

FINAL REPORT

SHENANDOAH COUNTY (Woodstock)

**Shenandoah Memorial Hospital – Valley Health
Critical Access Hospital (CAH)**

**Virginia Department of Health
Office of Minority Health and Public Health Policy**

**Medicare Rural Hospital Flexibility Program (FLEX)
Agreement Number: 08-557-14**

Submitted by:

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EXECUTIVE SUMMARY

Over one half of Virginia’s population attends church. By leveraging the 9,000+ churches in the Commonwealth as a force multiplier, the reach of public health can be much more extensive and effective. “The church is the only community-based organization that is found in virtually every community in this country. It is able to reach people of all ages, races, and economic backgrounds and it can strongly influence people’s values and personal life choices. Because the church is generally more integrated into the life of individuals and communities than our modern medical establishment, it can better enable people to assume responsibility for their own health.”¹

Churches are clearly underutilized as community health partners and lack health expertise and resources. By uniting the best practices of public health with faith-based principles and organizations, we can begin to close the gaps as health inequities are identified and their root causes are addressed at the core of communities. Congregational health (see Appendix A) brings together the best practices of public health and congregational-based principles emphasizing wellness, wholeness, prevention, and education. It simply cannot be ignored when considering public health.

Through collaborations and partnerships with other congregations and local, state, and national organizations, the church can provide quality health information and core health-related services to its members. However, a more formal process needs to be developed and implemented in local congregations. The Virginia Department of Health (VDH) has an opportunity to maximize the capacity of public health efforts and can take steps in closing the gap by supporting future congregational health efforts.

The Congregational Health ReSource, LLC (CHR) was commissioned by the Virginia Department of Health, Office of Minority Health (VDH OMHPHP), to perform congregational health assessments using federal Medicare Rural Hospital Flexibility Program (FLEX) funds.

The assessments were designed to fulfill the shared mission of each partner to address the health needs of congregations using public health ideas and efforts. In this pilot program, CHR was tasked with developing five congregational health assessments (clergy, civic, medical, government, and education) (see Appendix B), surveying the Town of Woodstock (Shenandoah County, Virginia), and providing recommendations to VDH OMHPHP and the community based on the findings. This particular assessment is unique in that it provides an extensive examination of faith-based efforts that are currently employed at a community-level in rural Virginia.

Survey Findings

The Town of Woodstock has a population of nearly 4,200 residents, of which nearly 90% are Caucasian, have an average income of \$44,000, and have graduated with either a high school diploma (81.9%) or bachelor’s degree or higher (25.8%). Out of the congregations surveyed for this project, most of the congregations are Evangelical, have been established for over 50 years, and have strong budgets. Pastors of these congregations firmly believe in the connection between physical, emotional, and spiritual health. They feel strongly that 1) it is the church’s role to help their congregations be physically healthy, 2) it is appropriate for their churches to provide health literature and services to their members, and 3) individuals have the right to have ready access to healthcare.

Despite the pastors’ beliefs and understanding of the need for congregational health, only one church in Woodstock has an active health ministry. However, all of the churches already provide one or more of the following health-related assistance: prayer, meals, visitation, transportation to doctors’ appointments, attending doctors’ appointments with patients, and assisting with health-related paperwork. Two churches

offered occasional health-related programs. This is an indicator that a health ministry is a fairly new concept.

The pastors indicated difficulty in starting a health ministry for a variety of reasons, including a lack of time, resources, finances, community partnerships, congregational support, healthcare expertise, and ministry leader support, as well as uncertainty about how to start a health ministry. In addition, the congregations faced several barriers that have hindered the potential for health ministry development, including language barriers and a lack of 1) adequate and affordable insurance, 2) knowledge of resources, 3) sufficient income to afford basic necessities, and 4) transportation.

Pastors' top health concerns for their congregations included cancer, heart disease/heart issues aging/geriatrics, and cost of medicine/insurance, mental health, and knee/joint issues. This is not surprising in that several of these concerns are consistent with major causes of death in Virginia.²

Responses from the civic, government, and medical communities provided clear and concise ways that the clergy could benefit from the health-related services/partnerships outlined, should they pursue these avenues and resources. Many of the organizations were willing to assist congregations; however, they must first define health needs.

As a result of this pilot survey, CHR recommends developing 1) a model health ministry program at a statewide level, 2) a health ministry toolkit/manual, 3) a church member survey, and 4) a pilot model rural health ministry program for congregations, as well as continuing future research.

Engaging the faith community in these recommendations is essential to program success. CHR also recommends the following to produce an increased response to future surveys: 1) convene a town hall meeting once key leaders are identified, 2) develop focus groups based on the community sector, 3) offer incentives to complete the survey, 4) identify successful and active health ministries in local congregations to mentor or partner with other churches, 5) develop a model health ministry program at a statewide level 6) develop a health ministry toolkit/manual, 7) develop an individual church member survey, 8) develop a model rural health ministry program, and 9) continue future research.

¹Health and Welfare Ministries, General Board of Global Ministries, The United Methodist Church, New York, New York.

²Virginia Department of Health, Office of Minority Health & Public Health Policy, *Virginia Health Equity Report 2008, Executive Summary*