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ABSTRACT: *The role of the Faith Community Nurse (FCN) is a multifaceted wholistic practice focused on individuals, families, and the faith and broader communities. The FCN is skilled in professional nursing and spiritual care, supporting health through attention to spiritual, physical, mental, and social health. FCNs can help meet the growing need for healthcare, especially for the uninsured, poor, and homeless. The contribution of FCNs on primary prevention, health maintenance, and management of chronic disease deserves attention to help broaden understanding of the scope of FCN practice.*

KEY WORDS: *chronic disease management, faith community nursing, health promotion, outreach, scope of practice, underserved, wholistic health*

Faith Community Nursing Scope of Practice: EXTENDING ACCESS TO HEALTHCARE

Katherine A. Balint, DNP, RN, CRRN, is Director of Clinical Learning Laboratories in the College of Nursing at Wayne State University, Detroit, Michigan, and teaches in the DNP program. She is a faith community nurse for an outreach program in the city of Detroit.

Nancy M. George, PhD, FNP-BC, is an Associate Professor and Director of the DNP Program at Wayne State University and works as a nurse practitioner in the Campus Health Center. She has experience in nurse-managed health centers based in community, hospital, and academic settings.

The authors declare no conflicts of interest.
Accepted by peer-review 8/25/2014.
DOI:10.1097/CNJ.0000000000000129

By Katherine A. Balint and Nancy George


Jim West / Alamy

Despite enactment of the Affordable Care Act and the requirement that all Americans have health insurance, 41 million Americans (13.1% of the population) remained uninsured in the first 3 months of 2014. This lack of healthcare coverage is more severe for those living at or near the federal poverty level and the unemployed. Poor and near-poor children and adults under 65 were uninsured at rates of 24.1% and 26.2%, respectively; adults under 65 fared worse at uninsured rates of 34.9% (poor) and 34.4% (near poor). Nearly half (46.4%) of unemployed adults lacked health insurance (Cohen & Martinez, 2014). Although all people are guaranteed access to emergency care, many go without basic healthcare services, such as health promotion or disease management.

Another challenging statistic is that every year, over 1 million adults experience homelessness, whereas over 100,000 are chronically homeless (U. S. Interagency Council on Homelessness, 2013). Homelessness is associated with preexisting chronic health conditions and complicates the treatment and management of such conditions (Fargo et al., 2012).

The huge number of uninsured, poor, near poor, or homeless shifts the burden of care outside the traditional care system to programs and clinics that provide services to the medically underserved. As one example of a nontraditional provider, outreach programs are healthcare services and activities that are located in areas where individuals and communities might not otherwise have access. Most *outreach programs* are nonprofit and can be affiliated with a faith-based organization.

The purpose of this article is to highlight the work of the faith community/parish nurse (FCN) in a faith-based outreach program serving clients in a large urban area in the Midwest United States. The nurse-managed outreach program provides basic health promotion services and screening, spiritual support, and social support 4 days a week for underserved and homeless populations. The program, covering an area of approximately three square miles, serves about 40 clients a month and has experienced an increased demand for health-related services over the past 2 years. The clients have multiple health conditions requiring nursing care focused on health prevention, maintenance, and safety, as well as the need for social services that require referral. Individuals seen in the outreach centers present with an overabundance of chronic health conditions that are impacted by their limited access to consistent primary healthcare (e.g., mental illness, congestive heart failure [CHF], hypertension [HTN], diabetes mellitus [DM]). To showcase the work of the faith-based outreach program, this article presents an exemplar of the practice of the FCN providing wholistic care to a client with cognitive limitations, HTN, CHF, and DM.

WHAT DISTINGUISHES FAITH COMMUNITY NURSING?

Faith community nursing, the practice of nursing knowledge with a spiritual care focus, has a rich history of the primary elements of faith and health dating back thousands of years. Today the role of the FCN is to provide wholistic care, focusing on the mind, body, and spirit, through primary prevention and management of individuals and communities as they move toward optimization of health and

self-efficacy. The FCN model is based on the work of nurses such as Lillian Wald, who took healthcare to where clients lived, and Florence Nightingale, who advanced social activism for health issues and promotion. The modern faith community nursing movement and role was further defined by the work of Reverend Dr. Granger Westberg, who created health centers in Christian congregations and referred to nurses serving in these centers as "parish nurses" (American Nurses Association [ANA] & Health Ministries Association [HMA], 2012, p. 7).

According to the *Faith Community Nursing Scope and Standards of Practice* (ANA & HMA, 2012, p. 55), the practice of the FCN is based on a philosophical belief of the intentional care of the spirit, which embodies the concept of health as the center of a wholistic specialty practice integrating mind, body, and spirit to create a sense of congruence in the healing process. The FCN combines counseling, consultation, referral, health teaching, screening, outreach, and collaboration to promote an interconnected totality approach to health and care that includes the values and beliefs spirituality has on a person's health.

The FCN dedicated to specialized practice in the context of a faith community must establish a model of care distinguished from that of the traditional registered nurse (RN) role of care of the sick in a hospital setting, and the nurse who only conducts periodic blood pressure screenings in the church lobby. According to the FCN Scope and Standards, "The preferred minimum preparation for a registered nurse or advanced practice registered nurse entering the specialty of faith community nursing includes: baccalaureate or higher degree in nursing with academic preparation in community nursing" (ANA & HMA, 2012, p. 78). The FCN intentionally cares for individuals, families, the faith community, and the broader community to promote wholistic health. The FCN's primary focus is to promote the intentional care of the spirit, which includes health promotion, education, and coordination of care with a centrality based on spirituality, "as part of the wholistic vision of the person's health, and not simply as just another 'dimension' of the person" (Miner-Williams, 2006, p. 814). The concept of *intentional care of the spirit* provides a foundation for the FCN to expand his or her practice to include development of measureable outcomes, and meaningful use of data collected through individual and community interactions. Such data can be used for the purpose of improved health promotion and coordination of care and services.

FAITH-BASED NURSING INITIATIVE

The faith-based nursing initiative in this Midwest urban area has been in existence for over 15 years and serves those from three parishes and surrounding neighborhoods. The health ministry and outreach program were developed through a shared model for resources between the Catholic Archdiocese and a private endowment fund slated for FCN and health ministry services. The long-term sustainability of the outreach and health ministry programs can be attributed to a triad model of cooperation and value between the archdiocese, the faith-based outreach program, and collaborating community partners. The outreach staff has committed to forming relationships with clinics, healthcare providers, pharmacists, and other nonprofit groups and coalitions aimed at building community capacity for improved health outcomes within the populations served. Additionally, success of the outreach program and health ministry relies heavily on mutual support, the ability to provide service excellence, and the commitment to service focused on the intentional care of the spirit—all while keeping in mind that the program is vulnerable. Maintaining stability of the services is an ongoing team effort to develop innovative structures and efficiencies to meet the needs of diverse populations.

The nurses in the outreach centers are both employed and volunteers. Some hold degrees in Advanced Public Health Nursing, and one has a Doctorate of Nursing Practice (DNP). They address the physical health and spiritual needs of parish members and neighborhood residents. The nurses promote, advocate, and strive to protect the health and safety of their clients through social support, healthcare referrals, and basic social services. Healthcare services consist of screenings, preventative outreach, medication management, and community resource referrals, in addition to spiritual outreach resources. The case report presented here is intended to showcase the FCN role, that is, intentional care of the spirit through the management of a client's chronic health needs.

A survey conducted by Takeda Pharmaceuticals U.S.A. (2011) identified hot spots for HTN and other chronic conditions and named a tri-city area that included the FCN program zip codes and surrounding community. The outreach area was ranked the number 2 hot spot out of 10. To further the challenge of managing chronic conditions in this area, the Michigan Behavioral Risk Factor Surveillance System (BRFSS) (Michigan Department of Community Health, 2012) reported significant rates of diagnosed diabetes (11.6%), cardiovascular disease (including HTN) (10.3%), and coronary heart disease (4.2%) for the residents. External disparities such as social isolation, poverty, and deleterious environments complicate the treatment and management of these chronic conditions.

In 2011, the average household income of this urban area was $25,193 (U.S. Department of Commerce, 2012). The clients of the faith-based outreach centers are often the poorest of the poor; the economic impact on their access to healthcare services and resources can be seen daily in the centers. Many of the clients rely on outreach programs for guidance, support, and resources for daily life. The parish communities are particularly vulnerable to the combined effects of external disparities and chronic diseases, creating a challenging environment for managing disease processes in this population. The care provided by the FCNs has positively impacted countless recipients. "Ms. S" is one such client.

MAKING A DIFFERENCE: A CASE REPORT

Ms. S is a 48-year-old Caucasian female who presented to the outreach program for assistance with food and clothing. While receiving this service, Ms. S complained of shortness of breath, nausea, and feeling dizzy. The staff alerted the FCN working at the time of Ms. S's condition. After completing a comprehensive assessment on Ms. S to determine the level of care needed, the FCN and Ms. S met to complete a client/provider intake that included her health history, physical assessment, and an assessment of her social and spiritual needs.

Health History. Ms. S described her overall health as "not so good. I have a bad heart and sugar. I think I should eat better and try to move around more. I just never seem to make a change; it's hard." She reported experiencing a myocardial infarction with stent placement 1 year ago. At the time of her hospitalization, it was discovered she had Type II diabetes and Stage II HTN. She was hospitalized in the last 2 months with a new onset of CHF, described as, "I couldn't breathe when I walked, and I coughed all the time." She reported mild neuropathy with pain in both feet, denied other medical conditions or surgical history, and reported no allergies. Ms. S was not able to name all of her current medications, stating, "I take a bunch of pills: blood pressure, water, heart, sugar, and one for pain." She did not monitor her blood glucose regularly. Her social history was negative for tobacco or illicit drug use. Ms. S reported living alone, had never been married, had an adult daughter with two young children who lived locally, and was not currently in a relationship or sexually active. Ms. S completed the ninth grade and struggled with learning in school. She said, "Sometimes when I read, I have trouble understanding what it says, or I just don't remember."

Ms. S was unemployed and receiving assistance for transportation and to pay her rent in government subsidized housing. She received food stamps and had access to groceries, and was on Medicaid for healthcare services. Her living environment consisted of a two-room apartment with sparse furnishings that included a plastic-covered mattress on the floor. She stated she feels "safe" but does not go out at night. Ms. S shared her recent experience with bed bugs from the donated mattress, resolved when the apartment manager "bug-bombed" the apartment.

Ms. S's support system was limited to acquaintances at church, the outreach program, and what she described as "a strained relationship with her daughter." She identified herself as Christian with "strong faith." Her spiritual assessment substantiated her practicing faith, with identified needs for continued support for prayer, friends, and guidance to maintain a balance of the mind, body, and spirit for optimal health.

From the perspective of an FCN, care means evaluating therapeutic and potential adverse effects...to provide clients with information and education that is evidence-based, while taking into consideration clients' comprehensive healthcare needs and spiritual needs, beliefs, and practices.

Physical Exam. The overall appearance of Ms. S was that of a Caucasian female, well-groomed, obese, and looking older than her stated age of 48. Her baseline vital signs were: blood pressure 158/92, heart rate 88, and respirations 22. Weight was 188 lbs (85.3 kg), height 64 inches (162.56 cm), and body mass index 32.3, which placed her in the obese range. Nonfasting finger stick glucose was 168. She was alert and oriented, speech clear and articulate, and denied fever, chills, or cough. Skin was warm, dry, pale, and intact. Heart and lungs were negative for adventitious sounds. She presented with a slow, steady gait reporting numbness and pain in her feet sometimes limits her ability to walk more than short distances. Upper and lower extremities had good strength and mobility with mild nonpitting edema in her feet bilaterally.

Plan of Care. The initial intake by the FCN provided information and direction for a plan of care focused on Ms. S's expressed need to improve her overall health, with specific focus on diabetes and coronary artery disease. The FCN and Ms. S made a verbal visitation contract, requesting that the client have a standing appointment at the outreach center with the FCN every other week for 1 hour. They discussed and prioritized interventions focused on nutrition, exercise, and disease management, including medication management and education, and the intentional care of the spirit.

Baseline data: vital signs, weight, and glucose were monitored and recorded with each client visit. The visits included reflections and Scripture readings, intended to provide comfort and strength to help with anxiety and fear related to living with chronic illnesses. Nursing diagnoses, interventions, and short- and long-term outcomes for Ms. S's plan of care, based on the nursing process, are provided in Table 1. The North American Nursing Diagnosis Association International, Nursing Interventions Classification, and Nursing Outcomes Classification systems (NANDA-I, NIC, and NOC) are helpful resources for developing care plan for clients.

Once Ms. S committed to this verbal contract, she and the FCN prioritized the interventions, such as medication education, nutrition related to disease management, exercise, pain management, and promoting wholistic health through the mind-body-spirit connection. All educational materials, resources, and contacts were placed in a three-ring binder for Ms. S to keep and reference.

FOLLOW-UP VISITS

Visit One. An intake revealed that Ms. S was crudely aware of her medications, but not sure of the names, dosages, and purposes. The FCN requested that Ms. S bring all her medications with her on the next visit. Ms. S was then asked to *go shopping* in the food pantry, and together she and the FCN reviewed food choices, labels, and discussed alternatives. The conversation focused on food groups, portion size, sodium, and exchanges. The exchange of food groups for diabetes management was an ongoing challenge for Ms. S. After discussion and remediation, a second visit to the pantry supported her ability to make better food choices, based on the application of interventions related to nutrition. The FCN prayed with Ms. S, and they discussed a daily Bible reading plan focused on God's help in time of need.

Visit Two. The focus was reviewing, documenting, and assessing Ms. S's knowledge about her current medications and introducing the concept of a food log and the *MyPlate* program for portion control (U.S. Department of Agriculture, 2013). Ms. S brought her prescribed medications (listed in Table 2). The FCN and client discussed each medication, verifying that she was taking them as prescribed and her knowledge as to why she was taking them. Ms. S expressed concern over the number of pills. It became apparent that she was overwhelmed, and stated, "I will never remember all these." The FCN suggested a medication binder that would introduce two new medications each visit, covering the basics of medication education (what, why, and when); Ms. S agreed to this approach.

Next, an introduction to *MyPlate* provided reenforcement of previously introduced content related to better food choices and portion control. The FCN explained that the program materials were easily downloaded and could be used week-to-week. The FCN and client returned to the food pantry to illustrate the five food groups and portion control for a healthy diet using the *MyPlate* program. The visit concluded with prayer.

Visit Three. Weight, glucose, and vital signs were reevaluated. Two more medications were reviewed, and a 7-day meal plan was introduced that focused on the diabetic exchange process based on an American Diabetes Association (ADA) exchange and low-fat diet. Utilizing the food pantry, the FCN guided Ms. S through the *MyPlate* concepts of food types and portion sizes that mimicked her ADA, low-fat dietary plan. Meal preparations were discussed, as well as limitations identified by Ms. S that impeded meal planning and preparation. Motivation to prepare meals

TABLE 1:

Nursing Diagnoses, Interventions, and Outcomes for Ms. S's Plan of Care

Nursing Diagnoses	Nursing Interventions	Behavioral Outcomes
• Inability to Manage Health Effectively	• Health Literacy Enhancement	• Self-Management: Diabetes Cardiac Disease Heart Failure Hypertension
• Desire to Improve Self-Care Practices	• Health Education • Spiritual Support	• Spiritual Health
• Inadequate Knowledge to Manage Health	• Medication Management • Teaching: Prescribed Medication • Respiratory Monitoring • Nutritional Counseling	• Knowledge: Chronic Disease Management Diabetes Management Cardiac Disease Management Energy Conservation Heart Failure Management Hypertension Management
• Poor Nutritional Intake	• Nutritional Monitoring	• Compliance Behavior: Prescribed Medication Prescribed Diet Prescribed Activity
• BMI > 30: Obese	• Teaching: Prescribed Diet • Weight Reduction Assistance	• Blood Glucose Level • Fluid Overload Severity • Weight Loss Behavior • Symptom Control
• Elevated Blood Glucose Level	• Teaching: Disease Process	• Activity Tolerance • Energy Conservation • Exercise Participation • Health Seeking Behavior
• Compromised Walking Ability	• Teaching: Foot Care • Energy Management • Exercise Promotion	• Loneliness Severity • Client Satisfaction • Family Integrity
• Potential for feeling lonely	• Active Listening • Listening Visits	
• Strained Family Relationships	• Family Integrity Promotion	

Sources: Used with permission.

Bulechek, G. M., Butcher, H. K., Dochterman, J. M., & Wagner, C. (2013). *Nursing interventions classification (NIC)* (6th ed.). St. Louis, MO: Elsevier Mosby.

Moorhead, S., Johnson, M., Maas, M. L., & Swanson, E. (2013). *Nursing outcomes classification (NOC)* (5th ed.). St. Louis, MO: Elsevier Mosby.

TABLE 2: Ms. S's Medications

Medication	Dosage	Frequency	Client Reason for Taking
Aspirin	325 mg	Daily	Thin blood
Lisinopril	10 mg	Daily	Blood pressure
Furosemide	20 mg	Daily	Water pill
Tramadol HCL	50 mg	As needed for pain	Pain in feet
Clopidogrel	75 mg	Daily	My heart
Simvastatin	40 mg	Daily (night)	My cholesterol
Metformin	500 mg	Daily	Sugar
Gabapentin	300 mg	Twice daily	Pain in feet
Carvedilol	25 mg	Daily	Heart
Isosorbide	60 mg	Daily	Blood pressure

was a barrier, as she shared, "Living alone makes it hard." They discussed various ways to overcome this barrier, such as cooking meals for the week in one evening and freezing them (decreases the need to cook every day, economical, allows for planning). Ms. S and the FCN reviewed two more medications, developed goals for the next visit, prayed, and discussed the Bible reading plan.

Visit Four. There were three objectives: reevaluation of baseline data, completion of medication education, and assessment of dietary issues. Ms. S's blood pressure was 130/64, heart rate 88, respirations 18. Nonfasting finger stick glucose was 218; body weight 186 lb. The FCN praised Ms. S for her improvements in blood pressure and weight management, and encouraged her to share feelings of success and disappointments over the past few weeks with meal preparation, portion control, and food choices. Ms. S shared the dietary plan was "hard" and that she had made only minor changes to her diet, but she was optimistic that these changes would be permanent. The struggles of lifestyle changes, especially while trying to manage chronic health conditions and living on a fixed income, were discussed. Barriers to lifestyle changes, especially dietary ones, were explored, and conversation focused on her inner strengths that in the past had helped her to have successful outcomes. The FCN and client completed the medication education and reviewed the health promotion binder contents for further clarification and evaluation. The FCN offered prayer and support with Ms. S, and they made plans for additional follow-up visits to monitor her progress and learning needs, provide spiritual support, and address additional issues such as her impaired walking and family concerns.

SUMMARIZING FCN PRACTICE

The FCN evaluation of a client like Ms. S begins with development of a plan to assess progress toward attainment of mutually agreed-upon outcomes. As partners, the FCN and client evaluate the effectiveness of the plan, using ongoing assessment data to ensure appropriate use of the interventions for attainment of the client's optimal health outcomes. The evaluation toward progress includes documentation of results from both the physical and spiritual realms. Evaluations are disseminated to the client and other involved partners such as the primary care provider (PCP).

Treatment of chronic conditions such as Ms. S had requires lifelong management, and typically, multiple prescribed medications. In some faith-based situations such as our outreach clinic, advanced practice nurses may serve as FCNs and work with another PCP to manage treatment. However, all FCNs will assist with management of illness and must be cognizant of current medications and treatments so they can provide education and make referrals. From the perspective of an FCN, care means evaluating therapeutic and potential adverse effects of treatments to provide the client with information and education that is evidence-based, taking into consideration the clients' comprehensive healthcare needs and spiritual needs, beliefs, and practices (ANA & HMA, 2012). Furthermore, all FCNs will work with clients on health promotion, maintenance, and restoration and need to be proficient in using the nursing process.

The many barriers to optimal health experienced by Ms. S are not unusual for people who have chronic health conditions and low socioeconomic status. Numerous studies have confirmed the relationship between socioeconomic status and health. Vuković, Bjegović, and Vuković (2008) found that people with a lower socioeconomic status had worse health than those with a better socioeconomic status. Pickett and Pearl (2001) reported that socioeconomic status in combination with the neighborhood social structure and infrastructure (presence or lack of parks, sidewalks, transportation, access to affordable food) were variables that affect health and disease. A study by Sturm and Gresenz (2002) analyzed relationships between family income, disease rates, and geographic inequities in a survey of over 9,000 participants across the United States. The researchers determined that income inequity alone could not be a risk factor for health disparities, and external barriers such as access to care, education, and perception of health were all potential contributors to health and disease rates.

These external barriers challenge healthcare providers to establish a care continuum to those in need. The clash between socio-structural and personal determinants of health calls for knowledge of both public and individual factors affecting health. In addition, providers need to be cognizant of the community resources available where their clients live. Further, they need to learn to work with faith-based community health partners, such as FCNs, in extending a safety net for clients who may be spiritually, economically, and socially isolated. Understanding the potential partnerships with faith-based initiatives can greatly improve the care provided to clients.

CONCLUSION

The relationship between the FCN and Ms. S illustrates an ongoing process that takes commitment from both

parties and includes the FCN's unique practice in caring for the mind, body, and spirit. According to Miner-Williams (2006), the FCN has knowledge in providing care focused on healing the body through the development of interpersonal relationships based on commitment, respect, and the belief that healing is more than hands-on. The relationships between FCNs, their clients, and communities represent a nursing practice culture that embodies spirituality and inserts the power of healing into healthcare management and treatment.

One universal philosophy in nursing practice is providing comfort and care to those we serve. Comfort could be categorized across the trajectory of the mind, body, and spirit. Comfort of the spirit mimics that of the body in the scope of practice of the FCN; we accept each individual's expression of spirituality and the presence of the power of healing so that the commitment to giving of oneself is unconditional. The commitment and utilization of faith community nursing provide a vital community resource focused on the whole-health needs of parishes and surrounding communities by providing an experienced RN who serves as a minister of health to uplift the relationship between faith and whole-person health.

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Disclosure Statement:

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