Health Minister:
Role and Guidelines – Second Edition

Health Ministries Association

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Preface

The Health Ministries Association (HMA) is an interfaith membership organization, serving people who comprise the Faith Health Ministry Movement. The Health Ministries Association exists to encourage, support and develop whole person ministries leading to the integration of faith and health. The Health Ministries Association has a broad membership made up of health ministers, faith community nurses, clergy, chaplains, faculty, educators, program coordinators, and others. The health minister network group is one of the many constituency groups in the Health Ministries Association that helps its members develop tools and resources to help faith communities bring whole person health into a greater reality.

The long-standing tradition of the Health Ministries Association has been to provide resources for members who are developing whole person health models. The first Health Minister Guidelines and the Core Curriculum Elements for Training Health Ministers published in 2011 has proven to be a seminal document. It has provided the language, concepts, and beginning framework for growing areas of faith and health work. It has engaged multiple professional disciplines and sectors, including public health, local and federal governments, faith groups, denominations, and many others.

The latest Health Minister guidelines continues to expand on the current role identification, scope, and responsibilities for health ministers. The guidelines also set further standards and exploratory criteria for potential professional advancement and growth. The role of the Health Minister will continue to grow and evolve as it responds to numerous cultural trends where faith and health meet, interact, and dialogue with each other.

At the foundation of every faith tradition is the call to care for the broken, the underserved, the vulnerable, the wounded, the sick and the dying. Every faith community has a role to play in advancing health, healing, wholeness and reducing disease, disability and premature death. Faith-based health programs have been established for many years and the Health Ministry concept is a model that has emerged over time and continues to grow into greater consciousness as people reflect more upon how spirituality is integral in their lives.

Faith communities face their own challenges and limitations. Faith communities do not have endless volunteers and ministries. Some faith communities rely heavily on resources, such as grants, financially supporting their service and ministry. Most of the ministries of faith communities are unpaid and require active engaged participation from its members to carry out their ministry and mission. There has been a recent decline in organized faith community attendance and participation. With this decline, faith communities face their own challenges in capacity and how much they can do to serve both the community and its members. Regardless of the limitations and challenges, the call to Health Ministry is a universal one to everyone from every age. It is part of humanity. Health Ministry is at the core of many faith traditions to serve one another and be in community. It requires everyone to participate through active engagement. From a faith perspective, Health Ministry requires a way of life to be practiced daily through conscious and purposeful actions toward wholeness.

The health sector, including hospitals, healthcare systems, public health, have undergone rapid changes in structure and function. Other changes in the health sector have occurred to manage chronic health conditions of the community through population based health management. Some

of the change has been due to the mandates and conditions of the Affordable Care Act. There is a recognition that health spending and systems were unsustainable in the short and long term. These legislative and economic factors have impacted the health sector and have driven new institutional directives in the last few years. This opportunity for realignment of priorities in the health sector has allowed it to reflect fundamentally on its role and purpose in society, especially how it works with other sectors, including faith communities.

More and more healthcare, government, nonprofits, social, and human resource organizations recognize the intrinsic value of faith and health based partnerships to reach a diverse population, especially those who are hardest to reach, including the underserved. All organizations recognize that they cannot single handedly do the work of building AND sustaining healthy individuals and communities alone. As organizational budgets in faith based and healthcare institutions get tighter and become more constricted, there is a rugged organizational urge and tendency to self-protect what each already has and a want to keep doing more with less. The common tendency is to venture into the work or ministry alone. However, our real hope for now and the future is rooted in a binding commonality to find ways to work collaboratively and be innovative. All parties and sectors have a stake in this work and this ministry. It cannot be assumed that parties will automatically act or do their part. Rather, it takes engaged, trusting relationships which are built and sustained over time.

Both faith and health sectors bring something unique to the table and they need each other more than ever today. In engaging each other, there is a need to understand each other's assets, limitations, challenges, needs, and wants. Respect for each other's gifts and talents is paramount. It is imperative that one party does not let its own self-interest supersede the common good for all. For example, one party should not use the other for its own economic, social, or political gain. Understanding the whole of what each party brings to the table can foster true and sustained partnerships. True trusting and lasting partnerships take a tremendous amount of ongoing work and care for each party. It is respecting one's weaknesses as well as one's strengths. It is the consistent attention and persevering hard work with each other that makes relationships last. Each party has a stake in the other. Each exists because the other exists. These are the common threads in the garment of our interconnected fabric of being a healthy society.

Training and educating people of diverse backgrounds in faith and health will be critical and essential for us to develop resilient communities. It is essential to develop leaders within these communities to assist in the next public health crisis or help in creative ways to manage long term chronic diseases. We need to envision together what a healthy community looks like. It will take investment in time and financial resources to train these leaders. Educating and preparing health ministers not only benefits our entire society, but it also assists faith communities to be ready and able to engage in partnerships with multi-sector organizations to partake in faith and health work. Without health minister education and preparation, it is difficult for these multi-sectors organizations, such as hospitals and public health, to readily engage and purposefully act in collaborative partnerships with faith communities.

Health ministry is about building meaningful and sustained relationships in, among, and outside faith communities. Health ministries are foundational building blocks for a healthy society. Developing organized health ministries takes time, money, and resources. It is a worthwhile

investment in our communities for today and the future. Every group, whether from a faith or healthcare based perspective, will need to take the commitment and challenge of coming together as a serious and critical issue. To be successful in this work, it will require each group to understand each other in a purposeful and meaningful way. Additionally, it will require innovation, compromise, creative thinking and action as well as support for long term sustainable, collaborative models.

As a means to support sustainable models, the Core Curriculum Elements for Training Health Ministers provides a way to build the capacity of faith and health sectors to work together. The Core Curriculum Elements for Training Health Ministers is based on a compilation of best practices, suggested teaching methodology, and resources. Education is one element of building capacity for this work and ministry. Another important element is to provide networks of support for Health Ministers. Informal and formal networks exist throughout the United States. The Health Ministries Association in collaboration with its partners works to connect Health Ministers with each other. HMA could only do the work and engage in this ministry based on your personal and institutional input and active participation. We ask that you join our efforts and join one of Health Ministries Association's various constituency networks. We encourage groups, especially educational, health, denominational, and academic institutions, responsible for educating people in health ministry to use Health Ministries Association's Core Curriculum Elements for Training Health Ministers to develop and shape your health ministers and health ministries for the future.

Health Minister Guidelines Revision
Final Review Committee

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Foreword

This document builds upon the 2011 HMA document of the Health Minister Role: Guidelines and Foundational Elements, the culmination of years of work by the Lay Health Ministry Network of the Health Ministries Association, and the 2002 Health Ministries Association "*A Guide to Developing a Health Ministry*" to assist faith communities in developing healthy ministries. As we write the second version of the Health Minister guidelines, we write this document still with the limits of language to express ideas and concepts that embody the faith and health movement. For example, the term "ministry" is a Christian term that means service. The term minister means "ordained" in some faith traditions. We are aware that these terms may or may not fit within some Christian sects as well as with those from other faith traditions. We have tried to balance this dichotomy in authoring the latest version of the document. Also we have struggled to find an appropriate language that would be inclusive and respectful as a multi-faith organization.

Some faith communities and a growing number of multi-sector organizations, including public health and government, use a variety of other titles for the Health Minister, such as Health Ambassador, Faith Community Outreach Worker, Caring Ministry, Spiritual Leader, or Congregational Health Minister; however, the role identification and responsibilities are essentially the same.

The terms "health ambassador", "congregational health promoter", "lay health promoter", "health advocate", and "congregational health leader" are terms that some, including those in the public health sector, have used to describe their work in the community.   At this time, we have chosen to use the term "Health Minister" because it represents the largest majority of who we are currently. It also more accurately reflects the relationship between faith and health.   As time evolves, we will revisit the term in order to reflect the multi-faith organization we hope to become.

Role Identification & Guidelines for the Health Minister

Health Ministries Association position statement
Co-authored by Tom Droege and Marsha Fowler, was adopted by the HMA Board of Directors on November 12, 1994 at Camp La Foret, Colorado Springs, Colorado

The basis of the Health Ministries Association's unity as a multi-faith organization is a common understanding of the importance of spirituality for health.

"Spirituality is the way in which a person understands and lives life in view of her or his ultimate meaning, beliefs and values. It is the unifying and integrative aspect of the person's life and when lived intentionally is experienced. . . . as a process of growth and maturity. It integrates, unifies, and vitiates the whole of a person's narrative or 'story' embeds his or her core identity, establishes the fundamental basis for the individual's relationship with others and with society, includes a sense of the transcendent, and is the interpretive lens through which the person sees the world. It is the basis for community for it is in spirituality that we experience our co-participation in the shared human condition. It may or may not be experienced in religious terms." - Marsha Fowler

Though, the content of spirituality will differ among the various faith traditions represented within the HMA membership, there can be mutual respect among those who differ, and the potential for learning from each other.

Since there is no spirituality without content, we make a common commitment to one another to give full expression to our faith rather than seeking the least common denominator in worship as well as dialogue, with the clear realization that such expression of faith are not the basis of our unity. Not what we believe, but that we affirm the importance of spirituality, for health unites us as an interfaith organization committed to health promotion.

The Health Ministry guidelines document was written in the spirit of invitation to professionals and individuals to contribute to the faith and whole health movement. We invite people to be part of this movement of being present to each other where people integrate their faith and experiences to be with others. People informed by their faith tradition from all walks of life- stay at home moms, stay at home dads, social workers, massage therapists, music therapists, and many others can find a place in the world by sharing a gift or talent. We all know of the great need our world has for listening ears and the even greater need for an understanding heart. Some people may offer the simple, yet beautiful gift of being present to someone.

The life and application of this document recognizes that we cannot serve others on our own terms. We need the support of our community and faith tradition and institutions. This requires proper training and supervision as our guide and standard. We also need to recognize the difference between our own needs and the needs of those we are listening to. Therefore, this is a professional endeavor and requires an infrastructure of support services and appropriate oversight for ministers.

In our busy and sometimes chaotic culture, we long to find meaning and purpose in the world. We also long to be in relationship to the world and each other to find this meaning. The growth of the Health Ministry movement asks us to engage actively in this search, it calls for our active participation, and ongoing reflection in how we live and impact the lives of others through thoughtful and purposeful action.   Our hope is that the movement continues to grow. Since our first edition of the Health Minister guidelines, it has grown into something larger. As we continue the journey of faith and health together, let us continue with these initial and beginning steps. This is a journey we are all on together. Please join us and be active in the movement of Health Ministry!

Tom Pruski, RN, MAPS
Health Minister Network Chair, Health Ministries Association

1. Foundations & Evolution of Health Ministry

Healing, being made whole and being saved have common roots in many faith traditions. The relationship between healing and religion has evolved over time influenced by cultural, political, social, and economic events. Religious groups founded hospitals to provide care to vulnerable populations such as the poor, immigrant, and homeless. These hospitals served not only as centers for healing but also training grounds for various professionals.   Today, faith communities are reclaiming their healing tradition to support and care for the people they serve.

"Wholistic health" was the term used by Rev. Dr. Granger Westberg to define a completely integrated approach to health and healthcare that integrates the physical, psychological, social and spiritual aspects of the whole person. The principles of whole person health arose from an understanding of human beings striving for wholeness in relationship to their God, themselves, their families and the society in which they live. In its contemporary context, we will use the term "whole person health" to describe the integration and relational aspects of health.

Reverend Doctor Granger Westberg developed a pilot project in the mid 1980's in which registered nurses and other health professionals were placed in faith communities. This project was designed to determine if health care services could be delivered in faith communities. At the termination of this project it was determined that nurses were the most successful health professionals in this setting. This was the beginning of faith community nursing (parish nursing).

2. Assumptions of Health & Wellness

      a. Health and illness are human experiences common to all.
      b. Health is the integration of the spiritual, physical, mental, emotional and social aspects of a person with the primary outcome being a sense of harmony with self, others, the environment, and God (or a higher power).
      c. Health may be experienced in the presence or absence of diseases or injury.
      d. The presence of illness does not preclude health nor does optimal health preclude illness.
      e. Healing is the process of integrating the body, soul and spirit to create wholeness, health, and a sense of well-being, even when full recovery, restoration or curing may not occur.
      f. Health occurs in a context of community where love and support are present.

g. Facilitation of health, healing and wholeness as a HM (Health Minister) requires knowledge and education but not a specific profession or degree.

h. Health is not primarily medical, treatment, or prescriptive care.

3. Definition of Health Ministry

a. Health Ministry is an intentional faith-based service ministry designed to promote health and wellness, prevent disease and facilitate healing and wholeness in groups and individuals.

b. A Health Minister may be a person who feels called to health ministry, affirmed by their community in their calling, and someone other than a faith community nurse (FCN), clergy, or chaplain.

c. The Health Minister is a servant leader with a commitment to show the love of God through promotion of health, healing and wholeness.

d. A professional health or professional ministry background is not required to be a Health Minister.

4. Why Health Ministry

a. There are many faith communities with various types of outreach programs. These ministries serve the faith community, local pastorate and the community at large.

b. Many faith congregations/or faith communities have people called by God and gifted with talents and abilities to serve in health ministry who are not registered nurses, clergy or health educators by profession.

c. Many faith communities are approached by their own members and members of the community seeking help in a time of crisis.

d. Faith community members may be more trusting of and open to health ministry leaders from their own faith community.

e. Faith communities embrace people where they are on their life journey and provide caring relationships in community; this is a foundation for health.

5. Settings for Health Minister & Whole Person Health Outreach

This outreach is based within the facilities of a faith community. The HM functions as a member of a multi-disciplinary team, providing care to the faith community as a whole, as well as the groups and individuals within this congregational and other care settings. Others from the faith community and community at large will assist in accomplishing aspects of the program.

Faith Community Nurses and Health Ministers have complementary roles. They may work together or apart in the community at large or a congregational setting based on varying models. Each role is supervised and supported by designated leaders in a community or congregation. A health minister is not meant to replace primary care providers already in the community. In the broadest sense, the congregation is seen as a health setting that provides pastoral and spiritual care and can partner with a variety of other care providers in the community.

Most encounters with congregants or members of the faith community will be within the buildings and programs of the faith community. The various offerings of the faith community, such as worship,

educational programs, special interest or support group, programs for spiritual growth or renewal, and support services such as soup kitchens, may be coordinated by the HM.

A community of faith may be composed of people of all ages. The members of this community may also offer a range of physical, mental, emotional, and cognitive development services or ministries. When an individual, family, group or the faith community as a whole experiences or desires a change in their level of physical, mental, emotional, social, environmental, or spiritual well-being, or maintenance of current levels of well-being, the HM will make referrals to appropriate resources.

The needs and desires of individual members of the faith community may require that the HM and/or co-workers conduct visits to members in the hospital, hospice facility, private homes, residential facilities, jails/prerelease centers or accompany clients as they access health services within the community or in another community. During these types of encounters the HM, if so authorized by the Pastor, Imam, Rabbi, or Senior Clergy/faith community leader, may also intervene with spiritual care and provide a supportive, healing presence for both the client and loved ones.

The size, concerns, unmet needs and expectations of the faith community will establish the expected role of a HM within a specific community of faith. As a recognized staff member, the Health Minister will most often be supported and guided within the faith community by a committee of faith community members assisted by volunteers. These volunteers may assist with wellness, health promotion events, and educational activities.

In the faith community setting, it is important that the Health Minister document activities as requested by designated administrative official(s). Any record keeping should uphold confidentiality standards. Records should only be for statistical purposes. Individual information should remain the property of the individual, especially in a health, self-care promotion health ministry. The Health Ministers should prepare a regular report for submission to the designated administrative official(s) of their local faith community. The report will help to evaluate the impact of the HM with the community. Accountability is an important part of the HM role.

6. Code of Ethics & Conduct

Since all professional organizations have a code of ethics and conduct, the Health Ministry Association suggests that the health minister's decisions and actions reflect and are guided by client, personal, and professional ethical considerations. In addition to the code of ethics and conduct listed here, a health minister is obligated to the ethical and professional code of their profession.

In some instances, the health minister is responsible for providing health promotion services to promote the client's desired health outcomes. With inevitable conflicts among client, societal, professional, and personal beliefs and values, the lay health minister must have knowledge of these beliefs and values and make ethical decisions in a systematic manner that respects client values and belief systems and achieves the best possible outcome. Ethical concerns in health ministry include the principles of client autonomy, the right of self-determination in health care decisions: confidentiality; beneficence/non-malfeasance, the obligation to do good and not to do harm; and justice, the distribution of limited resources (including time, energy, and fiscal and material resources). In addition, health ministers ought to consider the virtue ethics, such as caring, forgiveness, and compassion, in their decision making.

- The health minister maintains a professional and therapeutic relationship with the client at all times.

- The health minister respects the decisions of the client without being judgmental and delivers nondiscriminatory health promotion services.

- The health minister identifies real and potential ethical conflicts and seeks the facts and resources to assist him or herself and clients in making ethical decisions.

- The health minister is an advocate for the client's right to self-determination and for support in carrying out health care decisions that reflect the client's beliefs, values, and faith practices.

- The health minister reports unethical and illegal activities to the appropriate authorities.

- The health minister educates clients about their rights and responsibilities in making informed health care decisions.

- The health minister does not abandon a client when there is unresolved conflict between the client's and the health minister's values, but refers to appropriate resources.

- The health minister maintains confidentiality at all time.

- The health minister follows professional standards as defined by their profession if they serve in a professional role and function. It is important to be clear to the client in what role and function they are serving and in what setting they are practicing.

7. **Authority & Responsibilities of Health Minister**

   a. The HM is responsible and accountable to their local Pastor, Imam, Rabbi, Senior Clergy or other designated faith community leader.

8. **Educational Preparation for Health Ministers**

   a. Knowledge of belief and practices of the faith communities' tenets or "Statements of Faith."
   b. Completion of preparation course in health ministry/program
      - Health Ministries Association's 2016 Health Minister's Educational Committee suggested health minister education programs should include at least 22 contact hours and used HMA's Health Minister foundational curriculum elements).
   c. Basic education regarding integration of faith and health through:

   - Continuing educational programs
   - Certificate courses
   - Local faith community designated programs
   - Health facility Spiritual Care programs
   - Academic theological courses
   - Attendance at local, regional, or national conferences

National leaders of faith groups who recognize the importance of the integration of this specialty within faith communities have developed mechanisms for mentoring and providing informal and formal on-going education in concepts of spiritual beliefs, practices, and rituals. When available within the structure of the faith group, the health minister may work with the leadership of the faith community to obtain the educational practice requirements and formal designation as a spiritual leader.

Faith groups have different ways of designating or titling individuals who have attained an advanced level of preparation and undergone examination to determine fitness for providing spiritual care. The faith community indicating their achievement may then give a congregational member who achieves the requirements defined by the faith group within which they are practicing a title. Examples of such titles are: Deacon, Minister of Health, Spiritual Leader, Caring Minister, or Pastoral Associate. Titles such as these have a specialized meaning within the faith community served.

9. Continuing Role & Spiritual Development

a. Health minister practices needed to foster ongoing growth and development
- Participation in peer support networking opportunities at local, regional, and national level helps the HM grow and develop
- Engaging in ongoing spiritual direction, theological reflection, and/or other spiritual exercises allows for personal and professional development of the HM
- Publishing and disseminating Health Ministry best practices at local and national conferences allows for an exchange of ideas and helps HM develop a standard of excellence

b. Importance of Health Minister self-care and wellness
- Tend to regular, personal health and wellness (exercise, nutrition, time off, etc.)
- Setting limits and boundaries for ministry and personal life
- Balance between ministry and self-care to prevent ministerial and professional burnout

10. Areas of Health Promotion and Wholeness Activities for Health Ministers

a. Sponsor and or facilitate congregational/faith community outreach activities in the form of:

1. Communication boards
2. Newspaper advertisements
3. Mission trips
4. Spiritual retreats
5. Health fairs
6. Weekly support groups
7. Exercise classes
8. Health education programs
9. Speakers bureau
10. Other health related activities

b. The HM may lead or be a member of the Congregation's/faith communities' Health
   Cabinet and may function as:

   1. Coordinator of volunteers
   2. Visitor of the sick
   3. An assistant to children, fathers, mothers, teens, seniors and the disabled
   4. Health advocate
   5. Health educator
   6. Referral agent
   7. Advocate for social justice and/or legislative issues
   8. Liaison with other faith communities/local health interest groups,
      organizations and institutions

c. Community-Based Participatory Research.

Health Ministers can participate in Community-Based Participatory Research (CBPR). CBPR
are collaborative efforts to get people more involved in their communities through participation
in research studies. Residents of the community can partner with researchers to effect change in
the status of their community (U. S. Department of Health & Human Services, National
Institutes of Health Office of Behavioral and Social Science Research (n.d.). Community-
Based Participatory Research Health ministers can help bridge the gap in "partnering" with
faith communities in these research projects. These projects can benefit the community at large,
leading to a healthier community. It is extremely important that these partnerships are equitable
in the distribution of financial and staffing resources for all parties, especially faith
communities.

11. Current Trends and Issues Influencing Health Ministry

a. Role of Networking and Partnerships with Faith Communities

The collaboration between health care systems and faith communities can have a tremendous
impact on improving the health of individuals. Faith communities are the most trusted and
respected institutions and have the ability to reach large numbers of people on a consistent
basis. Due to the changing dynamics in health care and with the rising costs of chronic
conditions, it is essential for health care systems to begin building equitable partnerships with
faith communities. There are ways for both large and small health care systems to begin
building those relationships, which may include:

   1. **Building relationships with community clergy and lay faith leaders.** Most health
      care systems have established a network of community contacts through their Pastoral
      Care departments. Community clergy may provide pastoral care to patients or serve on
      ethics committees. Often clergy designate a lay leader to oversee a ministry, including
      health ministry. Get to know the lay leaders and try to build lasting relationships with
      them.
   2. **Hearing the voice of the community.** Invite area community clergy and lay leaders to
      an evening dinner or breakfast and begin to discuss ways in which you may begin to

partner to develop a community outreach program to promote wellness, prevention and wholeness within the congregational setting.

3. **Build relationships of trust**. Visit area clergy at their local congregations, clergy network meetings, or faith leaders gatherings. Get to know them and the communities in which they serve. Building relationships of trust is the foundation for any successful program.   Try to understand the challenges clergy and faith leaders are facing.

b. Health & Wellness Coaches

Health coaching is becoming recognized as a new way to help individuals with their illnesses and conditions. Health coaching involves helping clients to develop and maintain healthier lifestyles (NutritionEd, 2015). The following is an example of specific duties of a health coach, which may include:

1. assessing a client's current health condition
2. developing health goals for a client
3. providing counseling services
4. conducting behavioral health screenings
5. establishing a client's treatment plan (NutritionEd, 2015, para 3).

Health coaching provides motivation, encouragement, and health education in an atmosphere where full attention is given to the client and where the way to self-discovery is paved.

A health coach certification exam has been developed by such organizations as the American Council on Exercise (ACE) and the National Society of Coaches (NSHC). Once the health coach attains certification, the term "certified health coach" (CHC) can be used. (Nutrition Ed, 2015).

c. Stanford Chronic Disease Management Model

The Chronic Disease Self-Management Program (CDSMP) is an evidence-based program developed by Stanford University from California. This program is typically implemented within community settings such as senior centers, libraries, hospitals and faith communities. Workshops are facilitated by two trained leaders and are given for two and one half hours, once a week, for six weeks. Participants engage in interactive sessions where they focus on building skills to self-manage their chronic health condition, provide support to and share experiences with their peers. Facilitators do not need to have a health background to lead workshops, therefore, this is a perfect program for Health Ministers to conduct within their congregational setting.

There are numerous organizations across the United States and within several countries that are licensed to offer the CDSMP workshops and trainings. To see a list of those organizations please see: http://patienteducation.stanford.edu/organ/cdsites.html.

d. Fall Prevention

Falls are a public health problem that is largely preventable (CDC, 2015). Health Ministers can be utilized within the congregational setting to assist older adults to reduce the risk of falling through an evidence-based program called A Matter of Balance. This nationally recognized program was developed at the Roybal Center at Boston University. The program was designed

to help older adults reduce their fear of falling and increase physical activity. Initially, the program model utilized nurses and physical therapists to deliver the program curriculum. However, in 2003 a volunteer lay leader model was used instead of the healthcare professional model to conduct the program. It was found that the lay leader model reduced the cost of the program, therefore allowing for frequent program offerings and the ability to reach a larger number of older adults. Program participants engage in an 8-week interactive workshop where they learn to control their risk of falling, set realistic physical activity goals, make changes to reduce falls at home and exercise to increase strength and balance.

e. Faith Communities Partnering with Universities/Seminaries

There are opportunities for health ministers in faith communities to partner with colleges and universities and other higher education institutions for mentoring, research, and student internships. The following are suggestions for those partnerships.

I. **Curricula & Certificate Program Development Regarding Spirituality & Health**

a. Spirituality and health - academic vs real life conundrum.

Research shows that spirituality plays an important part in one's overall health and well-being. Colleges and universities recognize these important findings and the need to train professionals to provide competent care and approaches involving spirituality. Most of the training on spirituality in higher education takes place after the completion of degrees. In 2010, about ninety percent of medical schools had courses or content on spirituality and health with the content varying widely. Despite acknowledging its importance to patients, the majority of deans are uncertain about including spirituality and do not think more content is needed. The schools state that curriculums are already packed with content to prepare professionals adequately (Koenig, 2008). If professionals are going to meet the realistic and practical issues of the people they serve, especially the spiritual consideration, needs, and assets of the person, should not schools reconsider the presence of spiritual content in their curriculums in preparing competent professionals?

b. "Faith placed not faith based"

Research shows that spirituality is important in one's overall health and well-being. Colleges and universities recognize the impact of this research. When offering educational programs, most colleges and universities are encouraged to not promote one particular faith or ideology in their spirituality and health educational programs. Rather, the colleges and universities recognize the important place of faith and spirituality for the human person.

II. **Sample Health Minister educational programs sponsored by academic institutions using HMA's Core Curriculum Elements for Training Health Ministers (at least 22 contact hours)**

a. Wesley Theological Seminary (DC) Health Minster certificate (Catholic Health Association, Improving the Lives of Older Adults through Faith Community Partnerships: Healing Body, Mind and Spirit. October 2016.)

b. St. Francis University (PA) - Academy for Leadership in Community Based Health

Ministry offers a post-secondary certificate program

III. Professions Offering Post-Graduate Certificates (Special focus on profession & understanding client's spirituality)

1. Medical schools
2. Pharmacy schools
3. Social work schools
   a. Boston University, University of Michigan, Smith College and New York University
4. Nursing schools, hospitals, and other health related institutions
   a. Faith Community Nursing educational programs guided by HMA and American Nurse's Association's Scope and Standards for Faith Community Nursing
5. Chaplaincy

Nurses have been encouraged to include spiritual care in their practice, especially within the last ten years. A study by Delgado (2015) asked nurse participants to do the following: identify spiritual care practices that they use, describe their perceptions of the effectiveness of their spiritual care practices, discuss their preparation for spiritual care practices, and describe their comfort in providing spiritual care.

The results of this study of 123 registered nurses revealed the following. Approximately half of the nurses (46.8%) were very active or somewhat active in their faith, but a majority (89.5%) considered themselves as very or somewhat spiritual. The nurses reported that they initiated spiritual care more often (59.8%) than patients or their families. The results of the question about inclusion of spiritual care in nursing education had mixed results. The nurses reported the following: spiritual care was mentioned but not taught (38.3%), spiritual care was mentioned but not emphasized (34.2%), and spiritual care was not covered (11.7%). In the discussion the author notes that nurses seemed to be more comfortable giving spiritual care that was not overtly religious, such as providing physical care and comforting touch (Delgado, 2015).

f. Inter-professional Collaboration & Communication

A panel of experts from six health care organizations (American Association of Colleges of Nursing, American Association of Colleges of Osteopathic Medicine, American Association of Colleges of Pharmacy, American Dental Education Association, Association of American Medical Colleges, and Association of Schools of Public Health, 2011) published a report from their expert panel on inter-professional collaborative practice. This report became the "Core Competencies for Inter-professional Collaborative Practice". The core competency domains are: values/ethics for inter-professional practice, roles/responsibilities, inter-professional communication, and teams and teamwork. These competencies can be used for education of

health ministers, who will be working within inter-professional teams for care of their clients. Health ministers can use this information to assist in communicating with different agencies and different professionals to become aware of how to access resources. The report concluded that we need to reach out to create a "web of connection" among various professionals.

g. Mentoring

The term mentoring is often seen in conjunction with the term coaching. "Mentoring is to support and encourage people to manage their own learning in order that they may maximize their potential, develop their skills, and improve their performance and become the person they want to be" (Parsloe, n.d.). Mentoring involves the development of a partnership between two people—the mentor and the mentee. The mentor is an expert in the discipline and the mentee is a person who is entering the discipline or entering a new job within the discipline. The mentor and mentee share similar experiences. The role of the mentor is to guide and help the mentee to choose the right direction and develop solutions to situations that may occur. The mentor-mentee relationship allows for a safe situation in which the mentee can develop ways to handle experiences that may occur (Bohannon & Bohannon, 2015).

Faculty and experienced health ministers in various disciplines can serve as mentors for health ministers in faith communities. The health minister can select an appropriate faculty member, possibly a former instructor or leader, who will then serve as a mentor during the beginning processes of development of the health minister role. Once the formal mentor-mentee period is finished, the mentor can still serve as a resource for the health minister.

Mentoring will be a key to future sustainability of faith and health practice. Mentoring health ministers will help them to mature in their skills and understanding of faith and health. Mentoring will help health ministers to hone their skills in the particular area and setting they are working in. Mentoring helps to develop competent health ministers who often work in complex multisector environments. The health minister can grow in maturity and confidence in a supportive structure, such as a mentoring program.

h. Research

Faculty and students in universities where research is conducted can be an asset to the health minister who is interested in participating in research. In recent years there has been increased interest in conducting research studies that deal with the relationship between spirituality and health. Studies by nurses and members of other disciplines have demonstrated the benefits of participating in activities within a faith community. These benefits include, but are not limited to," social support, social identity, and a sense of power beyond one's self" (American Nurses Association & Health Ministries Association, 2012, pg. 16). Faith community nurses have conducted research studies which have demonstrated benefits from this nursing specialty practice. Results of these studies have shown "measurement of clinical outcomes and the cost-benefits of faith community nursing interventions" (American Nurses Association & Health Ministries Association, 2012, pg. 16).

The health minister can participate in similar studies to demonstrate the value of the health minister role in the health of the faith community. Partnering with faculty and students in

universities can be a beginning step in the process of validating the importance of the health minister role in the overall health of faith communities.

i. Student Internships

Internships, sometimes referred to as practicum experiences, are typically performed by college students in their junior or senior year. Unlike a mentorship program, an internship is a component of a college curriculum for certain disciplines. There are advantages to internships which include hands-on experience in the student's chosen field and networking opportunities (Mcnulty, Robinson, Johnson, & McCoy, 2013). Simons et al (2012) conducted a research study to determine if this experiential learning opportunity is beneficial to students. Results demonstrated that the student internship influenced the students' professional development and that the work performed by the student had a positive effect on the community (Simons, et al, 2012).

Internships are usually performed at the undergraduate college level. Students who have an interest in working as a health minister in a faith community can plan an internship in that area. Faculty at colleges and universities need to afford students the opportunity to utilize a faith community for their internship experience. Health ministers should welcome students into their faith communities for these experiences. It can be a beneficial experience for the student, the health minister, and the faith community.

j. National Health Agenda – Healthy People 2020

Healthy People provides science-based, 10-year national objectives for promoting health and preventing disease. Since 1979, Healthy People has set and monitored national health objectives to meet a broad range of health needs, encourage collaborations across sectors, guide individuals toward making informed health decisions, and measure the impact of our prevention activity. Currently, Healthy People 2020 is leading the way to achieve increased quality and years of healthy life and the elimination of health disparities.

Every 10 years, the U.S. Department of Health and Human Services (HHS) leverages scientific insights and lessons learned from the past decade, along with new knowledge of current data, trends, and innovations. Healthy People 2020 reflects assessments of major risks to health and wellness, changing public health priorities, and emerging issues related to our nation's health preparedness and prevention.

The HHS has published a progress update on Healthy People 2020 leading Health Indicators. The following areas have shown no improvement as of March 2014: persons with medical insurance, persons with a usual primary care provider, with diagnosed diabetes whose A1c value is > 9 percent (age adjusted, percent, 18+ years), obesity among adults, children, and adolescents, mean daily intake of total vegetables, binge drinking in past 30 days for adults, and adolescent cigarette smoking in past 30 days (HHS, 2014). There were three indicators that were getting worse: suicide, adolescents with major depressive episodes, and persons who visited the dentist in the past year (HHS, 2014). This information has implications for health ministers who can use this information in their practice for education and referrals with their clients.

k. National trend for healthier and safer communities

With Healthy People 2020 as its backdrop, there has been a national focus to create healthier and safer communities. The Healthy People Environmental Objectives focus on the following themes: outdoor air quality, surface and ground water quality, toxic substances and hazardous wastes, homes and communities, infrastructure and surveillance, and global environmental health (Healthy People 2020, 2015, para3). Poor environmental health can affect all residents of a community, but has a greater effect on those persons who are experiencing health problems. Health Ministers can impact the environment through such activities as advocating for a cleaner environment and education.

The Centers for Disease Control and Prevention (CDC) have developed many resources to assist in violence prevention in communities. One such resource is the document "Building Community Commitment for Safe, Stable, Nurturing Relationships and Environments". The following are the elements for developing a vision for safe communities:

1. Establish a process for developing a shared vision
2. Engage the community
3. Use simple, straightforward language in the vision statement
4. Analyze barriers to widespread adoption
5. Make the case
6. Recruit champions
7. Leverage influential allies
8. Determine clear, do-able roles for each partner
9. Create structures for accountability (CDC, n.d.)

The Health Minister can use this document to develop partnerships within the community to build a safer environment.

l. Healthcare, Health Systems Transformation, and Health Insurance Coverage

The Affordable Care Act was passed in 2010 and implemented in 2014 to help provide insurance to many Americans who were previously uninsured. With skyrocketing healthcare costs and over 30 million Americans without health insurance, there was increased attention to improve healthcare and lower costs for Americans. Even with the passage of the law, there continues to be great political debate on healthcare reform. For example, in June 2015, the national subsidies that are provided to qualified patients as part of the Affordable Care Act was upheld in the King vs. Burwell case heard by the Supreme Court of the United States. If this ruling was not provided, many thought that the entire Affordable Care Act would have been in jeopardy.

The preliminary results of the Affordable Care Act are beginning to be seen. The number of uninsured has dropped significantly from the third quarter of 2013, when the rate of uninsured Americans peaked at 18 percent. In 2015, the uninsured number of Americans has dropped to 12%. In 2007, 16% of the United States Gross Domestic Product (GDP) was spent on healthcare costs. Healthcare costs have consistently increased over time to become a larger part of the United States' GDP. In FY 2015, 22% of the United States Gross Domestic Product (GDP) was spent on healthcare costs. Access to health insurance has been one major hurdle that has been addressed by state and federal health insurance marketplaces and exchanges.

People who recently acquired health insurance as a result of the Affordable Care Act are learning how to access preventative and primary healthcare services. The increase number of people utilizing a variety of health services will undoubtedly deepen the need for individuals like Health Ministers who can guide consumers in accessing the healthcare system. New preventative services and initiatives will be needed in the community, including congregations, to support and sustain health and wellness lifestyle practices. Health ministers play an important role in assisting faith communities to sign up for health insurance coverage as well as help people access health providers, connect to health resources, and accompany people on appointments as they try to navigate through our ever evolving complex healthcare system.

People who now have health insurance need to educate themselves on how to use their health insurance in primary care provider or their primary medical home. Health ministers can serve as connectors, healthcare educators, and navigators of the healthcare system. Staff and resources need to be made available for supporting people on both the healthcare system and faith based sides. Each of these partnerships will be unique to each community and geographic areas.

Each state may have adopted or did not participate in implementing the Affordable Care Act. It is important to educate yourself and others in knowing your state's position in relationship to the Affordable Care Act. Some states may have Innovation grants (ex. Center for Medicaid Services) to try out unique approaches to implementing and measuring the impact of the Affordable Care Act for health care providers, insurance providers, and consumers. Understand your state's current Affordable Care Act programs and outreach. Advocate, as necessary, as a health minister for where there are gaps in services and care, especially for the underserved. Bring awareness of the gaps to local, state, and federal representatives.

m. Denominations/Faith Community Support for Health Ministry

A variety of faiths see health as a social justice issue where health and healthcare should be a basic human right for everyone. The Christian Medical Commission of the World Council of Churches published a report in 2002 about the churches' role in health. This report called churches to recognize the causes of disease as being social, economic, spiritual and bio-medical. The report further stated that "health is most often an issue of justice, of peace, of integrity of creation, and of spirituality" (World Council of Churches, 2002, pg. 1).

When discussing health as a justice issue, it was reported that the number one cause of disease is poverty, which is the result of oppression, exploitation and war. Churches are called upon to recognize this as a justice issue and to work locally, regionally, nationally, and globally to bring justice and health to all (World Council of Churches, 2002, pg. 1).

Health ministers, who are part of faith communities, seek to care for all by living out the mission and tenets of their faith.

n. Faith based organizations

Each faith may have an overseeing organization or organizations that supports health ministry on a national, regional, or local level. The structures can be assets to faith communities and

neighborhoods. It is important to know one's own faith structures and to know others that exist in other faiths in order to foster collaborative partnerships. Supports can range widely from no support to health ministry material resources to assistance with training health ministers to technical assistance to convening and developing ongoing faith community networks for communities.

It is important to know the current faith and health statements and positions on your faith as well as other denominations or faith groups. Faith competency alongside cultural and racial competency are important factors in rooting whole person health movements in communities.

o. Vulnerable populations

Faith communities have a longstanding tradition of serving the poor and underserved. Our modern hospitals find their foundation in religious movements. Healing is also part of numerous faith traditions and their role in health. In our contemporary times, there is a movement in faith communities to reclaim this healing tradition. Sr. Rosemary Donley, who is the Jacques Laval Endowed Chair for Social Justice for Vulnerable Populations at Duquesne University, Pittsburgh, PA, has examined the term vulnerable and its implications for individual health and the system of healthcare. Sr. Rosemary explained that the word vulnerable comes from Latin and means "to be wounded". Persons who are vulnerable are susceptible to negative events, have probability of poor health and may be dependent (personal communication, R. Donley, 2014)

p. Chronic Diseases

According to the Centers for Disease Control and Prevention (CDC) chronic diseases are the leading causes of death and disability in the United States. The most common and most costly chronic diseases include: heart disease, stroke, cancer, diabetes, obesity, and arthritis. These chronic diseases are also preventable (CDC, 2014).

Health promotion activities implemented by a Health Minister may assist persons in the prevention of chronic diseases. Resources are available through a number of organizations including the CDC. Health Ministers may also assist persons with chronic diseases in the management of their diseases through such activities as individual exercise and monitoring. Chronic disease resources available through the CDC include: cancer; community health; diabetes; heart disease and stroke; nutrition, physical activity, and obesity; oral health; population health; preventing chronic disease journal (PCD); and smoking and tobacco use (CDC, 2014).

q. Public Health

The core mission of public health is to ensure the health and safety of all communities across the nation. Public health agencies know that this mission cannot be achieved alone. Public health practitioners and policymakers recognize the importance of collaborating with diverse community partners, such as faith-based organizations. Partnerships between public health agencies and faith communities is not a new concept, however it is receiving a renewed focus at all levels of the government.

> "Lack of trust can cause health programs to fail with harmful consequences. Measles outbreaks in the United Kingdom and the United States and the spread of polio across Africa from Northern Nigeria underscore the importance of building – and maintaining – public trust in health interventions and in the authorities who provide them. Trust relationships must be built over time so that they become the social framework in which health interventions – and positive health outcomes – can thrive."
> **[Heyman & Larson, JAMA, 2010, pg. 272]**

I. American Public Health Association (APHA)

The American Public Health Association established the Caucus on Public Health and the Faith Community in 1996. "This Caucus represents the growing recognition that health issues are not the exclusive domain of the work force or community-at-large. Significant interventions and major health promotion programs can be found in the nation's churches, synagogues and mosques. Faith-based services reach individuals that might not otherwise receive services. There is an increase in the number of churches identifying parish nurses to help meet the needs of elderly and recovering congregations. The Caucus develops programs that inform and explore the growing health care and education movement among the nation's faith traditions." (https://www.apha.org/apha-communities/caucuses/caucus-on-public-health-and-the-faith-community)

Health ministers can partner with schools of Public Health to involve Master of Public Health students and faculty to implement and measure health promotion programs within their faith community setting. These services can reach individuals that might not otherwise receive these services through traditional health care delivery.

Community health worker role

A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy. (APHA website, www.apha.org/apha-communities/member-sections/community-health-workers)

Differences between Community Health Workers and Health Ministers

Community Health Workers (CHW) are public health workers who have a great understanding of their community. The CHW serves as a link and/or liaison between health/social services and to simplify access to services and improve the quality and cultural competency of care delivery. Their role is usually very specific and focused on addressing a specific chronic

disease areas, such as hypertension, diabetes, asthma, etc. (http://www.cdc.gov/dhdsp/docs/chw_brief.pdf)

Health ministers differ from CHWs in many ways. Health ministers have a "broad" understanding of personal and community health which is not focused on one chronic disease. Health ministers like community health workers may have valuable, working relationships with numerous institutions to help community members access health services and health care delivery. Additionally, health ministers know the culture, concepts, and language of health within faith communities. Health ministers are often members of the faith community in which they serve. By being a member of a faith community, there is an added layer of trust built into relationships with people. This quality is important in addressing health disparities within specific racial and ethnic communities because of the historical mistrust among traditional healthcare services. Often faith communities are one of the few places where specific racial or cultural groups get trusted information and resources.

How health minsters can work with community outreach workers for overall health

Health ministers are trusted health messengers in faith communities. Since faith communities are considered safe and trusted places by many underserved and minority populations, health ministers can play a vital and crucial role in health messaging and healthcare access. Working with health ministers, community outreach workers can often access hard to reach populations in local communities. In their own right, community outreach workers may be able to access hard to reach populations in communities based on their ties and relationships in the community.

Community health worker certification varies state by state and not under a national unified certification education policy or standard. Community outreach workers could cross train as a health ministers to improve knowledge of a faith based community. Health ministers could also cross train as community outreach workers. The role development in the future for both community outreach workers and health ministers is constantly evolving as more emphasis is placed on prevention and community based models of care. Reimbursement for such health services is also continuing to evolve as our model of healthcare delivery changes.

II. **Emory Interfaith Health Program (IHP) & Association of State and Territorial Health Officials (ASTHO)**

The Model Practices Framework developed jointly by IHP & ASTHO provides strategies and possible schematics to identify and engage faith-based organizations as partners in community health promotion and disease prevention outreach. Designed for both public health and religious leaders, the aims of the guide are to contribute to partnership-building capacity and to enhance the ability of public health to reduce the spread of influenza.

A valuable resource on Public Health and Faith Community Partnership is the Model Practices to Increase Influenza Prevention Among Hard-to-Reach Populations resource and toolkit (http://ihpemory.org/ihp-programs/public-health-and-faith-community-partnerships)

"The Interfaith Health Program seeks to encourage faith groups to improve the individual and collective health of their members and the local and global communities they serve.

We seek to improve health outcomes by integrating strengths and resources of the faith community with public health programs.

We want the definition of health, as understood by health professionals, to take into account the potentials of faith groups as partners, especially regarding behavioral and social risk factors.

We want the definition of faith, as understood by leaders of churches, synagogues, and mosques, to take into account the potentials of public health science as partners, especially regarding prevention of suffering and health promotion as aspects of redemption and wholeness.

Among both communities, we promote increased capacity for collaboration, development of common vision, and integrated action strategies."

**Rev. Gary Gunderson, Former Director of Interfaith Health Program,
Health Ministries Association 10th Annual Conference Booklet, 1999.**

r. Federal Government & Public Health Support for Faith Based Partnerships

Increasingly public health, federal, state and local governments and other agencies are recognizing the importance of the integration of spirituality and faith based approaches to health.

I. U.S. Health and Human Services - Office of Faith Based and Neighborhood Partnerships

a. Health Minister Guides

The U.S. Health and Human Services (HHS) Center for Faith-based and Neighborhood Partnerships has developed a new health minister guide series. The health minister guides are produced by HHS to bring the latest understanding of prevention, health, and medical science directly to local communities, especially faith communities. The health minister guides cover traditional and complex health topics impacted by social conditions. The guides are aimed at health ministers, including faith community nurses, who HHS recognizes as trusted messengers in communities. HHS recognizes the work of the Health Ministries Association in providing clarity and capacity building in developing the health minister role through HMA's first edition of "The Health Minister Role: Guidelines and Foundational Curriculum Elements."

HHS believes that health ministers can disseminate the latest health information and encourage the adoption of health behaviors in culturally appropriate ways. HHS sees health ministers as key influencers in their community to create "health literate" populations. The guides prepare

health ministers for educating their community and promoting health behaviors in a variety of topics, including seeking care and navigating the health system.

Currently published health minister guides on HHS' website include Bladder Health, Viral Hepatitis, and Seasonal Flu. Additional health minister guides are being developed or drafted to address social determinants of health and complex health issues.

HHS' key goals for the health minister guides:

- Address stigma that impedes health-seeking behaviors
- Promote positive health behaviors through community-based prevention and health promotion interventions and models
- Reduce socio-cultural barriers and medical mistrust that can impede health education—especially among hard-to-reach groups who often have disproportionate disease burden
- Establish and strengthen partnerships with advocacy and other groups
- Equip health ministers as faith community "first responders" by translating scientific and medical research into caring practices
- Increase and improve the provision of culturally competent care
- Establish a feedback loop between communities and HHS science agencies
- Integrate health minister guide series into health ministry programs of faith communities

b. **Trauma-Informed Congregation (TiCong) - U.S. Health and Human Services (HHS) Center for Faith-based and Neighborhood Partnerships**

The U.S. Health and Human Services (HHS) Center for Faith-based and Neighborhood Partnerships, guided and influenced by SAMHSA - Substance Abuse and Mental Health Services Administration research and work on trauma, hopes to build resilient communities that heal, connect, restore in all parts of the United States through its Trauma-Informed Congregation (TiCong) work. TiCong realizes the widespread impact of trauma and understand and have faith in potential paths for recovery. It also recognizes the signs and symptoms of trauma in clients, families, staff, and others involved. TiCong encourages communities to integrate knowledge about trauma into everyday policy, practices, and procedures; and TiCong hopes groups seek to actively resist re-traumatization.

II. **SAMHSA - Substance Abuse and Mental Health Services Administration**

"It is important to acknowledge that spirituality is an important, necessary, and inseparable component of individual's lives. Spiritual beliefs are key to how many people deal with the joys and challenges of life and have given many a sense of purpose and direction for life. When facing challenges such as addiction and mental health disorders, spirituality has been a powerful source of strength, connectedness, and support. Spirituality has helped many fight feelings of helplessness, restore meaning to life, and regain a sense of control. While a cure

may result from medical expertise, health interventions, and disease-oriented care, consumers have described "healing" that occurs as a result of their spirituality.

If we truly want to help people achieve "wholeness," then we cannot ignore a key component, their spirituality or faith. As behavioral health service providers and agencies, we must acknowledge the role that spirituality plays in the path to recovery."

Source: (SAMHSA, One Voice, One Community Conference, Rockville, MD, March 26-27, 2015)

III. **Association State and Territorial Health Officials (ASTHO) & Faith Communities**

Partnerships between public health and faith based organizations are encouraged and supported in a publication from the Association State and Territorial Health Officials (ASTHO) for the advancement of health management and prevention. The work of health departments could not be accomplished without faith based organizations (FBOs). Source: ASTHO - At-Risk Populations Fact Sheet Faith Based Organizations (FBOs) http://www.astho.org/Infectious-Disease/At-Risk-Populations/At-Risk-Populations-Fact-Sheet-FBO

s. International Health Ministry Practice & Models

Diakonhjemmet – Norway

Diakonhjemmet was founded in 1890, with the prime purpose of educating male deacons for church and society. Today, it runs a hospital, nursing care facility and a university college with more than 3300 students, operating within the areas of health and social work at the level of bachelor, master and PhD studies. As a faith based organization and independent foundation, Diakonhjemmet sees their work as a diaconal outreach or ministry of the Church of Norway. Over the last few years, Diakonhjemmet has been engaged in issues of forming a new identity of health ministry and innovation.

Kjell Nordstokke, past CEO of Diakonhjemmet, and 9 chaplain and deacons from Daikonhjemmet have had an ongoing conversation facilitated by Heidi Christensen at HHS' Office of Faith Based & Neighborhood Partnerships. In October 2016, HHS' facilitated conversations and visits with various United States faith and health partnerships and health ministries to share their experiences with Diakonhjemmet. Diakonhjemmet as a faith based organization and provider of health services has been engaged in innovations and challenges which face their role. Ongoing dialogue continues between the Norwegian group, HHS, and other U.S. partners. The conversation is helping to develop interdisciplinary competence and practices as well as how faith and spiritualty are integrated as health assets in both countries. The interaction between Diakonhjemmet has provided HMA and our members with unique insight into how health ministry is implemented and sustained in another country and in another cultural context.

For further information about Diakonhjemmet please see their website at (www.diakonhjemmet.no). A background paper about Diakonhjemmet can be obtained at the following link: https://kirken.no/globalassets/kirken.no/church-of-norway/dokumenter/church_of_norway_church_and_health_2015.pdf.

Appendix A

Assessment - Interest Survey for Faith Community/Community At Large

The first step in caring for any client (individual, family, community) is an assessment. An assessment identifies the client's needs, strengths and weaknesses, and problems or potential problems. When caring for a community, the health minister can assess both the faith community (internal) and the community at large (external). Information about the faith community which can be obtained from church records would include the number of parishioners and families who are registered in that faith community. The clergy or staff may be able to give additional information such as the ages of the members of that faith community and an overview of the number of persons who have problems. This can include the number of persons with walkers, wheelchairs, or portable oxygen who attend services. Finally a survey can be done of the people who attend the faith community (see sample). The survey can assess the needs as perceived by the people. The survey may be offered at the time of a church service or may be mailed to the homes of the registered members. In order to obtain more responses, the survey may be done at the time of a church service. One problem with limiting the survey to a particular church service is that people who could not attend on that particular day will not be surveyed. Mailing surveys can also be problematic, as the response rate for mailed surveys may be low. The health minister must decide which approach will be best to gather assessment data.

The health minister may want to assess the community at large in which the faith community is located. The health minister can use this assessment to find resources available for his clients or may find problems that affect his clients. One mechanism to obtain information about a community is a "Windshield Survey" (see sample). The idea behind a windshield survey is for the person to look at the community while he/she is driving or walking throughout the community. Another way to assess the demographic information about a community is to check the community website, if one is available. Combining these two methods can give the health minister information about the community, its resources and its actual or potential problems.

Once this information is obtained, the health minister can begin to plan programs to meet the needs of the faith community. The health minister can also work with other resources in the community to improve the health of the community at large, which in turn can impact the faith community, and improve the health of the faith community and its members.

Sample Assessment Tool Questions, Inquires, and Considerations
- faith community assets, needs, wants, talents, gifts
- assessment/evaluation to be done internal, external, or both
- assessment format by website, windshield survey, or compare two
- goal and purpose of assessment: What do you want to assess? How will the evaluation be used for
  planning?

Appendix B - Sample Job Description for a Health Minister

General Description

This position is designed to promote the integration of body, mind, and spirit by providing leadership in identifying and responding to the health-related needs of members of the local faith community.

Knowledge, Skills, Abilities Required
- Three to five years experience in a human services-related field
- Ability to understand and communicate the concepts of the interrelatedness of body, mind, and spirit to health, healing and wellness.
- Clear understanding and commitment to the mission and vision of the faith community relative to fostering wellness
- Good communication, interpersonal, listening, and caring skills

Job Relationship
- Reports to: Parish Pastor, Iman, Rabbi, or Faith Community Leader
- Related to: Health Committee; other professionals in health ministry; faith community staff; members of the faith community; general public.
- Persons directly supervised: Volunteers involved in health ministry

- See Health Minister guidelines for tasks and sample duties to list

Working Conditions
- May be exposed to infectious and/or contagious diseases due to interaction with multiple populations
- Occasionally subjected to irregular hours
- Occasional pressure due to handling multiple calls and inquiries
- Ability to drive and have access to a car; current driver's license and auto liability insurance

Physical Demands
- Manual dexterity and mobility
- Frequent standing, bending, sitting, and walking; occasional lifting, pushing, pulling
- Good eyesight; ability to see clearly at 20 inches or less

Hours per week
[When the position involves an unpaid professional, a realistic approach must be used when developing a work load and not overtaxing the individual. In starting a program a minimum of 10 hours a week is generally required]

Other considerations
Regardless if paid or unpaid, include hours for person to designate as self-care hours where the health minister will not be available and another person will be able tend to the duties normally assigned to the role. Designated time away from the position helps foster healthy behaviors and standards for role. This is an emerging, necessary component for people to maintain a well-balanced mind, body and spirit health in ministry and the workplace.

Appendix C

Sample Health Program Report
HEALTH MINISTRY/PROGRAM MONTHLY ACTIVITY LOG

Health Advocate/ Faith Community Nurse:
Congregation(s):

Month/Year:	Paid Hours:	Volunteer Hours:

Numbers of Individual Contacts: Total:_____
Men ___   Women ___   Children___
Congregation Member___   Community Neighbor___
Ages: ___0-12   ___13-17   ___18-30   ___31-50   ___51-65   ___66-80   ___over 80

Presenting Concerns in Individual Contacts:

Psychosocial/Spiritual	Health-related Behaviors	Physiological	Environmental
___spiritual	___diet/nutrition	___cancer	___finances--aging
___grief/loss	___weight loss/gain	___diabetes	___finances--non-aging
___transitions, aging	___medications	___heart	___living arrangements
___hospitalization	___substance abuse	___arthritis	___safety
___parenting	___exercise	___respiratory	___other-_____
___relationships	___gen. health/wellness	___pain	
___other-_____	___other-_____ ___other-_____		

 # Referrals to: ___Clergy Staff   ___Health Care Provider ___Community Resources ___Cong. Resources
 # Referred from: ___Clergy Staff ___Cong. Member ___Health Care Provider ___Health Facility ___Self

Sites of Individual Contacts:

SITE OF SERVICE	#	Comments/Results of Contacts
Home		
Hospital		
Nursing Home		
Health Office		
Telephone		
Other		
TOTAL		

Group Contacts: Screenings

Type	# Screened	Age Range	# Referred

Group Contacts: Education/Support Groups/Healing Services

Event/Topic	# Participants	Age Range	Comments

Activities: ___Bulletin/Newsletter ___Bulletin Board ___Pamphlet Display ___Meetings ___Other

What I did for self-care:

_____

_____

_____

Any additional support/ training needed:

_____

_____

_____

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Core Curriculum Elements for Training Health Ministers

Second Edition

Health Ministers Association

Foreword

Health Minister Core Curriculum Review Committee

Health Minister Core Curriculum Elements

References

Appendix

- **Appendix A – HELP Diagram**
- **Appendix B - Blessing from Indonesia**

Foreword

The health ministry movement is an exciting effort to re-integrate what our ancestors knew centuries ago—that we humans are an integration of body, mind, and soul. We are most healthy when we attend to all these aspects of the human person. Since the1980's, faith community nurses have been at the forefront of this movement, helping people address health and healing in the context of their faith and faith communities. Faith Community Nursing continues to evolve useful standards and training to equip faith community nurses to be most effective in their work/ministry. Faith Community Nursing continues to be one way for congregations to integrate a health ministry into their congregation and are an essential part of any Health Ministry/program.

An emerging trend in health ministry is that people from varying professional and personal backgrounds are stepping forward with a desire to participate and lead in the whole person health movement. These Health Ministers also need standards and training to be effective in their work/ministry. This document provides an outline of key elements in Health Minister training programs, drawing on models already in use. Also included is a list of resources to help facilitators in conducting the Health Minister training.

There are varying Health Ministry and Faith Community Nurses models. Congregations need to discern which model is most appropriate, as both can assume the leadership necessary to actualize a successful healthy ministry. Health Ministers do not replace Faith Community Nurses. Each role complements the other and seeks to be a conduit for whole person health in the faith community. Health Ministers and Faith Community Nurses follow set standards to maintain competency, respect, and integrity for the people they serve. In order to understand these standards, please see the Health Ministries Association's 2016 Health Minister: Role Identification and Guidelines.

The education for Health Ministers is a thoughtful process in which the learner has to be engaged actively. The methods and tools selected in the training should reflect this active process. The more the Health Minister's personal experience can be interwoven into the training, the better prepared the health minister is to act and think critically.

Hope and Timmel's training model incorporates Paulo Freire's popular education model where participant learning is central to the education process. The participatory learner model is contrary to the traditional teacher-student model, in which the teacher is considered the authoritarian bearer of knowledge and the student is considered a storage area of information for the teacher. Indeed, some of the foundational background will need to be presented in a lecture style. However, when it is possible, use the participatory learner model to allow participants to engage and experience actively the context for themselves.

Research has shown participatory learning method to be highly successful in allowing participants to use their own life's experiences to retain and grow from what they learn. After thinking and reflecting critically on their experiences, Health Ministers can adapt to different environments and challenges they face.

When moving from theory to practice, Health Ministers are eager to move directly into action after they are trained. Health Ministers may experience a lapse after their training in trying to apply what they have learned. This is a normal is part of being a lifelong learner. The goal of Health Minister training is to have the participants engage in an ongoing process of action and reflection. This intentional, spiritual process helps Health Ministers to sustain their work through difficult times as well as fulfilling times.

Health Minister curriculums should be at least 22 contact hours and include core skills and knowledge areas including exploring the definitions and relationship between faith and health, active listening, interfaith understanding and relationships, spiritual reflection, self-care, communication and organizing a health ministry, exploring various health ministry models, understanding chronic disease, legal considerations and accountability for the role of the Health Minister as well as the congregation. Specialty topics such as mental health, advanced care, domestic violence, and others should be strongly considered. Health minister curriculum designers and facilitators need to consider the length and breadth of training carefully based on resources, costs, and capacity. Additionally, educators who are part of accreditation bodies for institutions or professional preparation are required and held to designated standards. Therefore, it is more favorable based on these standards and need for accountability and transparency that these institutions implement and facilitate Health Minister training.

As Health Minister educational programs grows, it is vital that research is conducted on the curriculums. The Health Minister curriculums should have internal and external reviews by numerous trusted parties. Data analysis, focus groups of participants, unbiased surveys, curriculum content reviews, and other methods should be employed as research to ensure best practices. As Health Minister curriculums are reviewed regularly, the content taught will ensure that it is relevant to current health ministry practices. Another important aspect of health minister education is that health minister curriculums are inclusive to diverse faith, professional, and life experiences. The goal of Health Minister curriculum reviews are to maintain accountability and to reach for the highest standards of educational competency and excellence.

The recruitment and screening of Health Minister Candidates is vital. Assessing the spiritual maturity of a potential Health Minister is extremely important. Also it is important that the Health Minister's call to serve their community is affirmed by the community they belong to. One way to assess and evaluate a person's readiness to be a Health Minister is for candidates to complete a spiritual autobiography and have them reflect on what it means to be present with others. It is helpful for prospective Health Ministers to examine their intentions to serve others.

After Health Ministers are trained, it is equally important to support them and help them to integrate into their new roles and provide ongoing support in faith, community, or other networks. Commissioning the participants as Health Ministers in a congregational and community setting can help them and the community. Facilitating or linking Health Ministers to ongoing networking opportunities locally, regionally, and nationally to groups like the Health Ministries Association and local faith community health networks of those involved in health ministry/programs will further enhance their growth and their relationship and connections with each other. Networking is an essential part of being an active Health Minister. It requires attention of both individuals and institutions from both health and faith sectors. Under-resourcing networks in staff and resources is ill advised. Spirituality and health work is complex and challenging work. Faith and health networks and partnerships with proper staffing and resources will make work and ministry sustainable and fruitful.

May this document be helpful in furthering the health ministry movement—and in enhancing your vocation in bringing faith and health together. We hope this document helps to guide your work in training Health Ministers. It is not an exaggeration to say that our work is and will continue to be a positive influence on the health of our faith congregants, our communities, and our nation.

Bless you in your work and ministry!

Tom Pruski, RN, MAPS
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Health Minister Core Curriculum Elements

The following outline includes elements essential to a Health Ministry training. These elements can be adjusted or re-arranged according to your training time frame. Teaching staff should have expertise in the topics they present as well as knowledge of the health ministry concept. Please contact the national office of the Health Ministries Association if you need additional assistance.

I. Foundations of Health Ministry
  A. Identify religious, cultural, and historic events that have shaped the growth of Health Ministry.

  B. Discuss the current state and vision for congregational health programs/ministries.

  C. Discuss trends that are impacting the development of Health Ministry.

  D. Understand Theological Traditions of Different Faiths

    1. Explore how various sacred texts ground faith
    2. Discuss what faith traditions exist in your community and how they relate to each other.
    3. Explore how various faith traditions understand health and wholeness.

II.   Explore Faith-Health Connection

     A. Medical versus whole person health models.

     B. Discuss the definitions of health, religion, and spirituality.

     C. Discuss the important role of the faith community as a place of whole person health and healing.

III.   Exploring the Culture of the Congregation

     A. Discuss the importance of understanding the history, mission, and organizational structure of a congregation.

        1. How the congregation is organized/ structured.

        2. List current congregational ministries/programs.

        3. What are the congregation's strengths/assets?

        4. What is the congregation's mission statement? Is it an active declaration?

          a. Are there any supportive documentation/data on whole person health from your denomination?

IV.   The Working Relationship: Health Ministry Team & Spiritual Leader

     A. Build rapport with your spiritual leader (pastor, iman, rabbi, etc.)
     B. Plan with your spiritual leader & congregational leaders

        1. Discuss how the health ministry team/spiritual leader can connect spiritual/sermon themes of faith with their initiatives.

        2. Discuss where the health ministry team will be in the congregation's organizational structure.

        3. Develop job descriptions for the health ministry team and/or faith community nurse.

        4. Develop an ongoing plan for collaboration with spiritual leader, other ministries, etc.

V.   Building Blocks for Starting a Health Ministry Team

     A. Define the health ministry team's role in your congregation.

     B. Describe the function and role of health minister/faith community nurse.

C. Discuss different health ministry/faith community nurse models.

D. Discuss steps for developing a health ministry program.

E. Explore & utilize selected tools to assess, plan, and evaluate congregational and surrounding community needs and gifts.

VI. Chronic Disease

VII. Self -Care & Nutrition

VIII. Understanding How Adults Learn: Foundations for Change

A. Discuss the principles of adult learning.

B. Discuss the important adult learning principles of respect, immediacy, and experience.

C. Explore the philosophy of what it means to learn by experience.

IX. Exploring the Helping Relationship: Understand & practice active listening skills

A. Discuss how a health minister can be helpful and hurtful
Use David Hilton's HELP Diagram (Appendix A).

B. Discuss the concept of presence
1. active listening
2. being vs doing
3. companionship

C. Explore how active listening helps a person.

D. Explore what it means to provide spiritual care-giving.

E. Role Play Active Listening Skills
1. Identify Active Listening Techniques
2. Identify Roadblocks to Communication
3. Use case studies to practice active listening

X. Accountability, Professional Responsibility, & Legal Considerations of a Health Minister

A. Discuss definitions of accountability and professional responsibility.

B. Discuss the importance of documenting health ministry activities, using examples of documentation tools.

C. Use case studies to illustrate accountability, professional responsibility, & legal considerations.

D. Examine accountability of the Health Minister in his/her practice setting.

E. Consider health minister's responsibilities in relationship to any of his/her active professional standards.

F. Discuss the elements of negligence and malpractice.

G. Identify high-risk areas for potential violations of the health minister role.

H. Identify areas of policy and procedure development, including confidentiality, ownership of any records, etc.

XI. Evaluation of Health Minister Activities

A. Describe the importance for health ministry evaluation.

B. Provide different examples on how to evaluate program activities.

C. Discuss the importance of how evaluating and measuring health minister activities assist in planning and addressing future needs.

XII. Support for Ongoing Health Ministry Growth & Development

A. Spiritual direction/ guidance for health minister.

B. Congregational support for health minister.

C. Health minister's relationship to other colleagues

   1. Peer support for health ministers

   2. Faith community nurse(s)

   3. Congregational/Community health & wellness committees

   4. Clergy

   5. Public/community health professionals

D. Networks

   1. Local – Community, institutional sponsored

   2. National – Health Ministries Association

E. Share Health Ministry Best Practices with Peers

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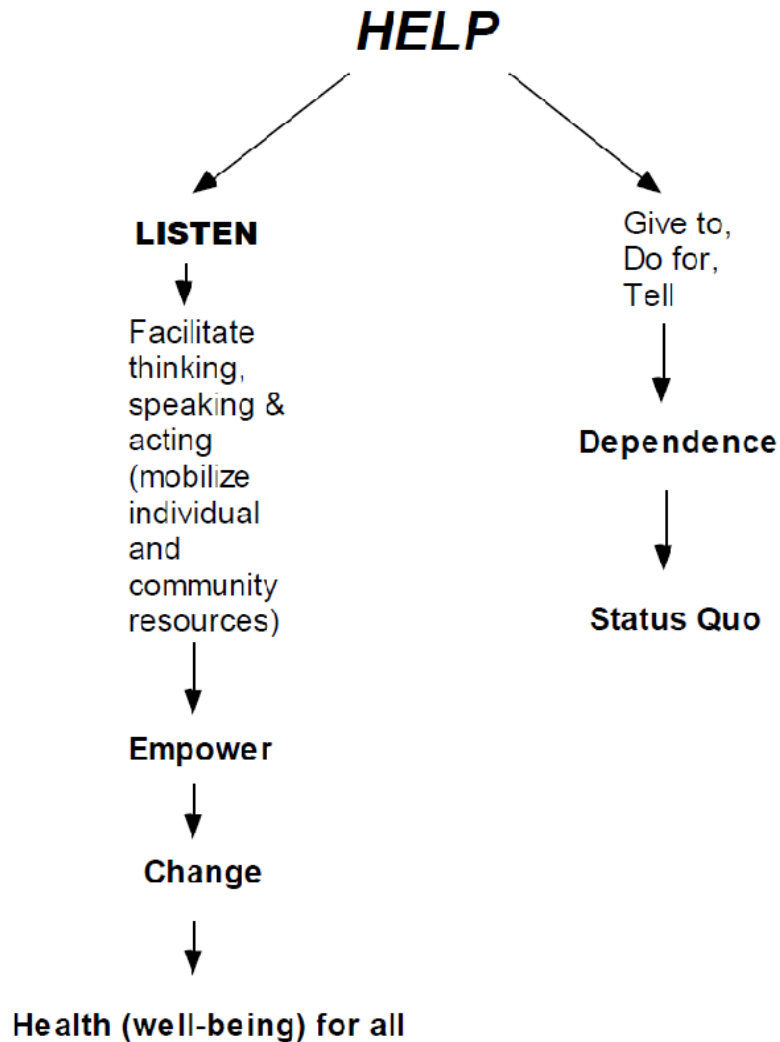
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Appendix A

HELP diagram – David Hilton, MD

HELP

LISTEN

Facilitate thinking, speaking & acting (mobilize individual and community resources)

Empower

Change

Health (well-being) for all

Give to, Do for, Tell

Dependence

Status Quo

Let's make sure our help is helpful!
Always accompany relief with empowerment.

Source: David Hilton M.D.

Used with permission

Appendix B

Blessing from Indonesia

May God bless you with discomfort at easy answers,
half truths, superficial relationships,
so that you will live deep within your heart.

May God bless you with anger at injustice,
oppression and exploitation of people,
so that you will work for justice, equality and peace.

May God bless you with tears to shed for those who suffer from pain, rejection, starvation and war,
so that you will reach out your hand to comfort them
and change their pain into joy.

And may God bless you with the foolishness to think
that you can make a difference in the world,
so that you will do the things which others tell you cannot be done.

(Author unknown. Sent to World Council of Churches from Indosesia after tsunami disaster.)