessee is one community that provides a devoted public health infrastructure for community diagnosis.

In each county, Community Diagnosis is implemented through local county health councils with support from the regional health office. The Blount County Community Health Initiative Steering Team is a non-partisan partnership between the Blount County Chamber of Commerce and Blount Memorial Hospital. The steering team was created "to work to identify and prioritize the health needs of the citizens of our community in order to respond to these needs and coordinate resources to promote a healthy community" (ETRHO, 1999).

The Community Diagnosis project began in 1997 by conducting a community survey and holding town meetings. The report published in January 1999 indicated one primary care physician for every 1,592 persons. There is one dentist for every 1,852 persons and approximately 40-50% of Blount Countians do not have dental insurance. The only county hospital, Blount Memorial Hospital, showed a modest 61% occupancy of their 324 beds. Community nursing homes average 94% occupancy rates. Table 2.1 identifies the services reported as available but not adequate by both key leaders and community stakeholders (ETRHO, 1999). The community diagnosis further identified lack of services, poor coordination of services, lack of facilities, affordable quality healthcare, and healthcare cost containment as factors contributing to more than one challenge in the community. Education and awareness was the fifth challenge and recognized increased community involvement by churches and preventive health education as important contributing factors (ETRHO, 1999). Current census data was reviewed and compared to the Healthy People 2010 and Community Diagnosis Report.

Table 2.1 Services available but not adequate in Blount County.

Service	Key Leaders	Stakeholders
Elderly meals	29%	44%
Nursing home / residential care	30%	31%
Mental health	30%	45%
Child abuse / neglect	37%	59%
Alcohol / Drug treatment	38%	58%

While community leaders were primarily concerned with psychosocial health needs such as coping with family life changes and with mental health/abuse issues, the self-reported census data contradicts their level of concern. In an adult health survey, only 8.9% of Blount County respondents reported ever having a mental illness; 8.1% said they often felt depressed, and 4.4% have attempted suicide (Tennessee Department of Health [TDH], 1998). Mental health issues are often under-reported because of the personal stigma attached to them. Mental illness often renders an individual un-employable; therefore negatively impacting the socioeconomic status of that family and community. Research has shown that poverty and poor health go hand-in-hand; if either of the two improve, the other is likely to follow. By comparing trends found at both the national and local levels, program leaders can identify opportunities to involve faith-based institutions.

Healthy People 2010 Focus Areas address many of the same issues revealed in the Community Diagnosis Status Report: Blount County, 1999. The ones cited in this literature review are referenced in Table 2.2. Both Healthy People 2010 and the Community Diagnosis Status Report acknowledges the role of faith-based organizations in undertaking activities to promote health for members of their congregation and their community. This concept has become even more popular under the direct leadership of President George W. Bush.

National Health Policy

"Government has important responsibilities for public health or public order and civil rights. When we see social needs in America, my administration will look first to

Table 2.2 Focus areas at the community level.

Healthy People 2010 Focus Area	Blount County Community Diagnosis
Access to quality health services	Identified as a local challenge
Educational and community based programs	Listed fifth in order of challenge but identified as an opportunity for religious organizations to be involved
Heart disease	Identified as the number one cause of death
Injury/violence prevention	Identified as service available but not adequate
Mental health	Identified as service available but not adequate
Nutrition	Identified as service available but not adequate
Substance abuse	Identified as service available but not adequate

faith-based programs and community groups, which have proven their power to save and change lives" (Bush[1], 2001). This statement was made minutes before the President signed two new executive orders on January 29, 2001. The first executive order created a new office, called the White House Office of Faith-based and Community Initiatives (OFBCI). This office establishes policies, priorities, and objectives for the Federal Government's comprehensive effort to enlist, equip, enable, empower, and expand the work of faith-based and other community organizations to the extent permitted by law (Bush[2], 2001). The second executive order established Executive Department Centers for Faith-Based and Community Initiatives within the departments of Justice, Housing and Urban Development, Health and Human Services, Labor, and Education was designed to eliminate obstacles for faith-based and community organizations to provide social services (Bush[3], 2001).

Numerous government agencies and programs provide funding and assistance to faith-based and community organizations through the Department of Health and Human Services (U.S. Department of Health and Human Services [DHHS], 2001). Many of the programs listed below support the health needs identified by Healthy People 2010 and the Community Diagnosis project conducted in Blount County, Tennessee.

- Administration for Children and Families (ACF) funds programs such as Head Start and programs for refugees, runaways, homeless youth, independent living, child-care, child support enforcement and child welfare.
- Administration on Aging funds programs which provide nutrition, senior centers, case management, in-home support, hospice, adult day centers, transportation, and education.
- The Centers for Disease Control and Prevention (CDC) Office of Minority Health funds the Congress of National Black Churches to promote health promotion and disease prevention initiative for the African-American community.
- The Health Resources and Services Administration (HRSA) has established the Faith Partnership Initiative designed to foster and build partnerships between agency's federally funded programs and faith-based organizations in order to increases access to quality primary and preventive health care, to reduce health disparities and to better coordinate health assets at the local level.
- HRSA has funded the National Hispanic Religious Partnership for Community Health since 1998. A national databank of Hispanic faith-based organizations will identify services, programs, and resources available to address health-related needs in the Hispanic community.

- The Office of HIV/AIDS Policy in HHS' Office of Public Health and Science (OPHS) has partnered with gospel music artists to raise awareness of the church's unique potential to facilitate HIV prevention efforts and to promote AIDS education in the African-American community.
- OPHS' Office of Adolescent Pregnancy Programs provides grants to support health, education and social services for pregnant and parenting adolescents at the community level. The office also provides grants to support abstinence education programs aimed at young adolescents who are not sexually active.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) was the first HHS agency to employ a full-time, dedicated staff to formalize the long-term, ongoing role of both spirituality and faith-based organizations in substance abuse and mental health programs.
- SAMHSA's School and Community Action Grants / Youth Violence Prevention Cooperative Agreements promote community wide efforts to prevent youth violence and substance abuse and promote healthy youth development (DHHS, 2001).

Even with the multitude of government programs, there are still too many Americans living in poverty and despair. The American society is in need of reform that calls for partnerships between the Federal government and community organizations that are close to the needs and trusted by the people. President Bush recognized that faith-based organizations have unique abilities to meet special needs that cannot be duplicated by the Federal government.

There is more attention on health education and health promotion in the United States than ever before. The focus on collaboration and partnering between healthcare providers and community organizations is essential for health promotion. Time and again, religion has played a role in health promotion by advocating for personal health and accepting responsibility for improving the health of others. Thus, faith-based health organizations provide an excellent venue for providing health programs.

Baptist Faith Community

A review of literature reveals a growing emphasis on faith-based health initiatives. The literature shows a movement toward parish nursing and health related ministries; however, most of the research simply identifies existing programs rather than examining the outcomes and the effectiveness of the programs. Many community health projects cite faith-based organizations as key players but there is insufficient data published in regards to program planning and identifying health needs prior to implementation. This section of the literature explores the Southern Baptist faith community's involvement in faith-based health initiatives at the international, national, state, and local community levels.

International Community

The International Mission Board (IMB), formerly Foreign Mission Board, is an entity of the Southern Baptist Convention, the nation's largest evangelical denomination, claiming more than 40,000 churches with nearly 16 million members (SBC, 2003). Medical mission teams are only one strategy used to help meet the board's main objective

of presenting the gospel of Jesus Christ, resulting in church-planting movements around the world. The IMB works with organizations such as the Baptist Medical-Dental Fellowship, the Baptist Nurse Fellowship, and Medical Missions Response deploying volunteer medical teams to work with missionaries in underserved, international communities. The following international projects are documented through the IMB:

- Medical Mission Response (MMR) is a network of health care workers using their professional skills and Christian commitment to carry the gospel to the un-reached people groups around the world. MMR does not initiate medical missions but rather, they respond to project requests made by the missionaries working in these undisclosed areas. The project request is passed to existing evangelical health care organizations and fellowships and their members are mobilized in response to the request. The people served by this group of missionaries and volunteer teams live in areas cut off from Christian religion but their governments welcome western health care workers (Medical Missions Response, 2003).
- A mission link for physicians in Thailand and Kentucky has enabled a 15-year Southern Baptist missionary doctor to return to work in the United States for a ten-month assignment. Dr. John Gibson is pioneering an arrangement that allows him to fill in for doctors in the United States while they each take three-month rotations to serve his patients in the Thailand health clinic (Henderson, 2000).
- What started as a medical and humanitarian aid project in 1993 between a church in Little Rock, Arkansas and a small Baptist church in Russia, resulted in a land donation to build a new church, donations of $3-4 million in medical equipment, and the development of a seminary training program (Backus, 1998).

- Southern Baptist international missionary, Guy Muse, worked with medical volunteer teams in Ecuador after the floods of El Nino displaced over 20,000 people and left their water supply contaminated. More than 2,000 people accepted Christ during this two-week period (Turner, 1998).
- Dr. Susan Smith from Kentucky works in the only Baptist hospital in Tanzania, Africa. The hospital has a reputation as a quality medical facility so the African Muslims are receptive to medical advice and to hearing about Jesus. The hospital admits over 100 patients per month, provides outpatient care to over 1400 patients per month, while enjoying one-two conversions each week (Henderson, 2000).
- Woman's Missionary Union ® sponsors Pure Water, Pure Love, a project to help Southern Baptist missionaries around the world have a healthier lifestyle while working in remote areas. The goal is to supply each missionary family with a "Living Water" filter designed to remove disease-causing microorganisms. Alpine Industries of Greeneville, Tennessee works with the WMU as individuals make financial donations to help purchase the filters. This mission project does not require international travel but is a means to support international missionaries with clean water supplies (Woman's Missionary Union, 2003).

The Baptist faith community is and has been involved in international medical missions for many years. Dr. Charles Black is noted as the first physician to conduct an international medical mission with the Foreign Mission Board, now known as the IMB. At the age of 90, Dr. Black continues to participate in international medical missions and

is recognized as a devoted leader to those who followed in his footsteps. While international travel and volunteer missions have plunged in the last two years, international medical missions have reached an all-time high. Dr. Fred Loper, Associate Executive Director for the Baptist Medical Dental Fellowship (personal communication, April 16, 2003) stated:

> There are many, many international medical trips that Baptist made each year. The majority are done independently by local churches, associations, state conventions; and are not known or recorded by BMDF, IMB or any other central organization. We know of 1,015 healthcare volunteers who went on trips associated with BMDF in 2002 to more than 50 countries.

While the international medical mission field appeals to many American volunteers, others are drawn to projects closer to home.

National Community: North America

The North American Mission Board (NAMB) recognizes that the poor and working poor people in the United States rarely obtain even the simplest types of primary health and dental care. The NAMB is actively involved in medical and dental ministries throughout the United States; however, there is no central place to track their efforts. Dr. Loper (personal communication, April 16, 2003) stated:

> The North American situation is even worse when it comes to numbers. Local folks from the community staff most healthcare ministries here. I know of just over 170 local churches, associational or state convention ministries; there are at

least 30 volunteers associated with each of these sites. The only North American ministry in which there are volunteers actually going on short-term trips is to work in the Rio Grande River Ministry in Texas.

NAMB has 5,081 mission personnel assigned within the United States; yet they rely on 250,000 Southern Baptist mission volunteers to complete their mission assignments and projects (North American Mission Board [NAMB], 2003). NAMB ministries make a measurable difference in the physical and spiritual health of the community. Members of the NAMB believe people respond best to the Gospel when presented by Christians with whom they have a relationship. "Ministry like health care leads to meaningful relationships which validate our talk about the good news of Jesus" ([NAMB, 2003). NAMB strives to empower community members rather than make them more dependent. Thus, local churches and associations are prime candidates for addressing health issues.

The church has been an underutilized setting for healthcare in America since the unspoken "business" of health care has been assumed by hospitals. However, the church is the setting that may offer ongoing successes in the provision of wholistic healthcare and health promotion (Armmer & Humbles, 1995). A 1997 survey polling wellness needs of Southern Baptist ministers, church staff, and their families indicate a significant need to include health promotion activities within the church.

According to the Southern Baptist Convention, the typical Baptist congregation has 90 participants -60 adults and 30 children and teens under age 18 - who regularly attend church service (Jones, 2003). Responses from a pilot study conducted by the

Sunday School Board's LeaderCare staff and the Annuity Board indicated a concern for high cholesterol, high blood pressure, inadequate exercise, excess weight and leading a tense/rushed lifestyle.

State Community: Tennessee

The Tennessee Baptist Convention (TBC) supports international, national, and in-state health ministries. TBC has partnerships with Iowa, Portugal, and Brazil for evangelical missions. TBC is actively involved in health-related aspects of the Mississippi River Ministry, Hunger Relief, and Disaster Relief. The partnership with Rio de Janeiro, Brazil routinely conducts medical missions for the urban poor. The following is a brief outline of the programs supported at the state level.

- Mississippi River Ministry of Tennessee evolved from a 1980s U. S. Government Delta Commission Survey acknowledging areas along the Mississippi River are as poverty-stricken as third-world countries. This Tennessee project involves 21 counties and 15 Baptist Associations in the western part of the state. In addition to the in-state support from the WMU, seven other states participate in the Mississippi River Ministry through the NAMB. Health clinics are only one of the primary interventions used to meet the physical and spiritual needs in these impoverished communities.
- Tennessee Disaster Relief team is primarily responsible for providing feeding facilities and volunteers during local, national, and sometimes international disasters. The Disaster Relief team works closely with the TBC and the American Red Cross to coordinate their efforts following natural disasters such as floods and

tornadoes. The Tennessee Disaster Relief team participated in the aftermath of the 9-11-01 terrorist attacks in New York by providing food, cooking facilities, and volunteers to serve meals for those working in the clean-up process (TBC, 2003).

- Tennessee-Rio Partnership started as a five-year commitment and has been in effect since January 1998. A three-year extension is pending approval to extend the partnership agreement through December 2006. Medical clinics are a routine part of this ministry. Southern Baptist Missionaries, Ray and Sharon Fairchild, reported the following statistics for 2002: 13 medical clinics; 10,508 patients; 33,547 prescriptions; 7,402 eye exams; and 2,281 dental patients (Fairchild, 2003).

In addition to medical mission projects, the TBC has developed a community assessment tool to assist local churches in identifying needs within the community as well as resources from among church's membership. The two-part survey is packaged in one instructional set entitled, Tennessee Baptist Reaching Out to Touch a Broken World: Ministry Survey Guide for Urban Communities (TBC, n. d.). The 100-item church survey is divided into the following major headings:

- Where are the people in our community?
- Who are the people in need in our community?
- What physical and emotional problems do people in our community have?
- Which of these institutional settings are in our community?
- Which of these people-groups in our community need help?

- Which of these socio-economic groups are in our community?
- What religious beliefs are in our community?

This type of community assessment is beneficial in determining the types of ministries needed, and is impressive that both physical and emotional health problems are recognized at this level of intervention. Blount County, Tennessee is a strong faith-based community and has the infrastructure to support health ministry.

Local Community: Blount County

Local physicians, dentist, and nurses are seeking opportunities to serve within their own Christian communities but are unable to find coordinated programs that allow periodic service other than the Good Samaritan clinic. The local Baptist Nurse Fellowship has been involved in small community projects such as the jail ministry and blood pressure clinics at the Baptist Center. Several members of this group have expressed an interest in health ministry but recognize the need for leadership to address the administrative responsibilities for such activities. Through a mini survey, BNF was able to determine the type of health-related services being provided through area churches and learned most churches support health needs through prayer and visitation; only a few of the larger facilities offered health education programs. This information was shared with leaders of the local Baptist association to identify new opportunities to serve members of their congregations and the community.

The current Director of Missions, Jim Snyder, and Missions Ministry Coordinator, Kelly Campbell, agreed there is a need for health-related care at some of their larger

community functions, such as: events held at the Townsend amphitheater, Heritage Day, and summer mission camps. Snyder and Campbell acknowledge their desires to bring a wholistic ministry concept to the local Baptist Center, which currently lacks health services. The Hispanic church has also been identified as an area where health services are needed. Thus, the Chilhowee Baptist Association recognize the health needs in Blount County, Tennessee and acknowledge that their organization may address the needs through faith-based initiatives.

Summary

Our nation has an ongoing commitment to improving the health of individuals, families, and communities. Working with faith-based organizations and conducting medical mission programs are effective in establishing strong relationships between faith and health. It is difficult to get an actual number for international, national, state, and local community medical mission projects because so many have developed independently at the local level and there is not a central reporting agency. Each project is uniquely designed to fit the community's need. Most of the programs in this literature review have been designed to serve the African-American, Hispanic, working poor, and the medically underserved members of a local community. However, many of the same health concerns were identified by the SBC, the Healthy People 2010 focus areas, and the Community Diagnosis Status Report: Blount County. The literature has shown that faith-based organizations can undertake activities to further the health of the community by encouraging individuals to pursue healthier lifestyle and by providing community-based health improvement programs. Individual churches and individual members participate

in health ministries and volunteer for medical missions. The CBA is not actively involved in health-related ministries; but recognizes the need to build this ministry to serve both congregants and members of the community. Thus, a framework such as Healthy People or Community Diagnosis can be useful to survey faith communities about their role in health care and provides a comparison measure for outcomes.

CHAPTER III

METHODOLOGY

Introduction

The primary purpose of this chapter is to describe the research design and methods used in collecting and analyzing the data from an association-wide study of member perceptions regarding the role of the Chilhowee Baptist faith community in healthcare. The study population, data tabulation, and statistical analysis used to analyze the research questions have been included in this chapter.

Research Design

The researcher utilized an existing validated survey form developed by the state of Tennessee to address Healthy People 2010 objectives to create the survey form utilized in this study. The data gathered in the course of this study were analyzed by various statistical methods that are described later in the chapter. The information gathered during the study may assist the Chilhowee Baptist Association (CBA) in program planning.

Members of the CBA were asked to complete an anonymous health ministry survey. The survey results were compared with the pilot data and with findings from the literature review to determine the level of involvement and the focus of responsibility for health needs as perceived by members of the Baptist faith community in rural Blount County, Tennessee.

Study Population

Blount County is one of the oldest counties in Tennessee and home to over 108,000 residents; the poverty level is 9.7% (United States Census Bureau, 2001). Key leaders and community stakeholders recognize the strong religious base of over 200 churches, retired individuals (volunteers), and an overall caring society (volunteers) as key assets within Blount County (ETRHO, 1999).

The subjects were adult members of the churches in the CBA in rural Blount County, Tennessee. Participation was voluntary and anonymity was maintained throughout the study. There were a number of reasons for choosing the CBA as the partner agency for this project. The Director of Missions and the Missions Coordinator were very supportive of this endeavor as they were seeking opportunities to provide wholistic care through member churches and affiliated ministries. Members of the local Baptist Nurse Fellowship were actively seeking opportunities to serve in a medical mission capacity. Local doctors, dentists, and optometrists had expressed a desire to serve their community beyond the hospital and office settings.

The member churches were listed alphabetically in an Excel spreadsheet and sorted by attendance. Fifty-two (52) percent of congregations had an average attendance of less than 250 and 48 % and more than 250 members attending Sunday school service (Chilhowee Baptist Association, 2002). The sample chosen for the study was based on the 2002 average Sunday school attendance reported by 76 of 84 churches. The reported attendance was 9,294. Special considerations were given to the task of selecting a random sample. Among the methods considered was: 1) having only the primary Pastor of each church complete the survey, 2) selecting every nth church on the alphabetized list

for adult members to complete the survey, and 3) separating the congregations into two groups - small and large and giving each church an opportunity to have members complete the survey. It was determined that the first option had inherent problems because the average age of a Pastor is 48 years (Jones, 2003) and would represent only the male gender. Option two did not take into consideration the size of the congregation or the member's church affiliation. Although it would result in a convenience sample, option three was the desired method and allowed for greatest potential to include more member churches and would most likely yield a high response rate.

Instrumentation

A comprehensive search of the literature revealed self-made or program-specific surveys used by parish nurse programs, none of which were research-based. The best results-oriented, research-based surveys were related to Health People 2010. An on-line survey, Health Priority Areas: Health People 2010 Questionnaire was used as a model for the survey developed for this study (Tennessee Department of Health and University of Tennessee Community Health Research Group, 2003). The original survey categorized data under three major headings: background questions, Healthy People 2010 priorities, and criteria for prioritizing health problems. The questions ranged from simple demographics to comprehensive, critical thinking in regards to health priorities and why each response was chosen. This survey was chosen as the model because it was comprehensive in nature and included many of the health issues identified in the community diagnosis project for Blount County. The Healthy People 2010 survey also affords the opportunity to compare outcome data on a state and national level.

The survey instrument used for this study categorized the 28 focus areas from Healthy People 2010 into four sections: personal health, medical health problems to include acute and chronic illnesses, coping and emotional health, and finally, mental health (see Appendix A). The survey was set up to elicit two responses from the participants in regards to the level of involvement and focus of responsibility. The level of involvement was measured on a three-point Likert scale using these responses: 3 = very involved, 2 = somewhat involved, 1 = not involved, 0 = no opinion. The focus of responsibility was also measured on a three-point Likert scale using the following responses: 0 = not at all responsible, 1 = individual church responsibility, 2 = association responsibility, and 3 = both church and association responsibility. Four demographic questions were included to determine participant's role in church, gender, age, and number of years involved in church. The participant's role was defined into four categories: 1 = pastor/minister, 2 = association pastor/minister, 3 = deacon, teacher, or staff, and 4 = regular member. Age was categorized into six groups: 18-24, 25-34, 35-44, 45-54, 55-64, and over 64. The last question addressed the number of years participant had been involved in church and was categorized into five groups: 0-2, 3-5, 6-10, 11-2, and over 20. The survey questions covered every aspect of the study and were considered relevant by the researcher.

Pilot Study

The survey was pre-tested by Baptist church members from the Knoxville and Sweetwater Baptist Associations. Those in the pilot study completed the questionnaire as directed and a critical analysis of all aspects of the instrument to include: sensitivity of

issues, wording, order/sequencing, response categories, reliability checks, physical layout, length of time for answering, and instructions. Demographics of pilot study participants are outlined in Table 3.1. Results of the pilot study are provided in Table 3.2 and instrument validity is shown in Table 3.3. The effort put into establishing validity of the document and the field-testing of the instrument established an early measure of reliability deemed to be acceptable for this study.

Materials

Self-reported data was collected in the form of a written survey from a pre-determined number of respondents with the CBA. Five hundred printed copies of the survey were distributed along with a detailed information sheet explaining the study. Large, seal envelopes were provided for each church to collect and return the completed surveys.

Methods

A closed-form questionnaire consisting of dichotomous questions and rating questions was designed for the purpose of eliciting anonymous responses regarding the level of involvement and focus of responsibility for health issues within the Baptist faith community. The surveys were pre-coded to aid in analysis of data.

Non-probability sampling by means of a convenience sample was used for this study. The probability that a particular church member would be chosen was not known, and the representation of the population is limited with this sampling method. Convenience sampling is the captive-audience approach in which the researcher selects

Table 3.1 Pilot study participant demographics.

Variable	N	%
Association		
Knoxville	3	60
Sweetwater	2	40
Church Role/Responsibility		
Member	5	100
Time in Church		
< 20	1	20
over 20	4	80
Gender		
Male	2	40
Female	3	60
Age (years)		
25-34	3	60
45-54	1	20
over 64	1	20

Table 3.2 Pilot study survey responses.

LEVEL OF INVOLVEMENT	Very Involved	Somewhat Involved	Not Involved	No Opinion
Promoting better personal health	40%	60%		
Managing medical health problems	40%	40%	20%	
Coping with family/life changes	60%	40%		
Addressing mental health	60%	40%		
FOCUS OF RESPONSIBILITY	**Baptist Association**	**Individual Church**	**Both Levels**	**Not At All**
Promoting better personal health		20%	80%	
Managing medical health problems			80%	20%
Coping with family/life changes		40%	60%	
Addressing mental health	20%	20%	60%	

Table 3.3 Survey validity.

Survey Analysis	**Responses**
Instructions clear and easy to follow	Yes = 100%
Wording / ease of understanding	Yes = 100%
Order / sequence appropriate	Yes = 100%
Response categories appropriate	Yes = 80% No = 20%*
Researcher bias	No = 100%
Time to complete survey	Minutes = 6.6 (average)
Overall impression / motivation to answer	Positive = 100%

* Participant comment: Survey specific to Baptist faith.

the closest and most convenient persons to participate (Neuten & Rubinson, 2002). Pastors attending the March 17, 2003 weekly conference at the CBA were instructed in the survey rationale, data collection process, and were given training materials. The Pastors volunteered to participate in the survey process by accepting an instructional packet and surveys to be administered among members of their congregation. The remaining surveys were distributed through alternate contacts such as the Baptist Nurse Fellowship, associate ministers, or other designated church staff. Training for the alternate contacts occurred individually when the researcher delivered the survey packets to them.

A pre-determined number of questionnaires were provided to each church; small congregations received 30 surveys and large congregations received 45 surveys. Methods were designed to enable members to complete and return the survey anonymously. Adult members were asked to voluntarily complete the survey during Sunday school or Wednesday night classes. Sunday school and Wednesday night services were recommended by the researcher in an effort to reach regular, dedicated church members. The surveys were gathered by the Pastor or designated member on the same date they were administered and returned to the CBA office in a sealed envelope where the primary researcher collected them.

Sample Size

A subset of a predetermined size was selected from the total CBA membership. A simple and convenient random-sampling survey table was used to determine sample size. The total population of 9,294 with a desired confidence level of 0.95, a permissible

error of .05 and population proportion of 0.50 yielded a sample size of 263 (Wang, Fitzhugh &, Westerfield, 1995).

The total number of surveys was divided between the two groups of small and large congregations. The researcher provided a total of 500 surveys - 250 surveys were distributed to large and small churches, requiring a 52.6% return rate to achieve the desired 263 responses.

Response rate was determined by comparing the number of completed surveys to the number of potential respondents who were eligible (Neutens & Rubinson, 2002, 113). The following formula was used:

$$\text{Response rate} = \frac{\text{Number of completions}}{\text{Number in sample}} \times 100$$

Data Analysis

The objective of this study was to determine the role of the Chilhowee Baptist faith community in healthcare. A descriptive analysis of data collected was made to present relevant information from the sample population. A descriptive, group comparison was compiled from the survey data. A descriptive analysis shows the level of involvement and the focus of responsibility based on small and large churches, participant's age, and number of years participant has been involved in church. Statistical Package for the Social Sciences software (SPSS, version 11.0) was used to run frequency tables and parametric statistics in this study (Statistical Package for the Social Sciences [SPSS], 2002).

Frequency tables were used to analyze responses to each question and to validate the response categories matched the pre-coded worksheet. Frequency tables allow for a precise presentation of the data without serious loss of information by plotting the percentage (%) against the frequency (n) (Wood & Haber, 1998).

The parametric statistics used for this study were t-test and analysis of variance (ANOVA). An independent t-test was performed to determine significances within each of the demographic areas - church size, age, and number of years involved in church. The t-test determines the probability that the difference between the means of small and large congregations is a real difference or a chance difference (Polit & Hungler, 1999). . All t-test were two-tailed. A two-tailed test was used because there was no directional indication between small and large congregations. The level of significance was set at 0.05 (alpha level); probability values greater than 0.05 alpha will be interpreted as "result is not significant".

The following criteria was met in order to use the one-way ANOVA: 1) observations were independent, 2) observations were normally distributed, and 3) variance of groups were equal (Neuten & Rubinson, 2002). ANOVA was used to determine the difference between groups variances and within groups variances; and is represented as "F". The between groups variance shows the influence of the experimental variable. The within groups variance represents the sampling error in the distribution. The Scheffe test was used to determine which means were different in this study because the groups (n) were of unequal size (SPSS, 2002). Each question related to level of involvement was compared to the corresponding question for focus of responsibility. Level of significance was determined at 0.05.

Summary

This section on methodology discussed what was to be used for data collection, how the data was to be collected and what techniques were to be used to analyze the data. The analysis of the data determined the extent of involvement and the focus of responsibility for health issues such as: promoting better personal health, managing medical health problems, coping with family/life changes, and addressing mental health within the Chilhowee Baptist Association. It showed if the size of the congregation or the member's demographic factors of church role, gender, age, and number of years involved in church influence their perceptions regarding the extent of involvement and focus of responsibility for the same health issues.

CHAPTER IV

ANALYSIS AND INTERPRETATION OF DATA

Introduction

The purpose of this study was to determine the role of the Baptist faith community in healthcare by analyzing member's values regarding the level of involvement and the focus of responsibility within the Chilhowee Baptist Association (CBA) of Blount County, Tennessee. This was done by analyzing data collected from a sample of church members during Sunday school or Wednesday night services. The participants completed a survey that focused on four categories of health issues: promoting better personal health, managing medical health problems, coping with family/life changes, and addressing mental health. Statistical software, SPSS version 11, was used for this research study. This chapter presents the findings associated with the survey data that were collected.

Sample Description

The subjects were adult members of the churches in the CBA in rural Blount County, Tennessee. There are 84 member churches in CBA, 17 of which volunteered to participate in this study. Of these, 12 were from the small church sector. The small church sector contributed 166 (53.9%) participants to the study. Five large churches participated in the study for a total of 142 (46.1%) participants from this sector. There was a total of 308 (n = 308) participants in the study. There were 178 (57.8%) regular members and 112 (36.6%) on staff as pastor, teacher, deacon, etc.; 17 (5.5%) participants

did not respond to this category. There were 227 (73.7%) members involved in church for over 20 years and 78 (25.3%) participants were involved less than 20 years. More females participated in this study than males. There were 181 (58.8%) female participants and 119 (38.6%) male participants in the study. Eight participants did not report gender. The age distribution of participants ranged from 18 to over 64 years with 126 (40.9%) being over the age of 55 years. The number and percentage of participants' responses to the demographic variables are depicted in a frequency table (see Table 4.1).

Each rating question used a minimum value of "0" and maximum of "3". The mean scores range from 2.29 to 2.71 for level of involvement. Based on the mean scores alone, participants believe the Baptist faith community should be most involved in coping with family/life changes (mean 2.71) and secondly with addressing mental health (mean 2.56). The mean scores for focus of responsibility range from 2.19 to 2.38; with members believing the individual church and the association should be most involved in addressing mental health (mean 2.38) and coping with family/life changes (mean 2.37). Descriptive statistics are shown in tables 4.2 and 4.3.

Statistical Analysis

The study was designed to elicit member's perception to two health-related questions: 1) to what extent should the Baptist faith community be involved in: promoting better personal health, managing medical health problems, coping with family/life changes, and addressing mental health; and 2) who should be responsible for

Table 4.1 Characteristics of Chilhowee Baptist Association respondents completing faith-based healthcare survey.

Variable	N*	%
Participants by Church Size		
Small	166	53.9
Large	142	46.1
Church Role/Responsibility		
Pastor / Associate	12	3.8
Deacon / Teacher / Staff	101	32.8
Member	178	57.8
Missing**	17	5.5
Total	308	100.0
Time in Church (years)		
0 - 2	8	2.6
3 - 5	14	4.5
6 - 10	23	7.5
11- 20	33	10.7
21 +	227	73.7
Missing	3	1.0
Total	308	100.0
Gender		
Males	119	38.6
Females	181	58.8
Missing	8	2.6
Total	308	100.0
Age (years)		
18 - 24	17	5.5
25 - 34	32	10.4
35 - 44	53	17.3
45 - 54	78	25.3
55 - 64	65	21.1
65 +	61	19.8
Missing	2	0.6
Total	300	100.0

*N = number of respondents.

**Missing indicate no response given.

Table 4.2 Level of involvement as reported by members of the Chilhowee Baptist Association.

Item	N	Mean*	SD
Promoting better personal health	307	2.42	.629
Managing medical health problems	304	2.29	.661
Coping with family/life changes	306	2.71	.514
Addressing mental health	303	2.56	.622

* 0 = no opinion, 1 = not involved, 2 = somewhat involved, 3 = very involved

Table 4.3 Focus of responsibility as reported by members of the Chilhowee Baptist Association.

Item	N	Mean*	SD
Promoting better personal health	304	2.30	.951
Managing medical health problems	294	2.19	1.045
Coping with family/life changes	304	2.37	.914
Addressing mental health	299	2.38	.950

*0 = Not At All, 1 = Individual Church, 2 = Baptist Association, 3 = Both levels

addressing these health issues: promoting better personal health, managing medical health problems, coping with family/life changes, and addressing mental health. These two questions serve as the foundation for the seven research questions presented earlier in the study. Responses to these questions indicated how the participants' perceived the role of the Baptist faith community in healthcare based on church size, participant's age, and the number of years participant has been involved in church.

Church Size Comparison

The perceived level of involvement of respondents from small (< 250 members) and large (≥ 251 members) is shown in Table 4.4. There was no difference in reported level of involvement for promoting better personal health, managing medical health problems, coping with family/life changes, and addressing mental health for members of small and large churches. The perceived focus of responsibility for addressing health issues by members of small and large churches is depicted in Table 4.5. Members of small churches indicated a significantly greater interest in shared responsibility between the individual church and the Baptist Association for managing medical health problems ($p = .014$) and addressing mental health ($p = .023$) than members of large churches.

Age Comparison

The perceived level of involvement for addressing health issues by age categories (18-44 years and ≥ 45 years) is shown in Table 4.6. Members aged 18 - 44 years perceived a higher level of involvement for coping with family/life changes ($p = .007$)

Table 4.4 Level of involvement based on church size* as reported by members of the Chilhowee Baptist Association.

To what extent should the Baptist faith community be involved in:	N	Mean**	SD	T	P
Promoting Better Personal Health				.205	.837
Small Church	165	2.43	.665		
Large Church	142	2.42	.586		
Managing Medical Health Problems				.265	.791
Small Church	164	2.30	.711		
Large Church	140	2.28	.601		
Coping with Family/Life Changes				-1.014	.311
Small Church	165	2.68	.561		
Large Church	141	2.74	.454		
Addressing Mental Health				.098	.922
Small Church	164	2.56	.693		
Large Church	139	2.55	.527		

*Small = < 250 church members, large = ≥ 251 church members
**0 = No Opinion, 1 = Not Involved, 2 = Somewhat Involved, 3 = Very Involved

Table 4.5 Focus of responsibility based on church size* as reported by members of the Chilhowee Baptist Association.

Who should be responsible for addressing these health issues?	N	Mean**	SD	T	P
Promoting Better Personal Health				.891	.374
Small Church	164	2.35	.950		
Large Church	140	2.25	.953		
Managing Medical Health Problems				2.482#	.014##
Small Church	159	2.33	.979		
Large Church	135	2.03	1.099		
Coping with Family/Life Changes				.760	.448
Small Church	164	2.41	.905		
Large Church	140	2.33	.925		
Addressing Mental Health				2.285#	.023##
Small Church	162	2.50	.907		
Large Church	137	2.25	.984		

*Small = < 250 church members, large = ≥ 251 church members
**0 = No Opinion, 1 = Not Involved, 2 = Somewhat Involved, 3 = Very Involved
#Equal variance not assumed
##Level of Significance = 0.05

Table 4.6 Level of involvement based on members' age as reported by members of the Chilhowee Baptist Association.

To what extent should the Baptist faith community be involved in:	N	Mean*	SD	T	P
Promoting Better Personal Health				-.284	.777
18 - 44 years	102	2.41	.586		
45 + years	203	2.43	.652		
Managing Medical Health Problems				-.315	.753
18 - 44 years	102	2.27	.600		
45 + years	200	2.30	.695		
Coping with Family/Life Changes				2.720#	.007##
18 - 44 years	102	2.81	.391		
45 + years	202	2.66	.560		
Addressing Mental Health				1.830	.068
18 - 44 years	101	2.65	.573		
45 + years	200	2.52	.642		

*0 = No Opinion, 1 = Not Involved, 2 = Somewhat Involved, 3 = Very Involved
#Equal variance not assumed
##Level of Significance = 0.05

than members aged ≥ 45 years. Table 4.7 shows the perceived focus of responsibility for health issues as perceived by different age categories. There was no difference reported in the focus of responsibility for promoting better personal health, managing medical health problems, coping with family/life changes, and addressing mental health for those aged 18 - 44 and those ≥ 45 years.

Number of Years Involved in Church Comparison

The perceived level of involvement of respondents involved in church for 0-20 years and ≥21 years is shown in Table 4.8. There was no difference in reported level of involvement for promoting better personal health, managing medical health problems, coping with family/life changes, and addressing mental health based on the number of years the member has been involved in church. The perceived focus of responsibility for addressing health issues based on the number of years the member has been involved in church is depicted in Table 4.9. Members involved in church ≥21 years indicated a significantly greater interest in shared responsibility between the individual church and the Baptist Association for addressing mental health ($p = .013$).

The extent to which each of the health issues should be addressed by the Baptist Association, the individual church, both levels and not at all was explored with one-way ANOVA. The health issues - promoting better personal health, managing medical health problems, coping with family/life changes, and addressing mental health functioned as the dependent variable while the focus of responsibility was the independent variable.

Table 4.7 Focus of responsibility based on members' age as reported by members of the Chilhowee Baptist Association.

Who should be responsible for addressing these health issues?	N	Mean*	SD	T	P
Promoting Better Personal Health				.886	.376
18 - 44 years	102	2.37	.900		
45 + years	200	2.27	.976		
Managing Medical Health Problems				.929	.354
18 - 44 years	100	2.27	.983		
45 + years	193	2.15	1.077		
Coping with Family/Life Changes				.466	.642
18 - 44 years	102	2.40	.893		
45 + years	200	2.35	.928		
Addressing Mental Health				.074	.941
18 - 44 years	101	2.39	.927		
45 + years	196	2.38	.966		

*0 = Not At All, 1 = Individual Church, 2 = Baptist Association, 3 = Both Levels

Table 4.8 Level of involvement based on number of years member has been involved in church.

To what extent should the Baptist faith community be involved in:	N	Mean*	SD	T	P
Promoting Better Personal Health				.033	.974
0 - 20 years	78	2.42	.593		
21 + years	226	2.42	.643		
Managing Medical Health Problems				.606	.545
0 - 20 years	76	2.33	.597		
21 + years	225	2.28	.684		
Coping with Family/Life Changes				.859	.391
0 - 20 years	77	2.75	.463		
21 + years	226	2.69	.533		
Addressing Mental Health				-.065	.948
0 - 20 years	76	2.55	.661		
21 + years	224	2.56	.611		

*0 = No Opinion, 1 = Not Involved, 2 = Somewhat Involved, 3 = Very Involved

Table 4.9 Focus of responsibility based on number of years member has been involved in church.

Who should be responsible for addressing these health issues?	N	Mean*	SD	T	P
Promoting Better Personal Health				-.836	.404
0 - 20 years	78	2.22	.107		
21 + years	223	2.32	.064		
Managing Medical Health Problems				.214	.830
0 - 20 years	76	2.21	.113		
21 + years	216	2.18	.073		
Coping with Family/Life Changes				-.094	.925
0 - 20 years	77	2.36	.104		
21 + years	224	2.38	.061		
Addressing Mental Health				-2.513#	.013##
0 - 20 years	74	2.14	.118		
21 + years	222	2.47	.061		

*0 = Not At All, 1 = Individual Church, 2 = Baptist Association, 3 = Both Levels
#Equal variance not assumed
##Level of Significance = 0.05

Promoting Better Personal Health

Table 4.10 shows that there was a significant difference in the level of involvement for the health issue - promoting better personal health ($p = < .009$). Significantly fewer respondents indicated that this health issue should not be addressed at all compared to those who indicated it should be addressed either by the individual church and/or the Baptist Association.

Managing Medical Health Problems

Table 4.11 shows that there was a significant difference in the level of involvement for the health issue - managing medical health problems ($p = < .009$). Significantly fewer respondents indicated that this health issue should not be addressed at all compared to those who indicated it should be addressed either by the individual church and/or the Baptist Association.

Coping with Family/Life Changes

Table 4.12 shows that there was a significant difference in the level of involvement for the health issue - coping with family/life changes ($p = < .009$). Significantly fewer respondents indicated that this health issue should not be addressed at all compared to those who indicated it should be addressed either by the individual church and/or the Baptist Association.

Addressing Mental Health

Table 4.13 shows a significant difference in the level of involvement for the health issue - addressing mental health ($p = < .009$). Significantly fewer respondents

Table 4.10 Focus of responsibility reported by the Chilhowee Baptist Association for the health issue promoting better personal health as the dependent variable.

Independent Variable	N	Mean	F	P
Not At All (0)	15	1.33*	19.21	.009**
Individual Church (1)	60	2.47		
Baptist Association (2)	47	2.45		
Both Levels (3)	182	2.51		
Totals	304			

Note. Maximum score on each item was 3.
*Mean is significantly different than other group means with Scheffe test.
**Level of Significance = 0.05

Table 4.11 Focus of responsibility reported by the Chilhowee Baptist Association for the health issue managing medical health problems as the dependent variable.

Independent Variable	N	Mean	F	P
Not At All	30	1.30*	39.96	.009**
Individual Church	47	2.30		
Baptist Association	53	2.36		
Both Levels	164	2.48		
Totals	294			

Note. Maximum score on each item was 3.
*Mean is significantly different than other group means with Scheffe test.
**Level of Significance = 0.05

Table 4.12 Focus of responsibility reported by the Chilhowee Baptist Association for the health issue coping with family/life changes as the dependent variable.

Independent Variable	N	Mean	F	P
Not At All	4	1.00*	17.97	.009**
Individual Church	78	2.73		
Baptist Association	21	2.81		
Both Levels	200	2.74		
Totals	303			

Note. Maximum score on each item was 3.
*Mean is significantly different than other group means with Scheffe test.
**Level of Significance = 0.05

Table 4.13 Focus of responsibility reported by the Chilhowee Baptist Association for the health issue addressing mental health as the dependent variable.

Independent Variable	N	Mean	F	P
Not At All	19	1.53*	22.87	.009**
Individual Church	41	2.61		
Baptist Association	43	2.56		
Both Levels	193	2.65		
Totals	296			

Note. Maximum score on each item was 3.
*Mean is significantly different than other group means with Scheffe test.
**Level of Significance = 0.05

indicated that this health issue should not be addressed at all compared to those who indicated it should be addressed either by the individual church and/or the Baptist Association.

Summary

The purpose of this study was to determine the role of the Baptist faith community in healthcare by analyzing member's perceptions regarding the level of involvement and the focus of responsibility for promoting better personal health, managing medical health problems, coping with family/life changes, and addressing mental health issues within the Chilhowee Baptist Association of rural Blount County, Tennessee. Statistical analyses determined the size of the church did not impact the level of involvement but did significantly affect the focus of responsibility for managing medical health problems and addressing mental health. Age was a factor in determining the level of involvement only for the health issue coping with family/life changes. The focus of responsibility was not affected by age. The number of years a member has been involved in church did not affect the level of involvement for either of the four health issues. Members involved in church 21 or more years were more likely to indicate that both the church and the association should address mental health issues compared to members involved 20 years or less. One-way ANOVA using the level of involvement as the dependent variable and the focus of responsibility as the independent variable consistently revealed the need for the church and/or association to be involved in promoting better personal health, managing medical health problems, coping with family/life changes, and addressing mental health compared to no involvement at all.

CHAPTER V

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

Summary of Study

The purpose of this study was to determine the role of the Chilhowee Baptist faith community in healthcare. This was accomplished by analyzing member's perceptions regarding the level of involvement and the focus of responsibility in promoting better personal health, managing medical health problems, coping with family/life changes, and addressing mental health within the Chilhowee Baptist Association of rural Blount County, Tennessee.

A survey modeled from the on-line version of Health Priority Areas: Healthy People 2010 Questionnaire, was used to collect the data from participating church members. The instrument was pre-tested for reliability using Southern Baptist Association members outside the Blount County, Tennessee area. The instrument was presented in the form of dichotomous and rating questions. Analysis of the pilot test data found the instrument was acceptable and covered every aspect of the study.

A convenience sample was used. Pastors volunteered to have congregants complete the survey forms during Sunday or Wednesday night church service. Alternate church contacts and members of Baptist Nurse Fellowship were instrumental in facilitating the survey process in many of the congregations.

The data collected was pre-coded and analyzed by using SPSS statistical software. Descriptive statistics were used to describe the participants, two-tailed independent t-test

were used to determine the level of significance, and a one-way ANOVA was used to analyze variance between group responses.

Findings

Based on the data collected in this study, the following findings were found.

Demographic information

1. There were a total of 308 surveys returned; yielding a 62% response rate.
2. There were 166 (53.9%) participant members of small (< 250 members) churches and 142 (46.1%) members of large (≥ 251 members) churches.
3. There were 113 (36.7%) pastors or affiliated church staff and 178 (57.8%) regular members involved in the survey process.
4. There were 227 (73.7%) members stating they had been involved in church for over 20 years.
5. There were 181 (58.8%) female participants and 119 (38.6%) male participants.
6. There were 102 (33.1%) respondents under the age of 45 and 204 (66.2%) were ≥ 45 years of age.

Is there a significant difference between large and a small church in member's perceived level of involvement in: personal health, medical health problems, family/life changes, or mental health?

A t-test found no significant differences between small and large churches in regards to level of involvement in either promoting better personal health, medical health

problems, family/life changes, or mental health. The small (< 250 members) church means were higher than large (≥ 251 members) churches for promoting better personal health, managing medical health problems, and addressing mental health.

Is there a significant difference between a large and small church member's perceived focus of responsibility in: personal health, medical health problems, family/life changes, or mental health?

A t-test found small (< 250 members) churches favored a shared responsibility between the individual church and the Baptist Association for managing medical health problems and addressing mental health. The small (< 250 members) church means were higher than large (≥ 251 members) churches for managing medical health problems and addressing mental health.

Is there a significant difference among age groups of members perceived level of involvement in: personal health, medical health problems, family/life changes, or mental health?

A t-test indicated members aged 18 - 44 years perceived a stronger level of involvement for coping with family/life changes than did members aged ≥ 45 years. The 18 - 44 year olds have a higher mean for coping with family/life changes and addressing mental health than respondents aged 45 and greater.

Is there a significant difference among age groups of members perceived focus of responsibility in: personal health, medical health problems, family/life changes, or mental health?

A t-test found no significant differences between age groups in regards to focus of responsibility in promoting better personal health, medical health problems, family/life changes, or mental health.

Does the number of years a member is involved in church affect their perceived level of involvement in: personal health, medical health problems, family/life changes, or mental health?

A t-test found no significant differences between responses based on the number of years (0 - 20 and ≥ 21) the member has been involved in church in regards to level of involvement in promoting better personal health, medical health problems, family/life changes, or mental health.

Does the number of years a member is involved in church affect their perceived focus of responsibility in: personal health, medical health problems, family/life changes, or mental health?

A t-test indicated members involved in church for ≥ 21 years perceived a higher level of involvement for addressing mental health than did members involved 0 - 20 years. The mean score for addressing mental health was significantly higher among those members involved in church ≥ 21 years.

Is there a significant difference in the focus of responsibility for health issues: promoting better personal health, managing medical health problems, coping with family/life changes, and addressing mental health?

A one-way ANOVA indicated members perceive focus of responsibility should involve both the individual church and the Baptist association in promoting better personal health, managing medical health problems, coping with family life changes, and addressing mental health.

Conclusions

Based upon the findings of this study, the following conclusions were made.

1. Variables such as church size, participant age, and number of years involved in church yield similar means across groups. Participating members of the Chilhowee Baptist Association perceive the level of involvement in promoting better personal health, managing medical health problems, coping with family/life changes, and addressing mental health to be somewhat to very important.
2. Variables within the focus of responsibility yield minimal differences. Members of the Chilhowee Baptist Association favor association responsibility for promoting better personal health, managing medical health problems, coping with family/life changes, and addressing mental health.
3. The 61.6 % response rate for this study indicates members of the Baptist faith community are eager to express their opinion about healthcare issues. Leaders of the CBA indicate this study yielded far greater response rate than any other conducted through their office.

Recommendations

Based upon the findings and conclusions of the study, the following recommendations were made.

1. Respondents indicated the Chilhowee Baptist Association should be somewhat to very involved in healthcare issues such as: promoting better personal health, managing medical health problems, coping with family/life changes, and addressing mental health. Efforts should be made to implement a health council or a health ministry program to address these health issues from a faith-based perspective, using Healthy People 2010 and the Blount County Community Diagnosis as a framework for measuring program outcomes.
2. The focus of responsibility reported by members of the CBA was highest in the area of addressing mental health. Injury-violence prevention, substance abuse, and mental health are all focus areas for Healthy People 2010 and have been labeled available but not adequate within Blount County. Efforts to implement programs and/or support groups that address mental health issues such as: anxiety, co-dependency, depression, eating disorders, grief/loss, stress, substance abuse, suicide, and injury-violence prevention should be explored by the CBA leadership.
3. The focus of responsibility for coping with family/life changes was of second most important to respondents. Early efforts to implement programs that address family/life changes such issues as: aging parents,

divorce, domestic violence, living wills/power of attorney, parenting, pregnancy, and unemployment should also be explored.

4. The literature has been flooded with faith-based initiatives addressing the same health needs identified in this research study. Educational and community based programs are focus areas for Healthy People 2010 and are listed 5th in order of challenges within Blount County; but were identified as opportunities for religious organizations to be involved. Efforts to educate board members on the role of the Baptist faith community in healthcare should be made to increase their overall awareness and to gain their financial support for program development both at the individual church and association levels.

5. Heart disease is identified as the number one killer in Blount County and is a major focus area for Healthy People 2010. CBA members indicate the need for promoting better personal health, which would address preventive measures to decrease risk of heart disease as well as teach those already diagnosed with heart disease how to manage their health problem more effectively.

6. Access to quality health services, another Healthy People 2010 focus area is a local challenge in Blount County, as reported through the Community Diagnosis Report. The CBA can be instrumental in meeting this need by duplicating the work of the IMB within their community. Volunteer doctors, dentists, and nurses are seeking opportunities to work in this

capacity but lack the organizational structure to facilitate the medical mission concept.

Recommendations for Future Research

Additional research using a random sample is needed in order to make inferences across the entire Baptist faith community. This study should be replicated in other faith-based communities within Blount County. Additionally, the study should be conducted in a larger geographic area to generalize beyond Blount County, Tennessee.

Summary

Churches are challenged today to rediscover their commitment to health and healing as the medical community embraces the concept that faith does affect health. As leaders within the United States have learned and accepted the idea that community health is a derivative of individual health, more attention has been focused on the individual's responsibility for health promotion and disease prevention. A statewide community diagnosis project recognized the valuable role of religious organizations in meeting local health needs in Blount County, Tennessee.

This research study was designed to determine the role of the Chilhowee Baptist faith community in healthcare by analyzing member's perceptions regarding the level of involvement and the focus of responsibility in promoting better personal health, managing medical health problems, coping with family/life changes, and addressing mental health. A summary of the study and the statistical findings were reviewed in this chapter, along with conclusions and recommendations.

Blount County has a strong Baptist faith infrastructure through the CBA. Leaders acknowledge the relationship between faith and health and recognize an opportunity to help meet health needs such as: promoting better personal health, managing medical health problems, coping with family/life changes, and addressing mental health. Participants in this study favor the Baptist association's involvement in healthcare, with emphasis on mental health and coping with family/life changes.

Each research question was analyzed and compared to Healthy People 2010 and the Blount County Community Diagnosis Status Report. Recommendations were made in areas where the CBA could intervene to help meet local health needs such as access to quality health care, education, and mental health. By using frameworks such as Healthy People 2010 and the Blount County Community Diagnosis Status Report, program interventions and outcomes can be monitored on a local and national level. The CBA has an opportunity to utilize volunteer doctors, dentists, nurses, and other health professionals to promote health education and disease prevention through classes, support groups, screenings, and clinics.

References

American Nurses Association (2002). *Scope and standards of practice.* Retrieved 7-23-02, http://www.nursingworld.com

Armmer, F. A., & Humbles, P. (1995, March). Parish nursing: Extending health care to urban African-Americans. *N & HC: Perspectives on community, 16*(2), 64-68.

Augustson, L. B. (2002). *CCHF best practices program: Clinic and parish nursing project.* Retrieved 7-23-02, http://www.cchf.org/BestPractices/abstracts/CHSClinicandParishNursing.doc

Backus, C. (1998, July 9). *Church's long-term commitment makes impact in Russian city.* Retrieved March 8, 2003, http://bpnews.net

Banks, A. M. (2002). *Gallup poll: Americans link faith to everyday life.* Retrieved March 8, 2003, http://www.crosswalk.com/news

Breckon, D. J., Harvey, J. R., & Lancaster, R. B. (1998). *Community health education: Settings, roles, and skills for the 21st century* (4th ed.). Gaithersburg, MD: Aspen.

Bureau of Primary Health Care (2002). *The bureau of primary health care's faith partnership initiative.* Retrieved 7-15-02, http://www.bphc.hrsa.gov/programs/FaithProgramInfo.htm

Burleson, K. & Williams, J. (2002). *CCHF best practices program: Recruitment and use of volunteerism.* Retrieved 7-23-02, http://www.cchf.org/BestPractices/abstracts/ICHCVolunteerism.doc

Bush[1], G. W. (2001, January 29). *Remarks by the President in announcement of the faith based initiative.* Retrieved 12-12-02, http://www.whitehouse.gov/news/releases/20010129-5.html

Bush[2], G. W. (2001, January 29). *Executive order: Establishment of White House Office of Faith-Based and Community Initiatives.* Retrieved 12-12-02, http://www.whitehouse.gov/news/releases/2001/01/20010129-2.html

Bush[3], G. W. (2001, January 29). *Executive order: Agency responsibilities with respect to faith-based and community initiatives.* Retrieved 12-12-02, http://www.whitehouse.gov/new/releases/2001/01/print/20010129-3.html

Carson, V. B., & Koenig, H. G. (2002). *Parish Nursing: Stories of Service and Care.* Radnor, PA: Templeton Foundation Press.

Chilhowee Baptist Association (2002, December 3). Statistics report for 2002.

Droege, T. A. (1995). Congregations as communities of health and healing. *Interpretations: A journal of Bible and theology, 49*(2).

East Tennessee Regional Health Office (1999, January). *Community diagnosis status report: Blount County 1999.* Retrieved 5-10-01, http://www.utk.edu/~chrg/hit/main/reports/commdiagnosis/blount/cover.htm

Fairchild, R. (2003). 2002 in review. *Reachin' Rio's urban poor for Christ.*

Henderson, T. (2000, October 9). *Small Baptist hospital offers strong Christian witness in Muslim region.* Retrieved March 8, 2003, http://www.bpnews.net

Henderson, T. (2000, December 12). *Mission emphasis links medical doctors in Thailand & Kentucky.* Retrieved March 8, 2003, http://www.bpnews.net

Huggins, D. (1998, March). A community-based outreach program of care. *Orthopaedic Nursing, 17*(2), S26.

Hughes, C. B., Trofino, J. O'Brien, B. L., Mack, J. & Marrinan, M. (2001, October). Primary care parish nursing: outcomes and implications. *Nursing Administration Quarterly, 26*(1), 45-59.

Jones, P. B. (2003). *Southern Baptists congregations today.* Retrieved 1-9-03, http://www.sbc.net

LoBiondo-Wood, G. & Haber, J. (1998). *Nursing research: methods, critical appraisal, and utilization* (4th ed.). St. Louis: Mosby.

McDermott, M. A., Solari-Twadell, P. A., & Matheus, R. (1998, 2-01-98). Promoting quality education for the parish nurse and parish nurse coordinator. *Nursing and health care perspectives, 19*(1), 4.

McGee, A. K. (1998, June). Parish nursing brings health care closer to home. *Texas Nursing, 72*(6), 4-5, 12.

Medical Missions Response (2003). *What is Medical Missions Response?.* Retrieved March 8, 2003, http://www.mmronline.org.what.htm

Miller, J. T. (1987, September/October). Wellness programs through the church: Available alternative for health education. *Health Values, 11*(5), 19-22.

Neutens, J. J., & Rubinson, L. (2002). *Research techniques for the health sciences* (3rd ed.). San Francisco: Benjamin Cummings.

North American Mission Board (2003). *Starting a medical, dental ministry.* Retrieved 1-9-03, http://www.namb.net/evangelism

Office of Disease Prevention and Health Promotion (2001). *Healthy people 2010: Viewing the national conference.* Retrieved 11-20-01, http://www.healthypeople2010.com/Documents/what_is_hp.cfm

Pattison, E. M. (1970). An overview of the church's roles in community mental health. In H. J. Clinebell, Jr (Ed.), *Community mental health: The role of the church and temple.* NY: Abingdon Press.

Princeton Religious Research Center (1994). *Religion in America 1993-94.* Princeton, NJ: Aughor.

Rydholm, L. (1997, April). Patient-focused care in parish nursing. *Holistic Nursing Practice, 11*(3), 47+.

Smith, C. M., & Maurer, F. A. (2000). *Community health nursing: Theory and practice* (2nd ed.). Philadelphia: W. B. Saunders Company.

Southern Baptist Convention (2003). *About us: Meet Southern Baptists.* Retrieved April 8, 2003, http://www.sbc.net

Statistical Packaging for the Social Sciences, 2002. Version 11.0. Chicago.

Striepe, J. M. (1993, Winter). Reclaiming the church's healing role. *Journal of Christian Nursing,* 6-9.

Swanson, A. (2003, April). Program director tackles faith head-on. *Research new & opportunities in science and theology, 3*(8), 5-6.

Tennessee Baptist Convention (2003). *Tennessee Disaster Relief.* Retrieved March 8, 2003, http://www.tnbaptist.org

Tennessee Baptist Convention (n.d.). Tennessee Baptists reaching out to touch a broken world. *Ministry Survey Guide for Urban Communities.*

Tennessee Department of Health and University of Tennessee Community Health Research Group (2003). *Health priority areas: Healthy people 2010*

questionnaire. Retrieved January 5, 2003, http://ns6.kii.utk.edu/surveys/survey2010.htm

Tennessee Department of Health, University of Tennessee Community Health Research Group, & Bureau of Alcohol and Drug Abuse (1998). *Adult health information survey.*

Trofino, J. Hughes, C. B., O'Brien, B. L., Mack, J. Marrinan, M. A., & Hay, K. M. (2000, October). Primary care parish nursing: Academic, service, and parish partnership. *Nursing Administration Quarterly, 25*(1), 59-74.

Turner, C. (1998, May 13). *2,000 salvations result from El Nino in Ecuador.* Retrieved March 8, 2003, http://www.bpnews.net

U.S. Census Bureau (2001). *Census: Blount County, Tennessee.* Retrieved 1-28-2003, http://quickfacts.census.gov/qfd/states/47/47009.html

U.S. Department of Health and Human Services (2001, March 15). *HHS and the President's faith-based and community initiative.* Retrieved 2-12-02, http://www.os.dhhs.gov/news/press/2001pres/01fsfaith-based.html

Via Christi Health System (2002). *Center for congregational health ministry.* Retrieved 7-17-02, http://www.via-christi.org/parisnurse

Wang, M. Q., Fitzhugh, E. & Westerfield, R. C. (1995). Research notes: Determining sample size for simple-random surveys. *Health Values, 19*(3), 53-56.

Westberg, G. (n.d.). *Parish nursing: The developing practice.* Park Ridge, Illinois: National Parish Nurse Resource Center.

Westberg, G. E. (1990). *The parish nurse: Providing a minister of health for your congregation.* Minneapolis: Augsburg, Fortress.

Woman's Missionary Union (2003, January 15). *Pure water, pure love.* Retrieved February 10, 2003, http://www.wmu.com/getinvolved/ministry

APPENDIX

The Role of Faith-Based Healthcare:
An Association-Wide Study of Member Perceptions

Check the box that best describes your response to the following questions:

Example: To what extent should parents be involved in a child's education:	Very Involved ✓	Somewhat Involved	Not Involved	No Opinion
1. **To what extent should the Baptist faith community be involved in:**	**Very Involved**	**Somewhat Involved**	**Not Involved**	**No Opinion**
PROMOTING BETTER PERSONAL HEALTH For example: adolescent health, dental care, exercise, men's health, nutrition, stop smoking, weight control, women's health				
MANAGING MEDICAL HEALTH PROBLEMS For example: AIDS, arthritis, cancer, chronic illness, heart disease, high blood pressure, lung disease, managing medications, stroke, vision				
COPING WITH FAMILY/LIFE CHANGES For example: aging parents, divorce, domestic violence, living wills/power of attorney, parenting, pregnancy, unemployment				
ADDRESSING MENTAL HEALTH For example: anxiety, co-dependency, depression, eating disorders, grief / loss, stress, substance abuse, suicide				
2. **Who should be responsible for addressing these health issues:**	**Baptist Association**	**Individual Church**	**Both Levels**	**Not At All**
Promoting Better Personal Health				
Managing Medical Health Problems				
Coping with Family / Life Changes				
Addressing Mental Health				

Circle the response that best describes you.
Example: The color of your car is: Blue Green (Red) White

3. **Your role in church:** Minister/Pastor Associate Minister Deacon/Teacher/Staff Member

4. **Gender:** Male Female

5. **Your Age Group:** 18-24 25-34 35-44 45-54 55-64 over 64

6. **How many years have you been involved in church?** 0-2 3-5 6-10 11-20 over 20

VITA

Lisa D. Van Camp is the wife of United States Air Force Retired MSgt. Michael C. Van Camp and mother of Marc and Ashley Webb and stepmother of Holli and Heather Van Camp. Lisa graduated from Fort Sanders School of Nursing in 1986 as a diploma Registered Nurse and obtained a Bachelor of Science in Nursing from Tennessee Wesleyan College in 2002. She was inducted into Sigma Tau Delta Honor Society in 2001 and received the Lippincott RN Award for outstanding achievement in nursing from Tennessee Wesleyan College - Fort Sanders School of Nursing in 2002. She obtained a Master of Science degree in Health Promotion and Health Education from the University of Tennessee, Knoxville in 2003. She has maintained certification as a Rehabilitation Registered Nurse since 1993 and completed certification training for Parish Nursing in 2001. She maintains active membership with the Association of Rehabilitation Nurses (ARN), and both National and Tennessee Baptist Nurse Fellowships.

Lisa has worked as staff nurse in acute neurosurgery, physical rehabilitation, home care, and medical/respiratory care within the Covenant Health System in Knoxville, Tennessee. She managed several outpatient programs and implemented a rehabilitation day hospital program for the Patricia Neal Rehabilitation Center in Knoxville, Tennessee. Additionally, she has served as education coordinator for Covenant HomeCare and currently serves as auxiliary staff for nursing education at Fort Sanders Regional Medical Center in Knoxville, Tennessee. Currently she serves as Congregational Health Nurse for Dotson Memorial Baptist Church in Maryville, Tennessee. Lisa hopes to use the data collected from this research study to implement a health ministry for the Chilhowee Baptist Association in Blount County, Tennessee.