

Case Study

<https://doi.org/10.34074/scop.3008006>

RESTORING CONNECTIONS USING HEALTH
PROMOTION STRATEGIES

Kathie Lasater

Published by Otago Polytechnic Press. Otago Polytechnic Ltd is a subsidiary of
Te Pūkenga – New Zealand Institute of Skills and Technology.

© 2023 the authors; © illustrations, the artists or other copyright owners.

RESTORING CONNECTIONS USING HEALTH PROMOTION STRATEGIES

Kathie Lasater

INTRODUCTION

Usual connections were almost instantaneously lost at the beginning of the COVID-19 pandemic. In the United States (U.S.), the disconnection commenced in mid-March of 2020, nearly a year before immunisations were widely available. One significant area of disconnection occurred in faith communities (churches).

At my church, all activities ceased, and the doors were locked for weeks, even on Sundays. All regular in-person meetings of church committees, Bible studies, and special interest groups ceased. As the weeks and months wore on, reports of large-scale effects of the disconnection began to surface—loneliness and social isolation—among those who regularly attended church, choir practice, Bible studies, or kids' groups. But the majority of reports of negative effects focused on older adults, many of whom lived alone in facilities. Not only were they isolated in their rooms, even during mealtimes, they were unable to visit their families or be visited. Armed with this information, the health ministry team (HMT) in our faith community began to consider some health promotion strategies to address an issue they never had to consider before. The purpose of this paper is to describe how a team of healthcare professionals sought to use health promotion strategies to restore care and connection primarily among older adults during a time of seclusion to prevent the effects of loneliness and social isolation.

BACKGROUND

Health promotion

According to the World Health Organization (2021), the purpose of health promotion is to improve the health status and quality of life for individuals, communities, and all people. One form of health promotion focuses on primary prevention – that is, equipping people to prevent the onset of health issues by addressing them before they become issues. This is exactly what the HMT sought to do: to prevent social isolation and all of its effects by restoring some connection in the lives of those in its faith community.

Social isolation

According to experts, social isolation or the lack of social connection in adults can lead to chronic health conditions, cognitive decline, depression, suicide, even premature death, and an increased risk of dementia (Centres for Disease Control and Prevention, 2020). This was well-known long before the COVID-19 pandemic: a systematic review acknowledged that older adults were at risk of the effects of social isolation and evaluated the effectiveness of a variety of interventions for avoiding it (Dickens et al., 2011). The effectiveness of interventions was highly variable, but those deemed most successful were participatory or group activities. Due to public health restrictions, these types of activities were clearly not possible during the early period of the pandemic

in the U.S. Of the individual interventions mentioned, 60 percent of home visiting and 25 per cent of internet training resulted in improved participant outcomes.

As the pandemic continued in the U.S., diminished quality of life among older adults was identified as a potential outcome of social isolation (Melei & Linder, 2022). Moreover, a review by Brooks et al. (2020) suggested that initial quarantine periods, once the virus was contracted, had a negative effect on psychological well-being and became worse the longer they continued. During this time, Baker and Clark (2020) stated it would be increasingly important for health professionals to look for and assess nuances of change in older adults' mental health. By contrast, Carstensen et al. (2020) noted that prior to 2020, research indicated that older adults' emotional well-being tended to persist even in times of prolonged stress. That said, the world was experiencing a much different kind of "prolonged stress" than had been previously suffered.

Faith Community Nursing

Before becoming the leader of the HMT, I was certified as a Faith Community Nurse (FCN) in mid-2019, and after much networking in my faith community, I quickly assembled a team of health professionals, both actively employed and retired, who were interested in the health of our faith community. This team of nearly 40 health professionals represented multiple disciplines.

Faith community nurses (also known as parish nurses) are "licensed, registered nurses who practice [w]holistic health for self, individuals and the community using nursing knowledge combined with spiritual care" (Westberg Institute, n.d., para. 1). The focus of their work is to support members of a faith community to optimise and integrate the health of body, mind, and spirit. This nursing specialty began in the 1970s when a hospital chaplain noted there were more churches than hospitals in the U.S. and thought it would be workable for a healthcare professional, typically a nurse, to focus on health promotion in faith communities. The ultimate goal was to prevent hospitalisations through health promotion efforts (Westberg Institute, n.d.). A church represents an aggregate of the larger population, comprised of all ages; therefore, faith community nurses practice population health. One source has identified seven roles for an FCN including integrator of faith and health, health educator, personal health counselor, referral advisor, advocate, developer of support groups, and facilitator of volunteers (Centracare, n.d.)

Faith community nursing is recognised by the American Nurses' Association (Sessanna et al., 2022) and is present in other countries, including the United Kingdom (<https://parishnursing.org.uk>), Australia (<https://afcna.org.au>), and New Zealand (<https://www.faithcommunitynursing.nz>). It is not a requirement for FCNs to belong to a national organisation to practise; in fact, the New Zealand national organisation recently disbanded (Tyrell, 2023) for lack of membership, but FCNs in New Zealand continue to practise.

STRATEGIES (INTERVENTIONS) TO FOSTER CONNECTION

Plans for 2020 and beyond were definitely interrupted and shelved by the pandemic. As a faith community nurse leading a nascent health ministry team during this tumultuous time, I and team members began to explore how we could address the issues brought about by social isolation and quarantine, stemming from the pandemic restrictions, particularly among our older adult members. A few months into the pandemic, a call for grant proposals to address *emerging needs* came from the synod (a regional governing body within the Presbyterian denomination). While other faith communities sought to improve their audio-visual needs and live-streaming capabilities, the team determined to improve connection and caring for older adults, both from the faith community itself as well as augmenting their electronic device capabilities to prevent further social isolation. The team identified and planned several interventions to promote health among multiple generations.

WeCare Project

Planning

Even before the pandemic began, the HMT started planning to make in-person contact with over 100 households (singles and couples) who were at least 80 years of age or had special needs that caused them to be homebound. The HMT Steering Committee agreed a small gift would be the entrée to make the visits – a means to an end. They determined that the small gift should be season-appropriate for spring – miniature bulb plants, such as hyacinths, daffodils, and tulips, because they were cheerful in color and in their bud form, a sign of hope.

Because of the infectious nature of COVID-19 and limitations imposed by social distancing, the team had to decide how the volunteer team members could make but limit contact with this vulnerable population. The team developed guidelines for porch visits, including wearing masks and making provision to leave gifts on doorsteps if the recipient was away from home (a rare occurrence at that time in the pandemic). In a few situations where older adults could not come to or stand at the doorway, the team gave guidance to volunteers for hand washing, social distancing, and very limited indoor visits, but it was always the volunteer's decision.

One team member was able to secure the number of plants needed, most of which were donated by a local florist and the remaining offered at a discounted rate by another florist. HMT volunteers picked up the gifts at a central place during a specific time and distributed them. A colourful, printed message of encouragement accompanied each gift, and recipients' names and addresses on a label were affixed to the messages for selection by the volunteers. Some volunteers preferred to select certain households; others used the recipients' post codes to plan deliveries close to their homes.

Implementation and evaluation

The HMT Steering Committee asked that the distribution take place over a few days so the plants would stay fresh and not completely bloom out. The volunteers arrived and enthusiastically took four to eight each of the plants to deliver. Their reports were that the recipients were delighted with the plants but not surprisingly, even more so with the brief porch visits. Unfortunately, in the case of those living in residential settings, they had to rely on facility employees to make the deliveries. Many of the recipients wrote thank-you notes, expressing how meaningful this small gesture was for them during this time of limited connection. The volunteers also found the intervention meaningful for themselves.

The HMT learned several lessons from this first experience: (1) although the plants were beautiful and provided cheer, it was challenging to get them all distributed over a few days, and there was the risk of mishandling, leading to plant demise; (2) the porch visits were an easy opening to collect data about older adults within the larger faith community for follow up; (3) this was a golden opportunity to engage others in the process of reaching out to this vulnerable population; and (4) connection was critical for these older adults, especially the oldest of this group, who were often homebound even without the pandemic restrictions.

In the aftermath of this first iteration of the project and as the restrictions began to ease, the HMT Steering Committee conducted a survey of all faith community members 65 and over to learn that those 65-84 years of age generally were quite active and independent, able to drive or find rides to get groceries or their vaccines, and largely meet their own needs. Those 85 years and over were less likely to be independent and able to connect with family, friends, and faith community. Six months later, as the church was resuming activity in limited ways, the team reduced the next distribution to those 85 and over. The outcomes of the project were and continue to be palpable: in that first venture, volunteers visited over 100 households on porches, making in-person contact and bringing small gifts.

Since the first distribution, the WeCare Project has continued semi-annually as the HMT found the data that was gleaned from our visits were helpful for the Pastor of Visitation to prioritise whom to visit as well as highlight some common issues, for example, a need for alternative ways to get the sermons for those with no access to the internet or DVD players. In 2022, we noted that the visits became longer because volunteers were increasingly confident about going inside (if invited), but the opportunities to learn more about the older adult also increased. As the project leader, I asked volunteers to send me a couple of sentences about those they visited to look for residents' challenges and/or issues. With this information, I have been able to cut and paste it into a lengthy report for the Pastor of Visitation.

Recently, the HMT Steering Committee began inviting other interested faith community non-healthcare volunteers to assist, but I wanted to provide guidance for their home visits and what questions to ask that would offer useful information. As a former home health nurse, I put together a handout to give volunteers this kind of information so that the contacts could be meaningful and also followed up on by other members of the HMT, as needed, or the Pastor of Visitation. There were, however, other elements of the pandemic plan to foster connection.

Device upgrades and support

Planning

One of the first responses to the locked doors of the larger church was to offer pre-recorded sermons online. To provide access for all, the church, assuming that most households or facilities had DVD players, mailed discs to those who lacked computers or technologic capability to otherwise access the pre-recorded online sessions. As we learned early in the pandemic, many felt cut off from friends and family because of their inability to use their computers adequately. Hence, I included funding in the grant proposal for digital enhancements or in some cases, even devices themselves.

Implementation and evaluation

One of our HMT Steering Committee members, who had worked in the tech industry, saw a way to help. Somehow, word spread throughout the older population in the church that this resource was available or they were referred to the team. Our colleague made home visits with full personal protective equipment so she could assess the tech needs of individuals. Some needed a simple set of headphones with microphones to increase their hearing, others needed something more, such as DVD players or plug-and-play video devices. Some had all the technology they needed but required a bit of one-on-one coaching to maximise their device use to connect with family and friends. Overall, our colleague was able to assist over 20 households at a critical time to reconnect with loved ones and/or to attend virtual meetings.

Other strategies for connection

Two additional parts of the grant budget included the purchase of a deep-cleaning room defogger, which could be shared by the church's preschool as well as its exercise facilities that were used on a regular basis. Such a machine enabled a safer environment for both groups so, along with some other minor adjustments, they could begin carefully to hold their in-person gatherings.

Having heard reports of anxiety, depression, and severe loneliness among many, the team recommended some funding for the grant proposal for counselling services for use by anyone in the faith community regardless of age. Costs of counselling in the U.S. can be prohibitive, but as it turned out, these funds were not used. Our faith community is generally well-insured, and/or felt enough support that they did not require this type of professional help.

CONCLUSION

The pandemic brought a great deal of individual uncertainty and anxiety, but as important, broken connections between friends and families. Older adults, particularly those living alone, were at greatest risk for social isolation, loneliness, and their consequences. This paper describes how a faith community-based health ministry team was able to help to reconnect individuals through an evolving visitation programme that continues, device upgrade assistance and education, and other ways to restore vital connections. Health ministry team members played a significant role and learned the power of simple health promotion interventions to foster connection.

Kathie Lasater is Professor Emerita at Oregon Health & Science University. Her clinical expertise was cardiopulmonary nursing and home visiting. She is a nursing education researcher who taught population health for nearly 20 years. She is currently serving as a faith community nurse at her church.

📧 <https://orcid.org/0000-0002-4834-6460>

Correspondence to: Kathie Lasater, Lasaterk@ohsu.edu

REFERENCES

- Baker, E., & Clark, L. (2020). Biopsychopharmasocial approach to assess impact of social distancing and isolation on mental health in older adults. *British Journal of Community Nursing*, 25(5) <https://doi.org/10.12968/bjcn.2020.25.5.231>
- Brooks, S. K., Webster, L. E., Smith, L. W., Wessely, S., Greenberg, N., & Rubin, G. J. (2022). The psychological impact of quarantine and how to reduce it: Rapid review of the evidence. *Lancet*, 395, 912–920, [https://doi.org/10.1016/S0140-6736\(20\)30460-8](https://doi.org/10.1016/S0140-6736(20)30460-8)
- Carstensen, L., Shavit, Y., & Barnes, J. (2020). Age advantages in emotional experience persist even under threat from the COVID-19 pandemic. *Association for Psychological Science*, 31(11), 1374–1385. <https://doi.org/10.1177/0956797620967261>
- Centers for Disease Control and Prevention. (2020). Loneliness and social isolation linked to serious health conditions. <https://www.cdc.gov/aging/publications/features/lonely-older-adults.html> <https://tools.cdc.gov/medialibrary/index.aspx?mediaType=eCard&displayName=eCards#/media/id/406617>
- Centracare (n.d.). Faith community nursing roles. <https://www.centracare.com/services/spiritual-care-services/faith-community-nursing/becoming-a-faith-community-nurse/faith-community-nursing-roles/>
- Dickens, A. P., Richards, S. H., Greaves, C. J., & Campbell, J. (2011). Interventions targeting social isolation in older people: A systematic review. *BMC Public Health*, 11(647). <https://doi.org/10.1186/1471-2458-11-647>
- Melei, K., & Linder, J. (2022). From isolation to connection: A cross-sectional analysis of older adults' social participation using the COVID-19-QoL Scale. *The Open Journal of Occupational Therapy (OJOT)*, 10(3), 1–17, <https://doi.org/10.15453/2168-6408.1929>
- Sessanna, L., Askew, Y. D., & Pomeroy, S. H. (2022). Faith community nursing practice and holistic nursing practice: A comparison of both specialties. *Journal of Holistic Nursing*, 39(1), 85–102. <https://doi.org/10.1177/0898010120928620>
- Tyrrell, C. (2023). New Zealand Faith Community Nurse Association closes. <https://kaitiaki.org.nz/article/new-zealand-faith-community-nurse-association-closes/>
- Westberg Institute (n.d.). What is faith community nursing? <https://www.westberginstitute.org/faith-community-nursing.html>
- World Health Organization (2021). *Health promotion glossary of terms 2021*. ISBN 9789240038349.