Growing a Health Ministry in an African American Church:

A Developmental Evaluation Case Study

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DEDICATION

I dedicate this work to the following important people:

Barbara Herman McCluney, my mother, for sharing with me the gifts of her lifelong love for learning and her ability to see the value in getting a good education. I appreciate the seeds of triumph she planted in me--they helped to support my successful journey to the completion of this undertaking. To my friend Shakur, the love of my life. Thank you for all your encouragement, for being my administrative assistant, for your selflessness, and for making me laugh when I wanted to cry. And to my siblings, Stephanie, Earl, Elroy, and Chip. Without your love and support, I could not have made it. And to my Church Family, I love and appreciate you all. To God, be the glory for the things He has done.

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KEY TERMS AND ABBREVIATIONS

ACA	Affordable Care Act
Black church	Christian church located in a predominately African American community, with an African American pastor serving more than 75% African American members.
CBO	Community-based organization
CBPR	Community-based participatory research
CHCS	Center for Health Care Strategies, Inc.
CMS	Centers for Medicare and Medicaid Services
DE	Developmental evaluation
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HHS	U.S. Department of Health and Human Services

NCCPHS	National Coordinating Center for Public Health Services and Systems Research
NC-DHHS	North Carolina Department of Health and Human Services
PHSSR	Public Health Services and Systems Research
SES	Socioeconomic status
	Systems Thinking
WHO	World Health Organization

Summary

This research explored how an African American church supported more use of the resources of the Patient Protection and Affordable Health Care Act (ACA) among its members and potentially the wider African American community, and in so doing, built the capacity of the church to address the social determinants of health and promote health equity. Community-based organizations (CBOs) played an important role in this research by helping the church members to identify and described social determinants of health and offer resources to help improve the health status of the members. This research illustrates how church members came together as a dedicated group to engage in a developmental evaluation (DE) inquiry that examined the church's current practices for health ministry program development and implementation in a way that lead to lasting systems changes as well as embodied the collective views, beliefs, and tenets of the church.

Study Objectives

From the outside, a learning organization can be recognized by its agility in changing how it relates to the external world and how it conducts its internal operations. It can be recognized from the inside by its central ethos to learn from challenges and mistakes (Sugarman, 2000). Learning from challenges requires a willingness and readiness to change. Change efficacy is higher when people share a sense of confidence that they can implement a complex organizational change collectively (Weiner, 2009). Research has shown that organizational readiness for change is a two-dimensional

construct that reflects the members' collective commitment (willingness) and efficacy (ability) to implement an innovation (Bowditch & Buono, 2001). As individuals might vary in their personal readiness for change, this study investigates collective readiness. The implementation of complex innovations such as research projects that focus on health disparities usually entails collective action among interdependent individuals (De Marco et al., 2011).

This study sought to add to our knowledge of the ways in which awareness of social determinants in the African American community affect health equity; education about these determinants can motivate individuals to make informed choices about their health and come together to design interventions that promote health within their community. This research may offer public health leadership a pragmatic strategy for reducing disparities and morbidity, ultimately leading to improved population health for African Americans.

The study is an action research case study, utilizing methods from the toolkit of Developmental Evaluation (Patton 2011) adapted to the church context, as well as qualitative analysis of interviews, focus groups, and survey data. It was organized into three phases that did the following: (a) explored the activities taken by Community Church to roll out and introduce ACA resources to the entire congregation and individuals in the surrounding community, (b) examined the results from the first phase to leverage the church's readiness and the organizational learning capacity to develop and implement a health ministry, and (c) identified and captured lessons learned throughout the process to replicate the findings in other African American churches in a way that adds value and benefit to their congregations. Given that much of the data collected was analyzed and introduced as a foundation for program improvement and a means of building of a body of evidence to implement a formal health ministry within African-American congregations, storytelling activities, key informant interviews, and focus groups helped guide this task.

CHAPTER 1: BACKGROUND AND PROBLEM STATEMENT

Background Context and Significance

Health Disparities

The societal burden of health and health care disparities in the United States is manifested in multiple and major ways (U.S. Department of Health and Human Services [HHS], 2011a). In one stark example, Murray et al. (2006) reported on a difference of 33 years between the longest- living and shortest-living groups in the United States. LaVeist, Gaskin, and Richard (2009) concluded that "the combined costs of health inequalities and premature death in the United States were $1.24 trillion" (p. 6) between 2003 and 2006. Such health disparities arise from biological and social factors that affect individuals throughout their lives. The leading health indicators have demonstrated little improvement in disparities over the past decade, according to recent analyses of progress on Healthy People 2010 objectives (HHS, 2014d). Significant racial and ethnic health disparities continue to permeate the major dimensions of health care, the health care workforce, population health, and data collection and research (HHS, 2014d).

The health disparities that plague African Americans are significant. The White House Health Reform for Americans (2014) reported that 21% of African Americans were uninsured in 2009 and more than 20% of African Americans did not have a regular doctor, compared with less than 16% of European Americans who were uninsured. African Americans are more likely to develop and die from cancer than any other racial or ethnic group. In addition, African Americans are diagnosed with AIDS at nine times the rate of European Americans and are more likely to use emergency rooms as their regular places of care than their European American counterparts. Moreover, African Americans are more likely than

either their European American or Latino American counterparts to report delaying or forgoing dental care and filling drug prescriptions (White House Health Reform for Americans, 2014).

According to the HHS (2014d), individuals' patterns of social engagement and sense of security and well-being may be strongly affected by where they live. Resources that enhance quality of life for a given community can thus have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency and health services, and environments free of life-threatening toxins (HHS, 2014d). The Centers for Disease Control and Prevention (CDC, 2013) reported that having an appreciation of how societal conditions, health behaviors, and access to health care affect health outcomes can increase understanding of what is needed to move toward health equity.

Community-based organizations (CBOs) can play an important role in reducing health disparities and increasing health equity. The Agency for Healthcare Research and Quality (HHS, 2003) suggested that such groups could be churches, church members, neighborhood organizations, community residents, or other social organizations. Research can be a first step in designing interventions to increase health equity, and these groups can play a direct role in designing and conducting research by bringing community members into studies not only as participants, but also as partners. Brownson, Baker, Leet, and Gillespie (2003) identified best practices that can be disseminated and used by the community to understand health problems and design activities that improve health care.

CBOs can also take steps to address and ameliorate factors that result in health disparities by connecting community members directly to the ways that research is done and providing the immediate benefits of the research results to the communities that have participated in the research (HHS, 2003). Churches are often effective in this role because they have the trust of their members, provide links

between less-educated and more formally educated community members, and have access to resources within their congregations and the larger communities. Typically, churches also have the basic infrastructure necessary to conduct health promotion activities, such as buildings with kitchens and meeting rooms. In addition, churches might provide access to groups that already convene regularly for weekly services and ongoing activities such as Sunday school and Bible study. Many religious organizations include health as part of their mission or ministry, and they often institute health committees and participate in community outreach activities such as soup kitchens. Churches may be venues through which to recruit and retain research participants, given that they tend to be stable institutions with members who attend frequently over many years (Campbell et al., 2007).

The Black Church

Although the phrase *Black church* encompasses many details of the racial and religious lifestyles unique to African American history, numerous differences among African American communities are reflected within churches (McMickle, 2002). For the purposes of this research, a Black church is a Christian church located in a predominately African-American community with an African-American pastor serving a group that is more than 75% African American. “Black church” and “African American church” are used interchangeably.

The Black church has a long history of addressing the worldly needs of the African American community. This legacy of struggle against oppression, mistreatment, and neglect has given the church a role that is as important today as ever. Black church life, which starts with the community, continues to be shaped by the African American experiences and encounters with two different groups in the United States, namely, the “haves” and the “have-nots” (Trader-Leigh, 2008). Social and economic disparities require the African-American church to remain vigilant in confronting the nature of inequality in this

country (Trader-Leigh, 2008). Because of the importance of the mission regarding health promotion within the African American community, the church provides a promising venue for the successful delivery of health interventions that address racial health disparities (Odulana et al., 2013). In addition, trusted community groups closely tied to ethnic and other communities are most effective in reaching individuals who are hard to reach otherwise (Hill, Courtot, & Wilkinson, 2013). The Black church has been and continues to be a place where African Americans trust and feel secure about the information they receive.

Purpose of the Study

This project explores how an African American church can support greater use of the resources provided by the Patient Protection and Affordable Care Act (ACA) among its members and potentially the wider African American community, and in so doing, build the capacity of the church to address the social determinants of health and promote health equity. In particular, the purpose of this study is to investigate how a particular African-American church linked a government program to the people it serves, built on these efforts to increase the capacity of the church for health ministry, and addressed adaptive challenges related to its congregants' health.

At the core of this research is an exploratory, action research case study that illustrates how a group of church members from Community Church (a pseudonym) came together as a dedicated team to examine the church's existing practices for program development and implementation in a way that led to lasting systems change that embodied the collective views, beliefs, and tenets of the church.

Case Study Overview

The church at the heart of this case study was founded in 1956 and will be known as Community Church in this study. The early church began holding services in a schoolhouse in Clayton County, Georgia. The founding membership consisted mostly of family and close relatives. Currently, there are 630 registered members. Although the church has a predominately African-American membership, there is diversity among these members, who vary in age, gender, education, socioeconomic status (SES), and health status.

Although Community Church is known as a Baptist church, it is an independent organization that does not belong to any larger religious group. Only one pastor has served the church since the death of the founding pastor. The current pastor has served in this leadership role since 1980. He is well known in the surrounding community and serves as president of a local County Ministers organization, a consortium of ministers in the greater Clayton County area.

The church is led by seven ministers, one of whom serves as senior pastor of the congregation; the other six serve in an associate pastor capacity. The deacons', mothers', and trustees' boards, along with a financial secretary, also serve on the leadership team. The church encompasses departments for youth, music, seniors, and Sunday school. The church is further subdivided into auxiliary boards and ministries that support functions essential to the operations of the church. These include ushers, the church secretary, pastor's aides, and committees for birthdays, audio/video projects, drama, education, transportation (van, bus), and kitchen services.

Other groups that provide support and help the church in its mission and service to the community include the New Members Committee, Food Pantry, Men on a Mission, and Women for Christ. Although these groups are not formally part of the leadership team, individuals in the

congregation often view them as having a leadership role and approach them with ideas to introduce health events and activities. Because no formal procedure is in place to capture and act upon such suggestions, the ideas rarely develop beyond initial suggestions. The committee chairs also frequently initiate activities and events related to health, such as walking groups, healthy eating demonstrations, and presentations on chronic diseases such as diabetes and heart disease. Again, however, because there is no synergy across the organization and the planning variables are interdependent and nonlinear, such initiatives rarely last more than six months. In the past there has been no attempt to introduce health promotion or disease prevention activities in the church or the larger Clayton County community in an organized manner that could result in sustained behavioral change.

Rollout of the ACA at Community Church

In September 2013, the Georgia House Democrats voted to host a series of town hall meetings in and around their respective districts to educate and inform the public about the ACA. On October 12, 2013, a Georgia state representative hosted an ACA town hall meeting in Clayton County, Georgia, which is located in his district. Because this state representative is also the minister of a church in Clayton County and a member of a local ministers' consortium, he invited other local clergy from this organization to attend. The pastor at Community Church was serving as the president of the ministers' group at the time. The ministers' group planned to use the member churches as vehicles to disseminate information about the ACA.

Because Community Church's pastor had a vision to connect his congregation to the ACA, he invited two members of his church who work in public health to lead the effort to roll out the ACA to the church members. His specific request was for them to share relevant information about the ACA. These members requested and received permission for the church to join the Champions for Coverage work

group, which is sponsored by the Centers for Medicare and Medicaid Services. Champions for Coverage shares information about the health insurance marketplace with its networks and communities. The two church members participated in regular national stakeholder calls and webinars that presented the most current health insurance marketplace information and sought feedback from stakeholders.

As part of the church's effort to roll out the ACA, these church members provided information to the congregation regarding ways the ACA benefited the African-American community and the importance of preventative health care in general. As a result, members of the church began to propose developing a formal health ministry at the church. Coincidentally, subsequent to the rollout, several health incidents occurred at the church during Sunday services that required calling an ambulance. Because there were no formal procedures for responding to these incidents, concerns were raised about the lack of a health ministry in the church. This began the process of the Community Church partnering with the researcher to engage in an evaluative intervention to identify if a formal health ministry would be an appropriate fit at the church. The idea was subsequently introduced to the pastor who was very supportive of the partnership. Please see the Community Church letter of support located in Appendix B.

A great deal of information was disseminated and countless resources shared during the rollout, which used the church's website and membership distribution list to send targeted messages to specific audiences related to the processes for and advantages of enrolling in the ACA marketplace. But despite the initial effort, no follow-up was made to conduct a formal evaluation of the results of the ACA rollout, other than determining the number of individuals enrolled in the marketplace. Because no effort was made to assess the process, it is unclear what organizational learning occurred in the church or how the church benefitted from these activities. Given the amount of information shared during the rollout,

there was certainly the potential to test the validity of the underlying assumptions related to organizational learning during the rollout, but this was not performed.

According to Patton (2011), the purpose of developmental evaluation (DE) is to provide real-time feedback and generate learning to inform development. DE's innovative, real-time learning and developmental design captures system dynamics and reveal surface pioneering strategies and ideas, giving it great potential for appraising the phenomena related to the ACA rollout at Community Church.

In certain circumstances, evaluating programs designed to serve disadvantaged and minority target groups might be threatening to stakeholders in those groups (English, 1997). Therefore, informed consent agreements were collected from all church members participating in the DE research activity before the study was conducted. The consent form specified that all information will remain confidential and will be used both to support the outcomes of this study and to address and support program development and implementation in the church.

The DE approach can be used when setting goals and objectives is part of the research process and when these goals are not obvious. It is also useful for organizations that want to build their capacity for reflection and learning and are willing to commit time and effort to the process. Similarly, it is a good fit when there is an adaptive challenge rather than a ready-made solution. Finally, the DE framework allows a step to occur that was absent in previous efforts: evaluation of the church's activities to roll out the ACA in a manner that had the potential to inform process improvement, enhance future program development, and sustain adaptation and organizational learning in Community Church.

The Researcher's Involvement with the Church

DE requires the evaluator to be embedded in the initiative as a member of the team. In addition, the DE role extends well beyond data collection and analysis; the evaluator actively intervenes to shape the course of development, helping to inform decision making and facilitate learning (Dozois, Langlois, & Blanchet-Cohen, 2010). The role of the developmental evaluator is one of a strategic learning partner and facilitator, which reflects a different role for most evaluators and their clients (Dozois et al., 2010). According to Patton (2011), DE refers to long-term partnering relationships between evaluators and those engaged in innovative initiatives and development. The researcher is a member of the Community Church as such, efforts were made to control bias. These efforts are explained in the materials and methods section. The developmental evaluator is part of the innovations group and brings a complex systems orientation to the evaluation (Dozois et al., 2010), making sound strategic decisions that involve all stakeholders and allow creative and innovative methods to collecting data. This approach was used to determine the potential development of a sustainable health ministry. The principle investigator of this research study also served as the DE evaluator. One advantage of being a member of the DE group is that the researcher is viewed as a trusted member of the congregation, a position that gives them access to the church community. It also allows the researcher to increase the credibility of the findings by implementing quality control checks during the data collection and analysis processes. One possible disadvantage is that the researcher's position in the church could skew the findings as a result of not being objective enough.

The Clayton County, Georgia Community

The demographic data presented below describe the community in which the church is located. Clayton County is one of Georgia's smallest counties, with an area of only 146 square miles. With nearly 260,000 residents, it also is one of the most densely populated. Over the past few decades, the county has experienced a dramatic change in its racial demographics, largely because of urban sprawl. Today, its minority population is approximately 80%; in 1980, it was approximately 20%. In 2009, 93,000 more people resided in Clayton County than in 1990.

Between 2000 and 2009, Clayton County had a significant change in its racial and ethnic composition that was much greater than that experienced in general by the state. The county's African American population rose 9.9%, and its Hispanic American population rose 4.8% to make up 62.1% and 12.2% of Clayton County's entire population, respectively. The county's European American population declined 11.0%, and in 2009, it comprised 30.4% of the county's total population (Georgia Tech Enterprise Innovation Institute, 2010).

According to the electronic database Community Commons (2014), within the reported area, 15.70% of adults aged 18 years and older self-reported having poor or fair health in response to the question, "Would you say that in general your health is excellent, very good, good, fair, or poor?" This indicator is relevant because it is a measure of general poor health status. Table A.I displays the Clayton County population demographics. Moreover, compared with the rest of the state, Clayton County has seen a greater increase in Medicare payments to the county and to individuals within the county.

History of the Black Church in the African American Community

Historically, the faith community has been a major focus of the spiritual, social, economic, educational, and political life of African Americans (Woodson & Braxton-Calhoun, 2006). Faith-based organizations (FBOs) and community-based organizations often provide a link between those who are the most vulnerable and the most difficult to reach and the health services they need (HHS, 2014a, 2014c). According to the PEW Research Center (2015), African Americans attend religious services and pray more frequently than the general population. Although 39% of all Americans reported attending religious services at least once a week, the majority of African Americans (53%) have reported the same.

Although the phrase *Black church* is very familiar in American culture, historically there has not been one homogeneous institutional reality known as the Black church. Instead, the term encompasses a full range of theologies, practices, and organizational structures (Pinn, 2009).

These churches are as complex as the African American congregants who attend them and as diverse as the experiences, values, and beliefs of those church members. The complexities between churches and their membership have posed leadership challenges for developing strategies that improve the public's health.

In addition, the Black church has a rich foundation of history that has created a wealth of assets related to culture, leadership, trust, influence, and reach. The Black church played a pivotal role in the mid-20th century civil rights movement, fueled by its tradition of social and political activism. African American congregations started many of the vital institutions within the Black community: schools, banks, insurance companies, and low-income housing. Ministers in these churches served as community leaders, social justice activists, and leaders of civil rights organizations (DeYoung, 2011).

Leadership approaches for leveraging assets in the Black church include engaging in a variety of activities that already exist, such as peer counseling and education, to improve the health of the African

American community population, as well as implementing interventions tailored to spiritual and cultural contexts. According to Heifetz, Grashow, and Linsky (2009), successful adaptive changes build on the past rather than abandoning it. In this way, the Black church continues to hold great promise for leaders looking for ways to address health disparities.

Access to Care

The Institute of Medicine (as cited in Bach, 2003) identified the lack of insurance as a significant driver of health care disparities. Lack of insurance, more than any other demographic or economic barrier, negatively affects the quality of health care received by minority populations. Racial and ethnic minorities are significantly less likely than the rest of the population to have health insurance (HHS, 2011b), and even though they constitute about one-third of the U.S. population, they make up more than half of the 50 million people who are uninsured (Smedley, 2008). The ACA, which became law on March 23, 2010, removed obstacles to care that many African Americans historically faced, increasing their access to stable, affordable health insurance and high-quality health care suited to their needs (HHS, 2013). Many uninsured Blacks have benefitted from these new pathways to coverage, which increase their access to and promote greater equity in health care (Duckett & Artiga, 2013).

The benefits and protections of the ACA are critical to promoting health equity among communities of color. As the law moves toward eliminating disparities, African Americans stand to gain from its health reform provisions, both those that affect all communities but have a disproportionate impact on communities of color and those designed specifically to eliminate health disparities (Villers, Hernández-Cancio, & Morris, 2014). For example, more than 400,000 young African Americans have already gained health coverage by remaining on their parents' plans (HHS, 2014a, 2014b). Prevention provisions in the ACA are also beneficial to communities of color. For example, early detection and

treatment are enormously important for illnesses like diabetes, where aggressive treatment and management can reduce serious complications like amputations, end-stage renal disease, blindness, and death. In addition, many states with high numbers of African Americans are expanding Medicaid, which has the potential to reduce the insurance coverage disparities among many low-income people, including communities of color (Villers et al., 2014).

African Americans experience higher rates of a range of illnesses than the general population (Robinson & Finegold, 2012). Specifically, African Americans, or Blacks, have a disproportionately higher prevalence of some conditions or behaviors across the life span than other racial or ethnic populations, including most major cancers, heart disease, stroke, and diabetes (CDC, 2014a). The general lack of knowledge regarding health services contributes to poor health outcomes in African American communities. Expanding opportunities for coverage and providing no-cost screenings and quality disease management to patients can improve health outcomes for African Americans (HHS, 2011a, 2011b).

Among African Americans, community-based health care strategies have proven to be successful in bridging gaps in the health care system. Early provisions of the ACA are already helping to bridge gaps in coverage among young adults and people with preexisting conditions (Collins, Robertson, Garber, & Doty, 2012). Such ACA benefits as expanded insurance coverage and better access to high-quality health care services are especially important to African Americans in helping reduce disparities in health care and health outcomes (Henderson, Robinson, & Finegold, 2012). Lastly, most African Americans across all major religious traditions, including those who are unaffiliated, prefer bigger government that provides more services over smaller government that provides fewer services. Nearly eight in 10 (79%) African Americans believe the government should do more to help the needy, even if it means going deeper

into debt; only 15% believe the government cannot afford to do much more to help the needy (PEW Research Center, 2015).

The ACA and the African American Community

It has been six years since the ACA was signed into law. Most provisions were implemented by early 2014 (Robinson & Finegold, 2012). Although there have been issues with the legislation, it has provided health coverage to more of the nearly 50 million uninsured people living in the U.S. (Brock, 2013). Although the HHS relaunched the website www.HealthCare.gov to give interested individuals answers to their questions and concerns in 2012, the most daunting challenge facing full implementation of the ACA was lack of awareness (Brock, 2013). According to a 2012 large national survey undertaken by Lake Research Partners for Enroll America, more than 78% of uninsured people were unaware of the new health marketplaces being established and the financial help becoming available (as cited in Pollack, 2012). The survey data also showed that among those who were potentially eligible for the Medicaid expansion beginning in 2014, an even larger proportion (83%) was unaware of the new health coverage options that were coming (Pollack, 2012).

A key provision of the ACA is Medicaid expansion. The law allows states to receive federal funding to fully cover people with incomes up to 133% of the poverty level, or $26,321 for a family of three, through 2016 (Wahlberg, 2014). Later, the federal government will cover at least 90% of the costs, up from its usual share of 60% (Wahlberg, 2014). This subsidy might impact state decisions to expand Medicaid under the law. Medicaid has never been an easy political fit, especially in the South (Pugh, 2013). When the program launched in 1966, states such as Alabama, Florida, Mississippi, and North Carolina were among the last to opt in. Critics at the time called it “socialized medicine” (Pugh,

2013). Currently, Blacks are at the highest risk of continuing to face coverage gaps resulting from state expansion decisions (Duckett, P., & Artiga, S. (2013).

Research from the Henry J. Kaiser Family Foundation (2013) revealed that even though Medicaid expansion is poised to fill historical gaps in eligibility for adults and was envisioned as the vehicle to extend insurance coverage to low-income individuals, the characteristics of the population who fall into the coverage gap largely mirror those of poor uninsured adults. For example, because racial and ethnic minorities are more likely than European non-Hispanic Americans to lack insurance coverage and are more likely to live in families with low incomes, they are disproportionately represented among poor uninsured adults and among people in the coverage gap. Nationally, about half (47%) of uninsured adults in the coverage gap are European non-Hispanic Americans: 21% are Hispanic Americans, and 27% are African Americans (Henry J. Kaiser Family Foundation, 2013).

Undoubtedly, even with Medicaid expansion, the lack of awareness and knowledge about the ACA will impact African Americans in greater numbers than other demographics receiving Medicaid, pointing to an inequity in health. As many of those charged with implementing the ACA realize, none of these reforms will fully succeed without efforts to make all of these opportunities understandable to the intended beneficiaries. Therefore, these expansions must be accompanied by targeted efforts to enroll under resourced populations (Somers & Mahadevan, 2010). Even with the coverage expansions, targeted outreach and enrollment assistance are vital to ensure that eligible individuals enroll in coverage.

Provisions in the ACA

Provisions in the ACA address the use of community-based organizations, culturally specific media campaigns, and patient navigators who use language that is culturally and linguistically

appropriate. The only specific reference to patient navigation in the ACA is in Section 3510, which reauthorizes Section 340a of the Public Health Service Act, located in the Patient Navigator Outreach and Chronic Disease Prevention grants (HHS, 2013; Sullivan, 2014). Although patient navigation is explicitly mentioned in only one section of the ACA, the principles of patient navigation can be found throughout the Act.

The core responsibilities of the ACA Insurance Exchanges Navigators Program (HHS, 2013) and the types of entities eligible to serve as navigators were specified in the legislation and reflected in the proposed rule. Specifically, ACA Exchange navigators are expected to provide expertise on eligibility, enrollment, and coverage details for each plan; provide information in a fair, accurate, and impartial manner; facilitate the enrollment process; and provide referrals for conflict resolution services for enrollees with complaints or concerns (HHS, 2013).

Although the Navigators Program (HHS, 2013) is a well-intended solution to the problems faced by African Americans enrolling in the Health Care Marketplace website under the ACA, a multipronged approach may be needed to address the enormous health disparities that exist in the African American community. As the health care law is introduced to individuals in communities throughout the country, it is critical that people receive accurate information from trusted sources so they can make the best choices for themselves and their loved ones. This study therefore, included details on social connections such as family, friends, religion, and spiritual leadership in the Black church having the potential to shape health outcomes.

Community-based approaches to evaluation are the cornerstone of efforts addressing racial and ethnic health disparities. In addition to involving the community at every stage of the evaluation process, community-based approaches involve field testing interventions and pilot programs within the

community of interest while considering cultural and social factors (Baker, White, & Lichtveld, 2001). For this reason, community-based evaluation may offer a particularly promising way to identify strategies to prevent illness and injury in communities disproportionately affected by various health issues, as well as feasible solutions to improve access and decrease barriers to health care, realistic approaches to increasing skills and knowledge among community members, and innovative ways to disseminate findings to inform future efforts (Schlueter, 2011).

Action Research

A growing body of evidence supports action research, particularly participatory action research (PAR) involving members of the community the research is designed to affect, as a viable method to address health disparities in urban disadvantaged communities (Braveman, 2003). According to one PAR researcher, this approach (a) encourages participation from key stakeholders outside the health care sector (e.g., businesses, church groups); (b) facilitates an examination of the sociopolitical context affecting the health of the community; (c) provides an opportunity to focus on upstream factors, such as the factors preventing the onset of diabetes and its complications; and (d) increases understanding of the importance of community research in marshalling social action aimed at community and systems change (Giachello et al., 2003).

DE, which can be characterized as a form of PAR, can be useful when working in situations of high complexity and on early stages of social innovation (Gamble, 2008). According to Perskal and Beer (2012), DE also is known as action evaluation and supports social innovation. DE is an evaluation approach that can assist people who are developing social change initiatives in complex or uncertain environments (Patton, 2011). DE facilitates real-time, or close to real-time, feedback to program staff,

thus facilitating a continuous development loop (Patton, 2011). DE is a participatory approach because of the need for high trust and quick feedback.

The results from this type of feedback in a complex system are new patterns of behavior and activity. Because of the ongoing and changing intensity, quantity, and quality of information generated by the system variables, the feedback might look different each time an evaluator examines it. With these new patterns and sense-making processes in place, smaller components within the systems will adapt to the changes created through the larger system, in this case, the changes occurring in the organization and the larger community.

According to the literature, effective action learning encourages leaders to be systems thinkers (Zuber-Skerritt, 2001). Often, major social change implemented by social innovators is meant to disrupt existing systems that were found to be unacceptable (Westley, Zimmerman, & Patton, 2006). Effective problem solving requires innovators to be systems thinkers who can see connections among issues, events, and data points; that is, the whole rather than only its parts. During action learning sessions, participants learn how to think in a systematic way and handle complex, seemingly unconnected aspects of organizational challenges (Marquardt & Loan, 2006).

Problem Statement

Healthy People 2020 is the result of a multiyear process that reflects input from a diverse group of individuals and organizations. (HHS, 2014 c) For the past two decades, one of Healthy People's overarching goals has been to eliminate health disparities (HHS, 2014d). Racial and ethnic groups in the U.S. continue to experience major differences in health status compared with the majority European American population. Although many factors affect health status, a lack of health insurance and other barriers to obtaining health services have markedly diminished minorities' use of preventive services

and medical treatments (Brown, Ojeda, Wyn, & Levan, 2000). The CDC (2014b) identifies health disparities as health inequities when they result from the systematic and unjust distribution of these critical resources. Although church-academic partnerships hold promise as a mechanism to conduct research that can lead to the elimination of racial health disparities, the paucity of research literature points to the need for further evaluation of church-based health programs. The current lack of such studies has resulted in a lack of confidence in programs conducted by FBOs (Hatcher, Burley, & Lee-Ouga, 2008). Moreover, PAR, and particularly PAR embedded within an organizational learning and systems change context, offers a promising means of linking research to effective intervention. Research by itself will not solve the problem. By giving church members the opportunity to contribute directly to the development and implementation of a church-based health intervention that assesses their organizational learning capability in a manner that leads to increased health equity, this study provides a chance to fill that void.

Summary of Study Questions

1. How does an African American church connect its membership to resources offered by the ACA in a way that increases health equity?
2. What is the relationship between developing health programs (i.e., programs that provide resources to educate and inform members about health) in an African American church, and increasing the capacity of the church as a learning organization?
    1. Does the development of health programming result in changes in the organization of leadership within the church (e.g., the formation of a formal health ministry or the ability of church leaders to respond to adaptive challenges related to health)? If so, how?

2. Does the development of health programming build the capacity of church leaders and members to engage in evaluation and reflection? If so, how? What factors support building an evaluation capacity?

3. What lessons learned from this process can be transferred to other African American churches?

Leadership Implications and Relevance

Achieving a healthier nation requires providing access to the care individuals need to prevent the onset of and manage disease (HHS, 2011b). The ACA holds the promise of providing affordable health care to more than 50 million Americans who now lack coverage, improving coverage for millions more, and relieving families of the persistent burden of medical debt. The ACA also has the potential to promote greater racial and economic justice. Access to affordable health care can have a profound impact not only on people's health but also on their ability to lift themselves out of poverty and achieve a higher standard of living (Miller & Kirsch, 2011). Many of the strongest predictors of health and well-being fall outside of the health care setting: social, economic, and environmental factors all influence health (Rogers et al., 2013).

When organizations–government-based, private, or nonprofit--succeed in meeting individuals' basic health needs, people are more likely to exercise, eat healthy foods, and seek preventive health services (HHS, 2011b). The HHS (2011b) suggested that multiple and diverse preventive strategies in clinical and community settings are necessary to improve health, as community organizations often cannot perform these tasks on their own. This study demonstrates the efficacy of the DE framework as an innovative research approach for monitoring and supporting social innovations that work in partnership with program decision makers.

Over the years, efforts to eliminate disparities and achieve health equity have focused primarily on diseases or illnesses and health care services (HHS, 2011a). The absence of disease, however, does not automatically imply good health. Improving access to comprehensive, quality health care services is a primary objective of Healthy People 2020 (HHS, 2014c). Having access to comprehensive, quality health care services is important to achieving health equity and increasing the quality of a healthy life.

Disparities in access to health services affect individuals and society. Limited access to health care impairs people's ability to reach their full potential, lowering their quality of life. Barriers to services include the lack of availability, high cost, and lack of insurance coverage (HHS, 2014c). Access to health care services in the U.S. is viewed as unreliable because many people do not receive the appropriate and timely care they need. The U.S. health care system, which is already under enormous strain, will face an influx of patients as the ACA is implemented. In 2014, about 4.5 million individuals signed up for subsidized health insurance on the Healthcare.gov website (86% of the 5.5 million enrolled); preliminary numbers show that 2015 enrollment is likely to be higher (HHS, 2015). This year, as of the end of the 2016 Open Enrollment Period on January 31st, just shy of 12.7 million people had selected Qualified Health Plans (QHPs) via either the federal exchange (HealthCare.Gov) or one of the dozen or so state-based exchanges (Gaba Charles, 2016). Evaluating the ability of the Black church to disseminate information and resources that can connect the membership to health services and insurance coverage presents an opportunity to address access to comprehensive, quality health care services and promote health equity in communities of color.

Strategies to engage communities of color and inform them about the ACA through education are known to reduce disparities in health and support health care reform. LaVeist et al. (2009) described the ACA as the most significant opportunity in at least a generation to reduce disparities in health and health care and improve health equity. They also suggested that the best chance for increased health

equity occurs when the communities that are the most affected by inequities are involved. Therefore, it is imperative that communities of color engage in health advocacy and policy work related to health equity (LaVeist et al., 2009). Leaders may benefit from identifying the key formal and informal leadership structures in the Black church as a way to leverage collaborative partnerships that can address health issues in African American communities. In addition, understanding the linkages among groups within the Black church, along with their assumptions about relevant health practices and their knowledge and education about health care services systems, is a plausible way to address leadership challenges.

Learning about past and current efforts to engage church members around health or related issues; understanding what worked and did not work, and why; and determining how those efforts may influence members' readiness or willingness to become involved in future efforts are all important leadership challenges. Moreover, gaining insight into the norms and values that exist in a faith congregation and the ways in which they might influence African Americans to participate in the health decision-making processes and their own health behaviors can enhance leaders' ability to make a difference in other communities of color.

Lastly, Ogden (2014) supported the introduction of systems thinking to test leaders' ability to hold different perspectives simultaneously and understand what it means to work toward integrity in and across dimensions. He further stated that systems thinking includes identifying existing patterns that undermine health and wholeness. Increasing the understanding of practices such as leading with values and value creation, creating deeper and more direct connections, storytelling, designing for emergence, and engaging greater systemic diversity can serve the community at large (Ogden, 2014).

CHAPTER 2: CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

Introduction to Conceptual Framework

The conceptual framework for this study, depicted in Figure D1, includes relevant theoretical foundations, such as the socioecological model, social capital theory, and the community-based participatory research (CBPR) model. Proven faith-based interventions that lead to changes in behavior are also included in the study framework. Additionally, the framework places the Black church at the center of this inquiry and describes the distinctive characteristics of the church—including its history, culture, existing trust, leadership, influence, and reach—to provide evidence supporting the framework. The conceptual framework further illustrates how the DE evaluator is part of a team whose members collaboratively conceptualize, design, and test new approaches in a long-term and ongoing process of improvement, adaptation, and intentional change (Patton, 2011). Systems thinking principles also are an element of the conceptual framework. These principles help exemplify the impact of knowledge transfer and organizational change in the church.

The literature reviewed here examines the DE approach to determine its usefulness in supporting forms of exploration and reflection that result in emergent ideas leading to organizational learning. This section also includes a review of how these approaches, employed in aggregate, have the potential to reduce health disparities and improve the health of African Americans.

Literature

Research is lacking, regarding how well Black churches are able to promote health among their congregations. Reid, Hatch, and Parish (2003) asserted that even though a significant number of African

American church-based programs have been described in the literature, few have been evaluated for effectiveness.

DeHaven, Hunter, Wilder, Walton, and Berry (2004) conducted a comprehensive literature review of African American church-based program effectiveness (1990-2000) to assess program objectives, features and outcomes, locations, scope, number of congregations involved, target populations, and conditions. The researchers found that the target populations tended to be adult African Americans. Although the review added important information about the positive effects of the programs, less than 8% of the studies reported program outcomes (Timmons, 2009). This literature review emphasized that not only is there a lack of research on program effectiveness and the Black church, but there is also a lack of understanding about how this evaluation could be accomplished. This study addresses this issue by providing an overview of the DE approach, how it differs from traditional evaluations, and what makes it a good fit for the research project reported here.

Researchers have argued (CDC, 2016) that use of the socioecological model supports relationships between individuals and groups that facilitate the design of more effective health interventions. This study sought to understand the effect of this model on change at the organizational level and focused its literature review on the socioecological model and levels of complexity and change. Included in this chapter is a review of literature on the efficacy of CBPR evaluations and health interventions in the Black church. Also considered in this section were the history of the Black church and the African American community in relation to the church's ability to encourage congregants to think about and participate in health interventions, and the work such tasks require. Lastly, this literature review presents an overview of health promotion activities in the Black church and shares lessons learned from participating in those activities.

Developmental Evaluation

For more than four decades, evaluation has focused mainly on educational and program assessments conducted by social science researchers in universities, organizations, and agencies (Patton, 2011). More-recent evaluative practices, however, have focused on increasing and sustaining interest in participatory, collaborative, and learning-oriented practices as a means of determining levels of a program's effectiveness. DE has emerged fairly recently as a way to support adaptive learning in complex and emergent initiatives. Combining the rigor of evaluation with the flexibility and imagination required for development, this new form of evaluation brings critical thinking to bear on the creative process in initiatives involving high levels of uncertainty, innovation, emergence, and social complexity (Gamble, 2008).

Evaluation is an important component of most community programs and projects. Internal evaluations are carried out by members of the project teams themselves. These evaluators understand the thinking behind the development, appreciate the problems that have arisen, and command the trust and cooperation of the other team members. On the other hand, such evaluators might find it difficult to criticize the work being carried out, and because of their close involvement with the project may be unable to suggest innovative solutions to identified problems. Such internal evaluators will know only too well the amount of effort put forth by members of the project teams to produce their courses, curricula, or programs, and as a result they might hesitate to involve them in more work.

Historically, two types of evaluation have been used to understand the processes, effects, influences, and impacts of programs and initiatives. Formative (i.e., process or implementation) evaluations typically focus on details of how a program model takes shape and summative, a periodic review of long-term progress on major program goals and objectives. The purpose of both evaluative

models is to improve, refine, and standardize the program (Patton, 2010). Although formative and summative evaluations still have relevance in certain program settings, more diverse evaluative approaches are being introduced to support the types of information needed for a broader variety of situations, groups, and settings (see Table A.II). These newer evaluation methods are more suited for examining dynamic, complex situations.

According to Senge (2006), when the same actions have dramatically different effects over the short and long terms, dynamic complexity exists. Senge also stated that when actions have one set of consequences locally and a very different set of consequences in another part of the system, the result is dynamic complexity.

Drawing on the theory of complex, dynamic systems, DE offers evaluators, nonprofit organizations, and funders a different way than traditional evaluation models for engaging in evaluative practice (Patton, 2011). Patton (2011) identified five purposes for which DE is particularly well suited: the focus of the evaluation, the intentionality of learning throughout the evaluation, the emergent and responsive nature of the evaluation design, the role and position of the evaluator, and the emphasis on using a systems lens for collecting and analyzing data as well as generating insights. Given this rationale, DE has been called part of *next generation evaluation*. This term is used by a group of social advocates at the Foundation for Social Growth and Stanford University to encompass three innovative approaches to evaluation: DE, shared measurement, and big data (Gopal & Preskill, 2013). These approaches collectively have the potential to change future evaluation practice.

An emerging body of research has focused on ways to implement DE effectively by identifying tools and processes appropriate for data collection, group facilitation, and reporting results (Langlois, Blanchet-Cohen, & Beer, 2013). There are several primary reasons for using a DE framework in research.

Evaluation, particularly collaborative evaluation, has the potential to promote actions that support appropriate program practices among particular groups. DE can be used in a range of settings for various purposes, including social experimentation, the need for innovation, or a implementing a systems change along a continuum. DE directs attention to process and provides a link between process and outcomes without losing the potential for effective documentation of these outcomes.

Lack of empirical research on outcomes evaluation of social service programs is not unique to FBOs; researchers have found that data on the impact of public and private social programs have been scant and existing data often are unreliable (Monette, Sullivan, & DeJong, 2005). Others have supported this view with respect to faith-based program evaluations, finding that not only have faith-based studies in general been limited, but also that the research designs and methods used to date have been questionable (DiIulio, 2002). Given the limited knowledge base available to compare faith-based programs with their secular counterparts, and the need to determine which faith-based efforts influence favorable client outcomes, using DE in the Black church can be useful. DE coupled with additional evaluation tools can also be useful in complex environments such as the African American church.

Needs Assessment

Needs assessment has been defined as the process of measuring the extent and nature of the needs of a particular target population so that services can respond to them (Becker –Wustli, 2015). The Community Church conducted a needs assessment as part of the health planning process. The assessment assisted with determining a gaps in health services as well as helped to assess member health status.

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Logic Models

The Kellogg Foundation defines a logic model as: "… a picture of how your organization does its work – the theory and assumptions underlying the program. Program logic model links outcomes (both short- and long-term) with program activities/processes and the theoretical assumptions/principles of the program." (Kellogg Foundation, 2004) Using the logic model as a program evaluation tool highlights priorities and program linkages (problems, goals, objectives, activities, outputs, and outcomes) and provides clear evidence about meeting program expectations (Timmons, 2014). Logic models provide an understanding of relationships among available resources to operate programs. It is crucial to understand how and why health programs work so the successful ones can be replicated. When a program does not produce the expected changes, it is equally important to understand why (Choi, 2008). Health research can provide the deeper understanding that enables churches to make organizational and policy changes that help programs succeed, allowing congregants to benefit fully from health promotion initiatives (Dusenbury & Hansen, 2004). Although experimental research designs are ideal for determining the effects of broad-based health programs, they have limited use with smaller populations in real-life settings such as churches (Bausell, 2006).

Complexity in DE

The ACA legislation is highly complex, and trying to raise awareness and understanding of ACA provisions presents an adaptive leadership challenge that requires learning the complex means through which health insurance is accessed, obtained, and used. Challenges presented to date have included the significant lag time between passage of the law and full implementation, increased pressure for

Medicaid expansion, the election of officials who are less committed to implementation, and an urgent need to increase public understanding of the key elements of the law.

Although news coverage about the ACA have appeared almost daily for several years, research from the Henry J. Kaiser Family Foundation (2013) found that U.S. citizens have a poor understanding of health insurance and health care reforms. This is particularly true of African Americans, who stand to benefit substantially from the law. Lack of health insurance is a major problem in the U.S. that has significant health consequences (Henry J. Kaiser Family Foundation, 2013). Academics and evaluators are increasingly embracing complexity thinking as an effective method of addressing the kinds of socioecological challenges presented by the ACA legislation. In this context, action researchers partner with stakeholders (e.g., communities, governance institutions, work resource managers, etc.) to address issues that involve adapting to complex environments. In doing so, researchers and stakeholders strive to internalize not only "intellectual complexity" (knowing) but also "lived complexity" (being and practicing; Rogers et al., 2013, p. 1). Complexity-based DE shifts the focus of accountability in evaluation: In traditional evaluation, accountability lies with the decision makers, but in DE, accountability rests with the researchers and stakeholders.

Socioecological Model

The socioecological model recognizes the interwoven relationship between individuals and their environment. From a socioecological perspective, churches and other religious organizations can influence members' behavior at multiple levels. Formative research is essential to determine appropriate strategies and messages for diverse groups and denominations. The socioecological model has been effective as a foundation for designing faith-based health promotion interventions because it

"considers the complex nature of the church community and provides a framework for intervening at multiple levels of influence on health behaviors and practices" (Campbell et al., 2007, p. 215).

The socioecological model supports culturally relevant, patient-centered approaches to health promotion interventions. Patient-centered, culturally sensitive health care addresses patients' cultural preferences and tailors care to their cultural needs (Geisz, 2010). The ACA mandates that the patient-centered delivery model be culturally competent; that is, sensitive to the beliefs, values, and cultural mores that influence how health care information is shared and received by individuals (as cited in Somers & Mahadevan, 2010).

Although there has been some indication that the socioecological model can promote an understanding of change at the interpersonal level, this study's focus is on change at the organizational level. Moreover, although culturally sensitive health care might help reduce racial and ethnic disparities, there has been little empirical evaluation of these interventions in the African American church; therefore, this study used DE-based inquiry to explore the outcomes of culturally tailored outreach related to the ACA, in order to gain insight into congregants' priorities related to health disparities and inequities in the context of designing health programs within the church.

Community-Based Participatory Research

An action research evaluation seeks to involve all stakeholders to fulfill its goals of being participatory and collaborative. The CDC (2013) noted that utilizing PAR evaluation can make projects more sensitive to the variety of needs of diverse communities. Action research is known by many other names, including participatory research, collaborative inquiry, emancipatory research, action learning, and contextual action research, all of which are variations on a theme (O'Brien, 1988). Put simply, action

research is learning by doing: A group of people identify a problem; do something to resolve it; see how successful their efforts were; and if they are not satisfied, try again (O'Brien, 1988).

Minkler, Blackwell, Thompson, and Tamir (2003) defined CBPR as "a collaborative process that equitably involves all partners in the research process and recognizes the unique strengths that each brings" (p. 1210). CBPR approaches are community driven and promote civic engagement and social action (Navarro, Voetsch, Liburd, Giles, & Collins, 2007). In contrast to individual health initiatives, community health research seeks to discover new knowledge to improve the health of populations. As such, community health intervention research does not necessitate, and traditionally has not utilized, a CBPR approach. However, CBPR provides community projects with appropriate guidance to ensure that communities implement evidence-based interventions whenever possible (Buchanan, Miller, & Wallerstein, 2007).

According to research, church-based health promotion interventions can reach broad populations and therefore have strong potential to reduce health disparities (Campbell et al., 2007). For African Americans, health interventions that incorporate spiritual and cultural contextualization have often been effective. From a socioecological perspective, community-based health promotion might be studied in the context of multilevel interventions that encompass the social network or multiple organizational levels (see Table A.III; Campbell et al., 2007). Community-based researchers can use evaluation models such as participatory evaluation (Patton, 2011) or empowerment evaluation (Fetterman, 1994) to guide community organizations through the evaluation process.

This study aligns with the participatory evaluation model, which is stakeholder focused and enhances evaluation utilization through the increased involvement of the primary user(s) in the research process (Cousins & Earl, 1992). In many instances, community members' involvement in research has

had a profound impact on environmental health issues and social determinants of health. A participatory evaluation approach is a useful vehicle through which community service providers might learn whether their programs are meeting the needs of their clients and/or achieving the programs' goals. DE, also known as action evaluation, can be characterized as an approach to CBPR that supports social innovation. DE is an evaluation approach that can help innovators develop social change initiatives in complex or uncertain environments.

Social Relationships and Social Capital

Drawing on the work of Stacey (2003), who focused on relationships and interactions in evaluation, Patton (2011) argued that social relationships are a key component of DE. Social capital is also key to supporting the related idea of social networks. The African American church possesses a wealth of *social capital*, defined as the social relationships and patterns of reciprocal, enforceable trust that enable people and institutions to gain access to resources such as social services, jobs, or government contracts (Snieder, 2004).

In the professional literature, researchers have pointed out that the African American church provides significant social support to its members (Davis et al., 1994). In addition, the church often provides direct services, such as giving clothing and food to community members, and indirect services such as disseminating information to individuals about community resources (Aaron, Levine, & Burstin, 2003). Social capital centers on connections and is defined by the presence of three elements: a network, trust specific to the network, and the ability of the network to facilitate access to resources (Snieder, 2004). The trust that characterizes social capital involves specific trust among network members, not generalized trust within the community or city as a whole (Snieder, 2004).

Church memberships often comprise family and friends, and offer an abundance of networking activities. FBOs are particularly central to social capital and civic engagement in the African American community. Churches provide spiritual enrichment and opportunities to develop and cultivate social connections. The existence of many communities is rooted in the church, which is often the resource of choice for public health practitioners seeking to help families address their needs and concerns (Hadley, 2006).

Social capital was a consideration during the assessment of the ACA rollout in Phase 1 of the study to determine whether there is any connection between the congregants' trust in the ACA provisions and their potential use of the ACA through the program proposed by the Community Church. The central premise of social capital is that social networks have value. Social networks are a key component of DE; networks are primarily self-organizing and manifest complex nonlinear dynamics (Patton, 2011). Network analysis can be used to study social relations between and among a set of actors (Borgatti, 2011). Social network documentation and analysis, both qualitative and quantitative, can be a powerful technique for tracking and documenting network development for evaluation purposes, including feeding back to the network information about its own emergent patterns and development (Patton, 2011).

History

A group's history of oppression and survival inevitably affects the way it is organized. The networks and organizations that form to protect the rights of their members influence the way in which they organize for self-help (KU Work Group for Community Health and Development, 2014). The Black church was established in the northern and southern states during the Revolutionary War and served as a training ground for future leadership, institution building, and communal organization (Jefferies,

2009). The church facilitated a remarkable increase in the literacy of African Americans in the southern states (from 5% in 1870 to approximately 70% by 1900). In addition, as in the northern states, it was instrumental in the success of many African American leaders outside the sphere of the church, in politics, education, and other professions (Maffily-Kipp, 2011).

The roots of the Black church extend back to the 1760s and 1770s, when African Americans began to respond in increasing numbers to the religious revivalism of the period (Jefferies, 2009). Out of this movement grew the independent Black church, which remains one of the most significant communal institutions in the African American community (Jefferies, 2009). The church is the oldest and most resilient social institution in Black America, due in great part to that fact that it was traditionally the only Black-controlled institution of a historically oppressed people (Bartkowski & Matthews, 2005).

The Black religious tradition combines religion and community affairs, encouraging civic activism (Ammerman et al., 2003). Black ministers have the dual role of preaching a transformative message of salvation and serving as community representatives. Social activism, social change, equality, and unconditional love are common subjects of sermons in African American churches. The Black church has traditionally been a force that stands against injustice and champions civil rights. The church builds bridges, meets unmet needs, and brings previously unavailable resources to the African American community. As the ACA transforms health coverage for individuals and families in communities and congregations throughout the U.S., it is important for people to receive accurate information so they can make the best choices for themselves and their loved ones (HHS, 2014a). This study builds on the church's historical role of providing a link between the individuals who are the most vulnerable and difficult to reach and the vital health services they need.

Assets in the Black Church: Culture, Leadership, Trust, and Influence and Reach

Culture.

Cultural attributes of the Black church provide a foundation for civic involvement and holistic health promotion programs, both of which have important roles in health promotion. Parsons (1955) described culture as "those patterns relative to behavior and the products of human action which may be inherited, that is, passed on from generation to generation independently of the biological genes" (p. 125). Culture represents a "constitutive dimension of all human action" (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1986, p. 333), and Black Christianity is a key element of Black culture. The power of prayer, songs performed in call-and-response interactions, testimonials or sharing stories, and shouting during worship all have roots in African culture and can be viewed as ways to cope with oppression and anticipate a day of greater freedom (Pattillo-McCoy, 1998). Such practices fall within a definition of culture as comprised of "symbolic vehicles of meaning, including beliefs, ritual practices, art forms, and ceremonies, as well as informal cultural practices such as language, gossip, stories and rituals of daily life" (Swidler, 1986, p. 273).

Physical and spiritual well-being are additional elements of the culture of the Black church. Healing is a focus, and the church is considered a place of refuge (North Carolina Department of Health and Human Services [NC-DHHS], 2004). African Americans have a long tradition of health and healing practices that shape, in part, how they care for themselves. Religious adherents might be more likely to adopt healthy practices because of the church's emphasis on respect for the body (Whooley, 2002). These aspects of culture in the Black church are useful to educate the membership about the

importance of health and to spread awareness of the ACA. They also have the potential to inspire members to enroll for health coverage.

Church leadership. Gunderson (2004) argued that for community leaders to see the full breadth of their communities, they must be able to reframe situations. Bolman and Deal (2003) use the concept of symbolic framing as a way to view organizational culture that characterizes leadership as potentially transformational. It entertains the possibility of leaders as visionaries who bring out the best in their followers. Effective symbolic leaders follow a consistent set of cultural rules and practices: They lead by example, use symbols to capture attention, frame experience, communicate a vision, tell stories, and respect and use history (Bolman & Deal, 2003).

Pastors in the African American church can play a pivotal role in their members' adoption of health promotion and research activities. The pastors' introduction and endorsement of programs to their congregations are essential to any such effort (Ammerman et al., 2003), as the engagement of pastors and other church leaders is critical to program acceptance and success. As trusted and respected leaders in the African American community, church pastors are thus instrumental to furthering research efforts. Because pastors have considerable demands on their time and extensive responsibilities inside and outside the church, however, they often rely on the assistance of lay church leaders.

Trust. Interestingly, while trust can be viewed as an asset in the Black church, it also can impede partnering with government agencies to conduct health interventions. Leadership, vision, and trust are essential in delivering health programs. This is particularly true within African American communities, given the suspicion that has resulted from the federal government's historical violations of trust related to health issues in these communities. Recent analyses of the relationships between minority patients and their physicians have demonstrated that provider racism and patient awareness of insidious past

events—such as surgeries without anesthesia (Spettel & White, 2010), experiments conducted in the mid-1800s on enslaved African American women, and the infamous Tuskegee syphilis experiment—have contributed to minority patients having less access to and knowledge of medical treatments than their European American counterparts, lower levels of trust, and less willingness to participate in clinical trials (King, 2003).

African Americans' mistrust of the health care system is a major problem that has to be addressed if health inequities are ever to be overcome. Leaders in African-American congregations are trusted messengers among congregants, who will often listen to their pastors and other church leaders more readily than they will accept the word of others. Therefore, it is critical that churches in the African American community educate their congregants about health insurance to dispel misconceptions about the ACA.

Influence and reach. The Black church is an influential institution in the African American community (Kaplan, Calman, Golub, Ruddock, & Billings, 2006). Today's churches are concerned about individual members' well-being, provide programs and services that support their members, and serve as focal points for their communities. Their leaders are highly respected (NC-DHHS, 2004) and can reach people, especially the most vulnerable individuals, with the tools and information they need to become healthy, stay well, and thrive (HHS, 2014a). Social services programs that aim to reach low-income individuals may be strengthened through collaboration with churches, which could then extend the reach of these programs to church attendees. These programs can also build on the traditional commitment of churches to reach out to non-members (Aaron et al., 2003).

African-American Churches and Health Promotion

The Black church has a long, rich history as the center of spiritual, social, and political life for many African Americans. Many individual Black churches contribute to the social, economic, and political welfare of their congregants as well as the community at large (Campbell et al., 2007). The Black church also has an important role in promoting health. The church and its leaders often have been identified as valuable counterparts to public health researchers with the ability to link formal and informal systems of care (Blank, Mahmood, Fox, & Guterbock, 2002). The CDC's (2013) Racial and Ethnic Approaches to Community Health (REACH) initiative provides grants to community coalitions to design, implement, and evaluate community-driven strategies to eliminate racial and ethnic health disparities. To date, the CDC has funded two rounds of demonstration projects: REACH 2010 and REACH 2020. The REACH 2010 community-based coalitions were formed or expanded to address health issues.

Many coalitions have included key stakeholders and community leaders, including those in faith communities. REACH coalitions have actively involved the Black church in helping to deliver targeted population-based health interventions. For example, in 2001, the Bronx Health REACH coalition was formed to conduct health interventions among vulnerable populations. This coalition, like many community-based health education efforts, looked to religious institutions to provide access to at-risk populations as well as social and emotional support for behavioral change (Kaplan et al., 2006). Further, the churches were viewed as potential leaders in the effort to address racial and ethnic disparities in access to care, given the long history of African American and Latino American churches leading efforts to support social equality and justice (Kaplan et al., 2006).

More recent REACH projects have focused on obesity and hypertension (CDC, 2013). There also have been numerous instances in which the CDC (2009) partnered with Black churches to conduct HIV prevention activities through its community-based organizations program and to implement capacity-building activities through its capacity-building assistance program (CDC, 2013). During the CDC's (2009)

heightened national response to the HIV/AIDS crisis among African Americans, the organization partnered with many FBOs in the African American community to mobilize against the disease.

Numerous additional programs have focused on Black churches as venues to reduce the health disparities between African Americans and other racial/ethnic groups (Campbell, 2000). The Black church plays a particularly prominent role in the positive appraisal of self (i.e., self-worth and self-esteem) and the affirmation of beliefs and attitudes among its members (Chaney, 2008). Many researchers have used the church as a vehicle to promote health and empower people to address their own health issues. DeHaven et al. (2004) conducted a systematic review of 53 health programs in FBOs from 1990 to 2000 to determine whether these types of programs could provide a measurable form of community-based care. The results demonstrated that faith-based health programs can produce such positive effects as significantly increasing knowledge of disease, improving screening behavior and readiness to change, and reducing the risks associated with disease and disease symptoms.

Hankerson and Weissman (2012) conducted a systematic review of studies of church-based health promotion programs for mental disorders among African Americans, to assess the feasibility of using such programs to address racial disparities in mental health care. Although they found limited research on this topic, they concluded that the Black church is positioned to overcome barriers such as stigma, distrust, and limited access--factors that can contribute to racial disparities in mental health service utilization. Their findings indicated that African Americans underuse traditional mental health services in comparison to European Americans and that the Black church is being underused as a potential mental health resource.

Body & Soul, a wellness program developed for African American churches, provides another example of a project established to address health disparities in the Black church. This program

encourages church members to eat five to nine servings of fruits and vegetables every day for better health. Churches that embrace the Body & Soul program help their members to take care of their bodies as well as their spirits (Resnicow et al., 2004).

Additional work that uses faith communities to achieve public health goals includes efforts focusing on the African American church and injury prevention and faith-based HIV/AIDS interventions. Falcone, Brentley, Ricketts, Allen, and Garcia (2006) noted that their findings on the African American church and injury prevention were used by an advisory board comprising a partnership between the African American faith-based community and an injury prevention group to develop a unique multigenerational intervention program targeting motor vehicle restraint use. The advisory board used these findings, as well as behavioral learning methods, injury epidemiology data, and the best practices of previously successful health promotion programs targeting African Americans to guide the development of the faith-based injury prevention curriculum. Once developed, the program was initially evaluated by comparing outcomes between control and intervention churches. The main objective was to observe adult and pediatric restraint use before and after program implementation.

Overall, the researchers found that there was excellent recognition and participation in the program (Falcone et al., 2006). Following program implementation, significant improvements were observed in restraint use compared to churches used as control groups. These results from Falcone et al. (2006) suggested that development and implementation of a culturally sensitive intervention program can significantly improve restraint use in a minority population. Falcone et al. also found that partnering with the community in all phases of the program was essential to its success. They confirmed that a partnership with the faith community is feasible and can be an essential tool in addressing health disparities, a finding that adds support for the community-based organization approach in the present study.

Limitations identified by Falcone et al. (2006) suggested that launching a partnership between an academic center and the African American church is a challenging endeavor. Building relationships with the church and all of the other partners requires extensive time and coordination. The DE design in this study sought to address this issue by requiring the evaluator to be part of the team, whose members collaborate to conceptualize, design, and test new approaches in a long-term, ongoing process of continuous improvement, adaptation, and intentional change. A gap in Falcone et al.'s (2006) study entailed community involvement, as attendance at some of community events was reported as lower than anticipated. Falcone et al. identified additional limitations, suggesting that some events were not focused on individual church needs and should have been combined with other health-related issues affecting the community. This study addressed this issue by allowing the involved individuals collaborate on solutions.

Lindley, Coleman, Gaddist, and White (2010) concluded that although programs such as Project F.A.I.T.H. (Fostering AIDS Initiatives That Heal) were initiated to reduce the stigma of HIV within African American FBOs in South Carolina, educational programs must also educate participants on how HIV can and cannot be transmitted, paying particular attention to educating males and older populations. These findings might be helpful to HIV-prevention efforts targeting African American FBOs in South Carolina and elsewhere. The majority of people surveyed said they were more interested in learning about healthy living through interactive workshops led by health ministry programs than from sermons (Lindley et al., 2010).

Additionally, researchers from the Center for Advancing Health surveyed more than 1,200 members of 11 African American churches in North Carolina about their church attendance, diet, physical activity, beliefs regarding the role of the church in health promotion, and interest in Bible-based healthy living (Stephens, S. 2013). The researchers found that the African Americans who believed their

church had a role in promoting healthy living also were more willing to attend church-based health programs. Furthermore, the congregants expressed a preference for receiving health information through interactive workshops and health fairs led by health ministry programs more than from sermons, suggesting that although the pastor was a trusted individual with an important role, he was not viewed as the expert on health matters.

Stephens (2013) supported the need for the type of research and the participatory methodology utilized in the present study. Stephens suggested that a stronger partnership between church leadership and health researchers could potentially reduce the impact of health disparities on African Americans (Stephens, 2013).

Lastly, the literature suggests generalizability of the results between African American communities and churches is challenging. In a research study conducted by Peter A. Lichtenberg (2011) entitled "The Generalizability of a Participant Registry for Minority Health Research" the researcher examined effective strategies to recruit minority elders into health research (e.g., through churches, partnering with community gatekeepers) often involve nonrandom sampling methods. The results of the research indicated generalizability was limited because nonrandom sampling was conducted which questioned how well the sample represented the population it attempted to study. The study noted that the demographic and health indices, differences in age, gender, and functioning between the two groups were not the same. Another study conducted to assess the effectiveness of a 6-month, church-based diet and physical activity intervention, conducted during 2010 through 2011, for improving diet quality (measured by the Healthy Eating Index-2005) and increasing physical activity of African American adults in the LMD region noted the limitations of generalizability (Tussing-Humphreys L.et al., 2011). This study revealed generalizability a limitation because the intervention was tailored specifically for African American adults in the Lower Mississippi Delta (LMD) region and they were predominately older,

churchgoing, and female. The study also highlighted that the overrepresentation of older women in LMD African American churches is common and reflects the low percentage of active male church members.

Lessons Learned

The scholarly literature provides evidence of the Black religious tradition of encouraging the mixing of religion and community affairs and invigorating civic activism. It also shows that the family-like connections in the Black church make it possible for African Americans to develop close relationships with church members that are comparable to those experienced within their families of origin (Campbell et al., 2007). According to Chaney (2008), community outreach is an important aspect of conducting health interventions in the Black church because it indicates that church involvement makes African Americans aware of the ways that the church supports church and non-church members. Other important facilitating factors for conducting health interventions in the Black church are access to target populations and a willingness to shed light on social taboos, as in the studies of mental illness and HIV/AIDS discussed above.

The results of research focusing on African Americans and the Black church indicate that health interventions can be successful with this population. However, although church leaders and congregants have generously shared their ideas, tips, and success stories with other churches, there is no evidence of organizational change or program sustainability. Evaluating church programs helps to determine their success or failure, whereas a lack of evaluation makes it difficult to establish program impact. According to DeHaven et al. (2004), increasing the collaboration between health professionals and faith-based groups offers one way to introduce evaluation strategies into programs and then disseminate the results to a broader audience.

The literature identified both recurring themes and lessons learned about barriers and facilitating factors. The most prominent finding was that church leaders have to make strong commitments when a church is involved in health interventions (Resnicow et al., 2004). The greatest benefits of church involvement for African Americans are the receipt of material, emotional, and spiritual assistance; pastoral sermons that provide hope; and the building of strong and supportive networks with others Chaney C. (2008). Research also has suggested, however, that pastors cannot undertake the task of health promotion in the African American church alone. Functioning in networks of interaction appears to be an important aspect of delivering effective health interventions in the African American community. Campbell (2000) asserted that clergy have particular strengths or interests, such as preaching, liturgy, pastoral counseling, and teaching. He noted that these areas must always be kept in perspective if clergy are to share in the ministry of oversight effectively leading their staff. Balance is a key component to systemic maturity (Boa, 2014).

Barriers to Delivery

Although it is often seen as a single entity, the Black church is comprised of many parts, enabling it to meet the varied needs of its congregants. The Black church can be organized in several ways, depending on denominational affiliation, although many individual Black churches use the ministry framework as a means of outreach and education. This framework allows the church to distribute information about particular health concerns to target populations. Ministries in the Black church are comprised of groups (e.g., seniors, youth, women, and men) that conduct activities such as food outreach, education, and health screenings. These ministries can be further subdivided demographically within their respective groups, based on age, gender, education, health, and SES. This diversity of

congregants provides a valuable pool of perspectives, representing various perceptions of knowledge transfer capabilities that lead to organizational learning.

Learning Organizations

Features of a learning organization include learning from others and transferring knowledge, two practices that also characterize in the Black church. *Co-learning* is a concept often used in the Black church to express the belief that learning together helps congregants approach the task of ministry in fresh and holistic ways. Senge (2006) described learning organizations as groups that expand people's capacity to create the results they truly desire, nurture new and expansive patterns of thinking, foster collective aspirations, and teach individuals how to learn together. This study explores the DE approach from a systems perspective to determine whether and how this concept is applicable to the Black church and what practices in the church do, or could, promote its capacity to be a learning organization.

Systems Thinking

The systems thinking perspective is integral to DE, which supports the emergence and transfer of feedback about how major systems change is unfolding, along with evidence of emergent tipping points. How an innovation is or might be changed as it is shared across an organization also is an element of DE (Patton, 2011). The traditional paradigm of formative evaluation (which seeks to improve an approach or model) and summative evaluation (which seeks to prove that an approach or model works) cannot fully account for the complex and emergent nature of social change. Thinking about evaluation from a systems perspective thus enhances knowledge transfer and promotes organizational learning.

According to Garvin, Edmondson, and Gino (2008), a learning organization is skilled at creating, acquiring, and transferring knowledge, as well as modifying its behavior to reflect new knowledge and insights. The Black church has long been viewed as an extension of the African American community that is capable of adapting to change. Sermons in the Black church often convey transformational messages aimed at both the head and the heart. The rollout of the ACA offers new opportunities to showcase these aspects of the church; such new ideas are essential if learning is to take place in any organization (Garvin et al., 2008).

Senge (2006) supported systems thinking as the cornerstone of organizational learning. Systems approaches can help to address health disparities in three ways: (a) systems thinking can promote the development of more sophisticated and dynamic conceptual models of the causes of health disparities; (b) systems tools (i.e., formal models and simulation) can help to explore and refine these models, and examine the effects of various interventions in the context of dynamic relations; and (c) systems approaches can enhance the use of existing data and promote the collection of new types of needed data (Diez Roux, 2011).

Findings from the Literature Review:

The Black Church's role as motivator, supporter, and provider in community life—as well as an agent of societal change--has been well-documented. But researchers have not adequately assessed its effectiveness as a promotor of health literacy and connectivity. Further, they also have not adequately established the best methods of studying such promotion in the Black Church. This study was designed and conducted to address this noted knowledge gap.

CHAPTER 3: STUDY DESIGN, DATA, AND METHODS

Analytical Approach

This study relied primarily on qualitative data collection and analysis methodologies; a quantitative data analysis of survey results provided additional data. Miles, Huberman, and Saldaña (2013) have reported that qualitative data analysis focuses on naturally occurring, ordinary events in a natural setting; it gives rise to a greater understanding of what real life is like; and is suitable for examining real-world phenomena. This study, which evaluated a faith-based intervention to increase the reach of a government program intended to improve health insurance coverage, is a real-world example akin to the phenomena Miles and colleagues describe in their definition of qualitative data analysis.

The study's action research design supported the qualitative data collection and analysis method. Koshy (2010) defined *action research* as an approach to improving practice through action, evaluation, and critical reflection; based upon the evidence gathered, changes in practice are then implemented. A DE approach was well-suited to guide this process because it harnessed a church membership's willingness to change while attempting to improve each member's understanding of good health and how to access the health care system in order to achieve it.

DE, like action research, follows a cyclical process that alternates between action and critical reflection (Dick, 2002). DE, therefore, can be considered one form of action research. Dick (2002) described a progressively refined process taking shape as the researcher applies early lessons to later cycles of the methods, data collection, and interpretation. Through this iterative procedure that tracks developments and applies them toward driving subsequent steps, the researcher gains a deeper understanding of the process as well as the innovations that were produced. In this study, a DE framework used church-member storytelling and the researcher's interviews, focus groups, observations, and surveys to guide and record a process that first enabled the church group to establish

a dedicated health ministry for disseminating information about the potential benefits of the ACA, then recorded the overall experience so it could be used as a template for bringing about future improvements within the church. DE also helped to test the congregation's readiness for change. Case research is defined by the primary research goal, which is to understand the case itself. Stake (2005) conceptually defined a case as a "specific, unique, bounded system" (p. 449). This statement suggests that the system's activity and functioning are of primary importance. However, even more important is examining the interactions between and among subsystems within the primary system, even if no evidence of influence is found (Lam, 2011). A case, therefore, can be characterized as social, cultural, situational, and contextual (Stake, 2005).

DE involves analyzing processes and procedures aimed at disrupting and challenging organizational systems that involve longstanding relationships and interrelationships; as a result, engaging social innovators in the DE process can become extremely arduous. Three levels of inquiry were made by the investigator (i.e., perspectives (participants), boundaries (church, community, family, and interrelationships (family, stakeholders,) to manage and untangle the systems aspects of the inquiry.

Design

The case study was organized into three phases: (a) exploring the activities taken by the church to roll out and introduce ACA resources to the entire church congregation as well as individuals in the surrounding community, (b) examining the results that emerge from the first phase to leverage the church's readiness and the organizational learning capacity to develop and implement a health ministry, and (c) identifying and captured lessons learned throughout the entire process in order to replicate the

findings in other African American churches in a way that adds value and benefit to their congregations. An overall work plan for all three phases is presented in Appendix C.

Although a particular objective of this study was to connect church members to the resources offered by the ACA, the boundaries of the study extend beyond the church's 630 members to include other church stakeholders, the surrounding community, and other partners such as the local county community health center. Gaining a greater understanding of the church's capacity to influence and empower its members to take action to improve their health status was another important part of this study. As noted in the abstract, members of other Black churches in the Clayton County area were also surveyed as a way to determine the overall usefulness of the results.

Data Sources, Collection, and Management

Over a nine-month period from October 2015 to June 2016, the researcher collected notes and meeting minutes from 13 DE work group sessions held with members of the Community Church. The workgroup members also helped to obtain survey data from church members via a congregational needs assessment and a logic model was discussed and developed in the DE sessions. Conducting a congregational needs assessment helped assess the church's readiness for change, helped the DE group members grasp the extent of the problem, and gather information that provided the DE group with an inventory of assets available in the church to support identifying gaps in services. Constructing a logic model assisted the DE workgroup members to identify church assets and provided clear evidence of resources needed to support program development. The researcher continually polled the DE workgroup members to ensure that they understood the process and were clear on the agenda and meeting task. Additionally, focus was placed on evaluating the survey data obtained from the Community Church's congregational needs assessment and on the DE work group logic model. These

activities were given particular attention as they were designed to help guide the research analysis; the results of the needs assessment and the logic model will be presented later in this report.

More than 10 documented observational accounts of community and church members at health-related events at the church were also made. Observation forms helped to standardize data collection and ensure coverage of all-important items. The observation forms facilitated better aggregation of data gathered from the principal church in the case study. Eight internal and external stakeholders of the church provided key information through an interview process. These stakeholders included: (a) the Community Church pastor, (b) a key leader from Community Church, (c) two members of Community Church who obtained health exchange marketplace insurance as a result of the church's ACA rollout efforts, (d) an ACA navigator from the local community health center who partnered with Community Church during its ACA rollout, and (e) two Georgia state representatives and one state senator whose districts fell within the boundaries of Clayton County. These informants were selected because of their long-standing relationships with the church. They described their experiences with health and wellness activities in the church and provided thoughts on establishing a church-based health ministry. Gaining their insight and expertise with church activities and programs was also helpful to validate the results of the research. The use of respondent validation, confirmation, or refutation of researcher interpretations, especially in action research, was important in controlling bias. These methodologies were also used during the DE church group sessions to corroborate, challenge, and refine the findings.

Focus groups can serve as a tool to understand views about issues and obtain ideas to resolve them. Three focus group discussions were conducted, all within the Community Church, to gain knowledge about the participants' attitudes and experiences regarding the activities conducted to roll out the ACA as well as to obtain insight into their thoughts about using elements in the rollout to

develop a formal health ministry in the church. Focus groups were conducted with the Women for Christ ministry and the Men on a Mission ministry, two gender-specific auxiliaries located at the church.

Storytelling, a form of reflective practice, was one way to obtain information about a project's outcomes from the participants' experiences and viewpoints. Stories from church members who enrolled in the ACA Marketplace as a result of the church's activities promoting the ACA rollout were captured. There has been a long history of exchanging stories in the African American church as a way to pass along traditions and legacies. This approach was employed not only because it is a natural fit in the context of this study, but also because it captured unintended consequences that might add rigor and validity to this study. Given that storytelling played an integral role in church culture, the investigator captured them in a variety of settings, such as, the DE workgroup sessions, services where members shared stories through testimonials, and focus groups. A focus group approach was also used to guide the testimonial story collection service.

Finally, a survey of pastors from other churches in the Clayton County community was conducted. All data collected during the study was stored in a locked meeting room at the church. All of these data were managed and housed in secure logbooks and spreadsheets. See Table I for a date-ordered matrix of all research data collected.

TABLE I. Data Collection Date Ordered Matrix		
Number	Data Collected	Date
Phase I		
6	DE workgroup meetings (stories shared)	October 2015 – May 2016
10	Developmental Encounters	October 2015 – June 2016
4	Observations	October 2015 – December 2015
3	Memos	October 2015 – December 2015
	Congregational needs assessment developed and implemented	December 2015 – February 2016
	Logic model development	December 2015 – February 2016
Phase II		
2	Interviews: Key church leadership	December 2015 – February 2016
2	Interviews: ACA marketplace insurance enrollees	November 2015 – February 2016
4	Interviews: Key community stakeholders 1. Local elected officials (3) 2. Community health center 3. ACA enrollment navigator (1)	January 2016 – February 2016
6	DE workgroup meetings (stories shared) 1. Congregational needs assessment 2. Logic model development	December 2015 – February 2016
3	Memos	November 2015 – February 2016
1	Focus group: Women for Christ	December 2015 – February 2016
1	Focus group: Men on a Mission	December 2015 – February 2016
1	Focus group: Testimony service (stories shared)	December2015 – February 2016

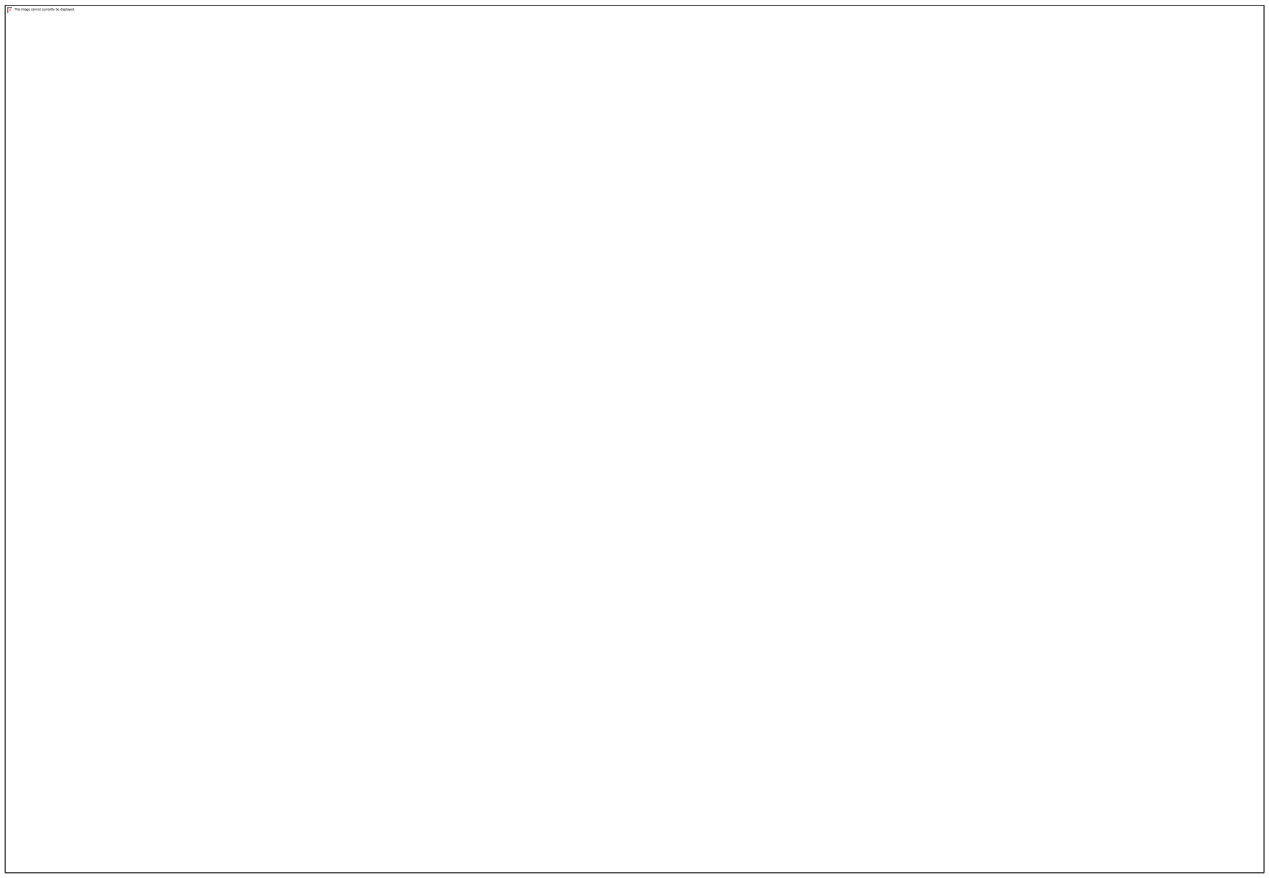
5	Observations	December 2015 -March 2016
	Phase III	
1	Survey: External church ministers (stories shared)	March 2016 – June 2016
2	Memos	November 2015 – February 2016
2	Observations	March 2016 – June 2016
1	DE workgroup meetings (stories shared)	June 2016

Examples of the data collection modes are located in Appendix E.

Recruitment and Sampling

Recruitment of research participants and sampling was conducted through various methods to include volunteering of the DE workgroup member, posting flyers at the church, sending formal written letter requesting external stakeholder participation. See Table II. Below for an overview of recruitment and sampling methods**.**

TABLE II: Recruitment and Sampling



Phase I: Developmental Evaluation

The developmental evaluation workgroup committee members volunteered to take part in the monthly sessions to reflect on activities the church conducted to rollout the Affordable Health Care (ACA) insurance market place (ACA), to evaluate if these activities promoted health equity and assess the potential for a formal health ministry at the church. During the workgroup meetings the committee members were asked questions by the researcher that solicited responses about their personal history and experiences with health and their trust of health professionals. The demographics of this group represented the larger church membership well. The volunteers ranged from 18 to 80 years of age and in some cases were provided a cognitive competency test to assure they understood the process for taking

part in the (DE) workgroup activities (Folstein, M. et al,). The researcher conducted an informed consent process with the participants by discussing their voluntary participation and offering an informed consent document information sheet. Because of the preexisting relationships in the church, which presented a risk of identity disclosure, the researcher requested a waiver of documentation of written consent to protect the privacy and confidentiality of the participants. There was no undue burden placed on the church members who volunteered to participate. Members were informed that they could withdraw early from the workgroup at any time without penalty. Researcher observations were made during this phase to capture participant behavior during the workgroup sessions as well as assist with recognition of intervening junctures into the discussion. Lastly, a congregational needs assessment and logic model was conducted during this phase.

Needs Assessment and Logic Model

The needs assessment helped to evaluate the church's readiness for change, helped the DE group grasp the extent of the problem, collected information that provided the DE group with congregational demographics, health status and identified gaps in services. For churches, the logic model is a useful tool because it offers an easily understood, consistent, and visual guide for program planning, implementation, and evaluation (Timmons, 2014). The logic model (see Figure D2) provides a guide for social innovators in the Community church to follow in evaluating the rollout of the ACA, as it can clarify the issue in a way that embodies the church's spirit and provides a clear foundation on which to build. The logic model enables innovators to document the direct results of activities they undertake. Lastly, a logic model can support the establishment of objectives and goals for proposed church programs prior to starting the group's process. The DE church group worked to develop and finalize a logic model used to guide health planning during the DE process. More detail on the development and the use of the logic model by the workgroup will be shared later in the research.

Phase II: Interviews and Focus groups

Key informant interviews and focus groups were conducted in this phase along with the ongoing work in the DE group, to help examine the results from the first phase to leverage the church's readiness and organizational learning capacity to develop and implement a health ministry. Stakeholder interviews provided a combination of both convergent and divergent participant perceptions. Participants were selected from the Community Church and surrounding area in Clayton County, Georgia, to participate in interview and focus group sessions that asked questions about the church processes, procedures, and their past experiences involved with health activities. Additional stratification methods were used, such as demographic stratification of key informant interviewees and focus group members based on age, gender, and social class, to add integrity to the study design. The goal of the interviews and focus group sessions was to ask questions that solicited responses that increased the capacity of the church to develop a sustainable health ministry and to address adaptive challenges related to the congregants' health. The interview and focus group respondents were selected from various groups both internal and external to the church. This sampling dichotomy served to strengthen the validity of the research results. Each interview and focus group session lasted approximately 1 hour and the questions used during the sessions were administered from guides developed by the researcher which can be found in Appendices D of this research. All responses were kept confidential and only used in the study. Participation in the interviews and focus groups was strictly voluntary. Oral consent was given by the participants as a means of keeping their confidentiality and their responses secure. The participants were given the opportunity to withdraw from the sessions at any time. Additionally, during this phase, the researcher made observations of interactions between participants in the focus groups and between church members during church service and other activities related to health at the church. Moreover, in this phase the researcher also captured stories from the

congregants during a testimonial service focus group which entailed individual members sharing personal stories about their spiritual beliefs connected to their past and current health situations.

Phase III: Surveys

The researcher used a purposeful sample for survey dissemination. The surveys were administered to a small group of ministers in Clayton County, GA. This group of ministers belongs to a church/religious organization comprising pastors from 11 African American churches. The 11 churches in this organization have memberships that are 75% African American and are under the leadership of African American ministers. The survey provided the researcher with the opportunity to gain information about the existing leadership structure of churches in the same county as the Community Church. The surveys also served as an initial investigation into what data were available relevant to any preexisting health activities, such as health fairs, presentations on specific health topics, or physical activity initiatives, that they have completed. Additionally, surveying this small group of ministers allowed the investigator to test the relationship between the attitudes and beliefs of leaders and congregants from other similar Black churches in the Clayton County, Georgia, community, determining whether lessons learned through the DE process conducted by Community Church might reflect their own efforts or motivate them to implement a formal health ministry.

Survey questions asked whether the churches already had a health ministry, were in the process of creating one, or were in the contemplation- or pre-contemplation stages of creating one. Additional items addressed whether the churches had previously offered health-related activities that failed versus those that were successful, and what kinds of leadership structures, processes, and partnerships were associated with either outcome. The Balm in Gilead, Inc., African American Denominational Leadership Health Initiative Needs Assessment (Balm in Gilead, Inc., 2008) was used as a foundation for the

development of the external ministers' survey. The survey included both open-ended questions that allowed respondents to provide their own input and closed-ended items that required Likert scale responses—a protocol commonly used in public health evaluations, often to measure respondents' attitudes by asking the extent to which they agree or disagree with a particular question or statement.

A better rate of return was obtained by distributing a paper survey during one of the ministers' meetings than by using any electronic modes of survey distribution methodology because the investigator could answer any questions the respondents had at that time. A purposeful sample for survey dissemination was employed and the results analyzed by developing categories of similar responses, reviewing and arranging them into major themes, and identifying patterns and trends. Although Patton (1990) contended that purposeful samples permit logical generalization and maximum application of information to other cases, a Cronbach's alpha test on the Likert scale survey results was also applied to measure internal consistency and test for comparison. The survey steps are presented in Table A.IV. Information about the data sources is available in Table A.V.

Memo Writing

Memo-writing exercises helped the researcher-as-evaluator take critical inward looks at strengths and weakness possessed by the researcher-as-DE facilitator. This personal consideration supported the evaluator's continued review of the literature on DE and served as a motivator to pursue further training on evaluation methods and tools, which helped the researcher become a more effective DE facilitator. Subsequently, this also helped to elucidate insights offered by the work group members without blurring the lines between the researcher's personal thoughts about the inquiry and the collective, agreed-upon intervention taking place. Seven memos were developed by the researcher to help prepare for data collection activities.

Writing memos motivated the investigator to lead this inquiry through self-introspection and acquisition of greater knowledge and skills. Additionally, writing memos of recorded thoughts helped the researcher prepare for focus groups and key interviews, and strengthened relationships with stakeholders in Phase II of the research analysis. For example, a memo that documented summary notes from an evaluation work group session was created as a way to fortify the researcher's evaluation skills. This memo provided the researcher with additional information and helped enhance proficiency, resulting in more effective facilitation during the DE work group meetings at the church. An example of the memo summary notes is presented below:

February 2015

The Developmental Evaluator needs to ensure active participation of the workgroup members so that the discussions in the group meetings will be more robust. Be sure to listen carefully in order to discern the information shared during and after the work group sessions. Encourage members and show empathy and appreciation for their input by acknowledging that what they are offering to the group adds value to what they are accomplishing. Continue to clarify the evaluation process periodically during the sessions.

The researcher's efforts to jot down memos during the 3 phases of the research greatly added to the validity of the study. Although, the researcher had assistance with note taking during the developmental evaluation sessions in the first phase of the study, capturing other actions during the research study was left up to the investigator. Given, the numerous data collection activities and events that occurred throughout the study, it was particularly important to capture incidents in real time. Memo writing supported validity during this study by the researcher's action to record notes into memos that captured phrases, participant interactions and quotes and key words as they occurred. This assisted the researcher to not only remember incidences that occurred but to also make sense of events that were later complied. An example of how memos assisted the researcher to strengthen validity during the study can be illustrated by the memo blow:

Date: October 18, 2015

Church member giving testimony about her experience with breast cancer. Member noted that she could not have gone through her treatment without family. Member would not come up before the congregation alone she insisted that her cousin, who is also a member of the church accompany her. She noted that her mother decided to cut her hair as a gesture of encouragement and to let her know that "it was only hair", it would grow back. Her mother stood and removed her hat when the member mentioned her gesture. Lastly, the member's family all rushed up and hugged her as she fought through tears to thank everyone that contacted her and prayed for her during her treatment for the illness.

The researcher referred back to this memo when writing about spirituality and storytelling at the church. This memo helped to validate the connection between family support, encouragement, spirituality and health. From this memo the researcher concluded that it was not only important to note the church member's story, which was captured via audio recording but to also note the actions, emphasis and value she placed on family encouragement while doing so.

Developmental Encounters

The evaluator utilized ethnographic research methods such as observation to participate in the lives of the people being studied. The evaluator also used reflective practice techniques to help the group members look at past and present actions in an effort to assist with personal growth. During group facilitation the evaluator intentionally watched for key "developmental encounters" to occur during the workgroup meetings. Identifying key "developmental encounters" is an important tool for Developmental Evaluation (see Patton 2011). These unfolding situations help with the momentum of a workgroup's discussions, identify leverage points, assess group efforts, help workgroups to stay true to the core intent and principles of an initiative, represent jumps or turning points in a group's ability to understand situations in their environment, and can provide the basis for tipping points in the group's ability to act. Dozois et al. (2010) defines developmental encounters as instances in which the initiative shifted or moves forward in some significant way, as well as moments of clarity, strategic insight,

serendipity, connections, and movement that occurred. To provide a clear chain of evidence during the DE intervention, the researcher has identified the key developmental encounters and characterized them via the ideas that emerged during the DE work group sessions. More specifically, as an action research technique, the evaluator used the real-time identification of these encounters to reinforce the workgroup members'insights and support learning from their past to help assess where they were currently and to improve their present and future state. More information on the developmental encounters unfolded will be provided in the results section.

Triangulation

Triangulation facilitates validation of data through cross verification from more than two sources. The researcher triangulated the data by comparing information collected within and among the three phases of the case study. These data were also triangulated by comparing sources, notes/memos, and journal entries with data from observations, interview notes, and storytelling sessions. Qualitative data were compared and contrasted with the needs assessment survey data, which included quantitative data from the Likert Scale survey question, as an additional measure of thoroughness and strength. The lessons learned from these findings then formed the basis for developing the empirical survey in phase three. Following the collection and analysis of the survey data in phase three, the researcher also applied triangulation to compare the external survey results to the results from the Community Church case study. See the Table 2 below displaying the triangulation methods described above.

TABLE III. Research Data Triangulation

Phase 1	Phase 2	Phase 3
Documents (meeting notes, surveys, memos)	Observations	Interviews and storytelling

Quantitative	Qualitative
Community Church lessons learned	External ministers survey responses

Data Quality / Validity Considerations

Data quality was tested through various methods, including checking for representativeness, checking for researcher effects, and triangulating. The investigator checked for representativeness by ensuring that all data collection methods that involve selecting a group of respondents for a survey, focus group, or interview reflected the demographics (by age and gender) of the total adult population in the church.

The validity of qualitative research often is referred to as trustworthiness or credibility (Miles et al., 2013). Cho and Trent (2006) offered two general approaches to validity in research: transactional and transformational. *Transactional* methods include data-consistency checks and stakeholder checks and *transformational* validity occurs from the forward progression of the research itself. This study used both approaches, assessing data consistency through data-coding techniques and respondent feedback and using transformational validity to evaluate the study's outcomes (Wainwright, 1997). Cho and Trent asserted that transformational validity is determined by the actions that are prompted by the study, suggesting that there needed to be a clear recognition and understanding of alterations as they occurred during the inquiry

Given the researcher's role as a member of the collaborative team during the DE process and firsthand knowledge of the experiences, insights, and priorities of DE group members, it was important to be cognizant of the potential for researcher bias. Because of the researcher's relationship with the

participants and the potential for the members to please and support the investigators ideas by not challenging or critiquing the researcher, it was also important to ensure the purpose of the evaluation, the evaluation questions, and methods had supportive and similar elements to reduce the risk of introducing bias into the study. Key informant interviews that used semi structured, open-ended questions supported these bias control measures as they further helped to expand or clarify issues for the respondents.

According to Miles and Huberman (2013), qualitative data analysis is not intended to generalize to a larger population in the same way a statistically analyzed large-scale survey is; therefore, a survey was introduced in phase three, using questions developed from lessons learned in Phases one and two, to support transferability. By studying a representative sample of organizations, the survey approach sought to discover relationships that were common across organizations and make generalizable statements about the object of study (Gable, 1994). Surveys can accurately document the norm, identify extreme outcomes, and delineate associations between variables in a sample (Jick, 1983). This suggests that survey research might contribute to greater confidence in the generalizability of the results.

Data Analysis Plan a Hybrid Approach

Data Preparation

The initial examination strategy used in the analysis of the research data involved two different tactics: a priori and grounded theory (also known as qualitative content analysis). These two methods were employed by the investigator to analyze the case study. The first analysis approach, a priori theory, involved using codes identified by the researcher prior to reviewing the research data collected. Secondly, grounded theory or qualitative content analysis, was also used, these methods share similar

qualities. Both are based on a naturalistic inquiry that entails identifying themes and patterns and involves rigorous coding (Yin, 2009). At this time, the researcher also began data-reduction efforts by weeding out ancillary information that did not appear to trigger any significant developments. A simple cut-and-paste of information, such as participant identifiers was applied, using word-processing software to accomplish this task. Additionally, there were several voice recordings of memos, DE work group meetings, focus group sessions, and interviews. Because the data included sound recordings, a good portion of it was professionally transcribed. The initial analysis also included listening to the voice recordings and making notes of similarities and differences expressed by participants in the recorded data. Finally, the transcripts were read several times to ensure they were clear and made sense.

Code Development

After the researcher thoroughly read and examined all data collected, they were then uploaded into Atlas.ti qualitative research software program. Atlas.ti was used by the investigator to organize concepts, and codes applied for conceptualizing chunks of data, and the program also helped to organize and relate these concepts in a way that supported the case study analysis. Additional data analysis entailed continued review of the source information by searching for larger segments of text and tagging them with predetermined codes that characterized their meaning. This technique helped to subdivide the source documents into smaller chunks, which proved to be a much easier way to scan the volume of information collected.

More specifically, given the phased approach of the case study, segmentation of the data for coding involved two levels. The first level entailed reviewing large portions of information captured from each phase of the research and applying a priori codes to parts of data. This analyses set out to test whether information gathered was consistent with prior assumptions and theories identified by the investigator. Examples from the list of a priori codes that were derived from concepts in the research's theoretical framework were: equity, ACA roll out, the church as learning organization, leadership culture, church assets, health ministry planning, reflection, evaluation capacity and, finally, lessons learned.

These predetermined codes or concepts were applied by linking the words and phrases across documents collected during each phase of the research study. The documents included notes from the DE work group meetings which were captured predominately in phase one of the research. Additional reports resulting from the focus group sessions and the leadership/stakeholder interviews, as well as stories captured during testimonial sessions, all which occurred primarily in the second phase of the study were also tagged with a priori codes. Finally, the investigator repeated the review of the source information several times and tagged the chunks of information with codes that characterized their meaning and further subdivided these portions into even smaller chunks of information. Table IV below illustrates the first level of data segmentation described above.

TABLE IV. Data Segmentation First Level

A Priori Codes	Emergent Concepts and Constructs				
ACA rollout	Reflections of past health insurance enrollment experiences, Testimonial Service	What the church members said about what worked well / what did not.	Social Media, church announcements, electronic communications	Greater understating of the law (ACA, Medicaid expansion in GA)	Community canvassing and stakeholder assistance. Voting and policy
Equity	Advantages /disadvantages and past experiences with	Differences in beliefs regarding male and female health issues.	Greater / better access to health care. Human rights, opportunity.	Trust, fair treatment, family history, gender differences and health	Individual health vs. Community health, Equity checklist, Stakeholder

	medical professionals.			myths.	collaborations and Partnerships.
Church assets	Meeting rooms, member skills and expertise, funding, Leader, Access to the community Testimonial service	Love, trust, family, spirituality	Faith in prayers for healing. Accompanying members to the doctor, Encouragement	Members acting like family, friendship, fellowship, relationships, kinships, and empowerment.	Pastor sermons, Hearing the health message in the church.
The church as a learning organization	Greater understating of the law (ACA, Medicaid expansion in GA)	Gender differences in learning styles.	Social Media, church announcements, electronic communications	Testimonial service, Pastor's sermons, Transferring information and resources	Barriers (questioning, we already tried that , knit picking, short evasive answers)
Leadership culture	Gender difference in roles and responsibilities, Formal and informal	Delegation, Serving by example, Taking risk, Bringing people together	Followership, Influence control or mentorship, Wisdom, Team building	Power, Effective spokesperson /Ambassadors	Love, confidentiality, trust. Follow-up, recognition
Health ministry planning	Make it the norm, Common vision, communicating common vision	What else can be done internally and externally	Community partnerships, legislative stakeholders	Follow-up, recognition	Auxiliary and committee routines,
Reflection and evaluation capacity	Strategy for administering education and training	Sharing stories, plans for measuring outcomes	Ownership, policy, processes, equal work across genders	Meeting with other church health ministries	Continued quality improvement, needs assessment baseline. Logic model

After additional review, the investigator then began to develop a list of codes from what was actually occurring in the data and not based on the theoretical framework of the case study. This began the second level of data analysis or open coding. The second level of data analysis consisted of developing a list of open codes created from the meaning that emerged as the researcher continued to review of the data. Open coding entailed looking for meaning in the source text. Subsequently, a list of codes was developed.

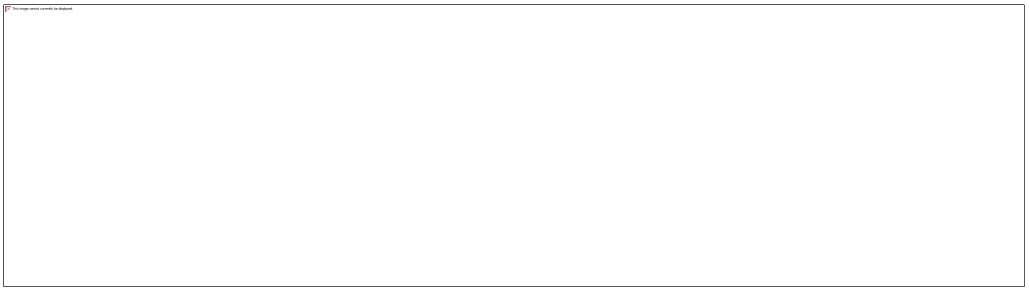
Because of the volume of codes, Atlas.ti was further used to classify and organize families of words to help with code management. Using families of codes in Atlas.ti as part of the data analysis

helped to organize the data quickly by viewing codes placed into groups of words or families. This technique allowed the researcher to manipulate a group of codes all at once and assisted with adding structure. Employing Atlas.ti as part of the data analysis helped to organize the data quickly by identifying word families at a glance. It also facilitated the development of reports that tracked trends and showed information in a dashboard view, presenting a broader picture of how the text in the data had begun to coalesce.

Thematic Coding

Uncovering regularities or patterns among categories is a process known as thematic analysis (Shank, 2006). As patterns reoccurred, the researcher placed these patterns into common categories and themes. For example, natural groupings, such as gender-male-female, which were branched out even further by the investigator by assigning attributes such as attitudes and behaviors, and eventually subdivided (connecting them with them into different themes such as health. This thematic technique is illustrated in the figure below.

Figure 1.Thematic coding technique



Given the new patterns of behavior and activity that appeared during the DE inquiry in the church, thematic analysis was also instrumental in recognizing the themes that emerged during the facilitation of the work group meetings.

CHAPTER 4: A Descriptive Case Study of the Developmental Evaluation Process in the Church

Introduction

Fetterman (2010) asserts that analysis in ethnographic qualitative research is as much a test for the researcher as it is a test of the data. The researcher must find a way through a forest of data, theory, observation, and distortion. This chapter summarizes the descriptive results from ethnographic approaches taken by the researcher which included observations; participant observation including facilitation of the DE workgroup members in reflective practice techniques to uncover insights related to health equity and health planning at the church, and organizing sessions for story telling by church members; leading focus groups; and conducting interviews both with individuals internal and external to the church. Data from these multiple sources of data were analyzed to answer the initial research study questions as well as additional questions which emerged as a result of these actions and preliminary analysis and discussion with church congregants. The process results of the afore mentioned ethnographic methods will be described in this chapter in an effort to uncover and detail the steps taken by the members of an African American church as they used the DE approach to examine practices and processes to determine the best ways they could address health disparity in their community through reflecting on their previous experience in disseminating information about the ACA as well as other efforts to address health in the congregation. . Details on facilitating factors supporting organizational learning also emerged over time and will be addressed further as part of the analysis in in Chapter 5.

The DE approach taken by the church members sought out solutions which required iterative and reflective processes that supported new discoveries and change, a process that Heifetz et al. (2009) described as adaptive leadership. An element of ethnography entails analyzing data that involves explicit

interpretation of the meanings and functions of human actions; the product of this analysis primarily takes the form of verbal descriptions and explanations (Hammersley, 1995). The application of ethnographic methods by the researcher in this case study is well suited for the DE process given that it is a group assessment approach used to evaluate discussions amongst a dedicated group involved in an innovation undertaken to implement change in and across their organization. The DE inquiry process in this study serves as a precursor to other evaluative tools used at broader level such as the congregational needs assessment and development of a logic model. Other complementary evaluative tools such as observations, interviews, focus groups and storytelling are discussed in this chapter in a similar manner to that described in the data collection (see the date ordered matrix in chapter three above). Additional concepts that emerges as key in understanding the facilitators and barriers to organizational change and learning in the church during the process of collaborative data collection and discussion with the DE group and other church members, is including, trust, equity, gender and health behavior, health myths, family health history, limited male participation and leadership are also explained and further detailed in this chapter. Results from the researcher's preliminary analysis of her observations, focus group, and interview data were tested and further developed through discussion with the DE group.

In addition to the activities of the DE group, as explained in Chapter 3 assessment activities contributing to a developmental evaluation supporting church ministry efforts also involved the whole congregation, and included quantitative as well as qualitative data from a congregational needs assessment survey as well as the aforementioned focus groups, storytelling sessions, and interviews. The results from the congregational needs assessment survey will also be presented in this chapter. Furthermore, in an effort to explore the transferability of the results from this church's experience, a survey of ministers from other African-American churches in the region was developed and administered: results will be given in the final section of this chapter. Lastly, answers based on formal qualitative content analysis (utilizing ATLAS.ti) to the initial research study questions and the additional emergent questions will be expanded on in the following chapter, Chapter 5.

Phase 1: DE Work Group Meetings

A parable in the bible states that: "No one puts new wine into old wineskins. If he does, the wine will burst the skins—and the wine is destroyed, and so are the skins. But new wine is for fresh wineskins" (Mark 2:21-22, King James Version). This parable provides an interesting look into innovation and change; in essence what is being said here is that people, even Christians, prefer things to remain as they are; they feel comfortable and secure with what they know and have gotten used to. Change frequently requires getting out of one's comfort zone to venture into the unknown and not every is willing to make that move. The parable also parallels the discoveries and findings uncovered overtime by the DE workgroup in this evaluative case study which shows how church members came together as a committed, dedicated group to take part in a newly introduced process to explore an intervention as a new way to address change at the church. The work group members partnered with the researcher to contribute directly to the development and implementation of a church-based health intervention that assessed their organizational learning capability in a manner that led to increased health equity and offered a plausible opportunity to help eliminate racial health disparities.

A review of the notes from the first few DE work group meetings showed that the meetings were well-attended; the first meeting, for example, had 15 participants, although there were no male participants in attendance until the last two sessions. Further review of the meeting notes from the first several meetings described significant attention paid to the structure of and procedures for managing the meetings. The group members voted to develop the mission of the workgroup later, after several meetings had taken placed, this decision was made based on their assumption that they would have a greater understanding of the direction in which to go after several meetings had taken place. Although the members were familiar with each other their introduction to the process proved to be awkward at first however, with the assistance of the researcher guiding the group's efforts the members quickly developed relationships which helped them freely engage in group discussions. The researcher also made efforts to

settle in with the group particularly in the beginning by directing, moving them along, coaching and delegating. The researcher served as the evaluator and presented the overall work plan to the committee. The researcher and evaluator are used interchangeably in this chapter.

The Researcher and other Group Roles

In developmental evaluation the relationship between the evaluator and the evaluated is very important. During the evaluation (as an action research intervention) the researcher had a seat at the table serving as an embedded group member. The evaluator sought to build trust with the workgroup members by being up front about the process and providing an assurance that their efforts would help to influence a change in opinions related to health at the church. Additionally, the evaluator was clear that members input would be valuable to the success of the group. This emphasis on mutual trust assisted with group's learning dynamics. In her effort to understand the workgroup members and be able to facilitate the dynamics of the discussion, the evaluator had to have a familiarity with the participants' understanding of the world. The researcher, in acting as facilitator to guide the workgroup discussion, described the iterative nature of the work group process as well as shared other pertinent written reports from other data sources such as key leadership interviews, congregational surveys, focus groups, and storytelling testimonial sessions with the work group members. It was important for the group evaluator to have assistance so she could monitor and observe group dynamics closely as well as steer the member discussion; therefore a note taker and Chair were necessary. DE facilitators help groups to identify overarching patterns amidst the flow of complex information, relationships, and activities. They support effective decision-making by using their analytical skills to categorize information, identify emergent themes, and make critical connections. Although evaluation of the data for the purpose of theory building commenced in the first stages of the analysis plan, the examination of the data started even earlier, in the collection stage. Two key individuals assisted me with this research study and facilitation of the DE inquiry at the Community Church. They consisted of a research assistant approved by the University of

Chicago at Illinois's (UIC) Institutional Review Board (IRB) to assist me with note taking during the DE work group meetings, and a work group chair, who was selected by the group members at the first session.

The workgroup voted to have a note taker, the evaluator met with the note-taker regularly, immediately following the work group meetings. They came together to review and discuss the meeting notes for consistency in documentation, to ensure clarity, and to compare and contrast essential developments that occurred during the DE sessions. Additionally, everyone needed to check whether the data were providing original and accurate descriptions of what was happening in the DE meetings. A chair was also chosen by the group members. The evaluator met routinely with the DE work group chair to review data collected from previous meetings and to capture ideas that emerged during our DE work group sessions. The facilitator updated the group regularly by sharing with the entire work group the patterns and themes that surfaced based on the review of the meeting minutes. This helped to steer the workgroup away from the negative introspective state they were moving towards in the initial meetings to a broader collective assessment that could help them make sense of the concepts that emerged from the shared stories. Given that developmental evaluation required making sense of the information presented by everyone involved, the evaluator continually sought to make the meeting discussion a collective process by asking questions, guiding discussions, sourcing or providing information, demonstrating group creative techniques such as brainstorming, pausing the action, reminding, and identifying and connecting similarities that emerged from the discussion. These emerging similarities served as the foundations for establishing the developmental encounters that occurred during this research.

Equity

The evaluator guided the members in an exercise that produced information and insights on trust to uncover their views regarding equity. The researcher employed the tactic of reflective practice in several of the initial DE workgroup meetings by asking the members to examine their past experiences

with trust and medical practitioners. This analysis technique enabled clearer thinking and reduced members' tendencies toward emotional bias. Trust emerged out of the discussion as a result of the participants watching parts two and three of "Social Determinants of Health," from Discovery Channel Online' s series of documentaries on science- and health-related topics. These two episodes portrayed how the environment and the conditions in which an individual is born, lives, works, and worships can affect a broad range of health and quality-of-life outcomes. One episode showed how an African American church in the District of Columbia sought to address these inequities. After watching the episodes, the work group members were asked to reflect on the videos and comment on what they were feeling. Although the researcher's intent was to lead the workgroup in a discussion on equity, the focus of the group member's discussion revealed issues they were having related to trusting medical professionals. The work group members also commented on past medical experimentation in the African American community, specifically the Tuskegee experiment. The workgroup membership included two church members who had grown up in Birmingham, Alabama, and as a result, were very vocal about what they personally recalled regarding these experiments. One of these members commented during the meeting that she knew someone personally who had been "experimented on" and that family members spoke of it frequently when she was growing up in Alabama. The other commented that she thought it was a "shameful thing" to do to someone. This discussion began the first of many developmental encounters related to trust. Examples of quotes from workgroup members were similar to the following one:

> "I grew up in Alabama, where we were always aware of stories told by the older folks regarding the Tuskegee Experiments. So we knew the stories of how they experimented on us."

> "I do not understand how someone could intentionally do that to another human being…It is just shameful"

Trust

In an effort to continue the discussion as well as manage it, the researcher developed a series of questions to ask at the next meeting that would further create an opening to push group thinking, identify values, highlight common ground, and reveal differences that could be approached appreciatively and could thus become a strength. At the next workgroup meeting the questions posed by the researcher to the DE group were: (a) Please share an experience when you felt you could not trust a doctor or medical professional. (b) Can you share memories of family members' accounts of being treated unfairly by a physician? (c) Please tell me about health remedies that were passed down to your family members over the years? A glimpse of the stories shared by DE work group members related to trust is below:

> "After being misdiagnosed for breast cancer several times in the past by the same doctor, I do not trust that doctor to give me the correct information. I have been seeing this doctor for some time now, and every time I'd see him, he would make me feel like he was not very interested in helping me. When I asked questions, he would not give me direct answers and made me feel like I did not know what I was talking about."

> "My doctor keeps trying to get me to participate in clinical trial research to test a new medication for diabetes; however, I do not trust that she will give me the right medication or [not] conduct experiments on me."

Gender Preference and Health Behavior

Researcher observations raveled that most of the comments and stories being shared had a negative tone, and that most of the experiences shared provided indicators of inequities in health. Upon further examination of the stories shared during the DE work group meetings, the evaluator began to notice patterns and themes not biases as well. The evaluator detected new themes emerging during these meetings, such as the male preference for medical care and male perceptions about health conditions and the treatment of these ailments. For example, some of the group member's commented that:

> "My husband has issues going to see medical professionals. He says he has heard a lot of bad stories about certain treatments related to men's health. I keep trying to tell him that he needs to go to the doctor, but he will not go".

> "My husband does not want to go the doctor if it is a female; he only wants to be seen by male physicians".

These personal accounts indicated a diversity in preference for medical care which the evaluator thought should be further explored by the workgroup.

Myths

Continued discussion from the workgroup members showed some confusion indicating myths about health, medical facts and poor health behavior. A few observations shared by the group members that bolstered this assumption were:

> "My mother use to take a spoonful of vinegar for high blood pressure, but the doctor says it will not work; I do not believe him".

> "My doctor keeps saying that my blood sugar levels are elevated, but I feel fine. I can't understand why he keeps telling me that when I have no symptoms at all".

> "I do not like drinking beverages that have artificial sugar in them; I do not believe it is safe to introduce the artificial sugar into my system. I'd rather use the old remedies that were passed down by my parents; I do not believe in taking a lot of medication, and that's all my doctor wants to push on me."

Family Health History

Furthermore, the evaluator noticed the workgroups lack of knowledge of consistent family medical history and a limited understating of health care in general. This was evident from the members who remarked:

> "I never trusted doctors, even when I was a young girl. I knew that my family had a history of cancer, but the doctor tried to tell me that my condition was not hereditary. My mother died from cancer, my sister died of the same type of cancer, and now I have been diagnosed with it".

> "My family has a history of sugar diabetes; however, I do not feel like I have full-blown sugar, and besides, the doctor only gave my cousin pills to treat his sugar but he tried to make me take insulin by the needle."

Limited Male Participation

During further reflection of the workgroup meetings, the evaluator also observed that there were no males attending the workgroup meetings and noted other group members' commenting that there were no men at the group meetings. The evaluator discussed the group's comments and misperceptions about health along with the absence of men from the work group with the group's note taker and chair. This was also an opportunity for the evaluator to confirm assumptions made from early review of the meeting minutes.

Leadership

Additionally, given the multiplicity of issues related to trust and the medical profession, the workgroup chair and the evaluator decided to take this information to the pastor to see if he had any prior knowledge or awareness of these issues among church members. Although the pastor had some knowledge of the lack of trust of the medical profession in the African American community, he did not

know the degree to which it permeated the lives of this group of congregants. His response was to further explore the issues that surfaced related to trust and other misgivings about health with the larger church membership. He also suggested we make an additional appeal during the upcoming Sunday announcements for more male participation on the DE workgroup.

Once the pastor's suggestion was shared with the workgroup members, the members decided they wanted to share the findings with the larger congregational body during the upcoming testimonial services where members would be given an opportunity to share their stories and experiences about trust and health. Subsequently, another meeting was scheduled with the pastor and workgroup chair to inform him of what the group members thought and to get his consent; at that time the Pastor proposed that we hold the testimonial service focus group on Wednesday night, the church's traditional bible study service night, as he was certain there would be more members in attendance. During this meeting the evaluator also recommended that a screening of the movie entitled "Hole in the Head a Life Revealed" take place prior to the testimony service focus group. The movie is a true story about two church members singing next to each other in a church choir for over 20 years, one man finally reveals to the other member a tragic and horrific secret he was forced to conceal under a wig for 70 years. This member had been subjected to human experimentation in early to mid-twentieth century. This revelation started a journey of the church members that uncovered that at the age of five this individual became the victim of a medical experiment. As a result, this individual had to live with severe physical deformity all his life, but endured his condition without anger or bitterness towards the perpetrators of the experiment. (Smith, 2011). The researcher's intent was to use the story in the movie to stimulate further discussion. Additional information from the testimony focus group will be discussed in further detail in phase II of the analysis.

Turning Points

The following accounts in this section demonstrate the first of many turning points in the tone, attitudes and perceptions of the group member's views on health planning and equity at the church. Over

the next few meetings, the evaluator guided the work group in more critical reflective discussions to examine their knowledge and beliefs about inequalities in health. The evaluator continued to lead the work group in further by asking the group to think about the activities that took place during the events to roll out the ACA and health insurance enrollment at the church for the past two years. Finally, the evaluator asked the members to think about how those activities made them feel and to share their perceptions on how effective they thought the activities were.

ACA Rollout

The ACA roll out group discussions focused on the education and awareness aspects of the resource materials received from the church during the ACA rollout and health marketplace insurance enrollment events. Some members' mentioned how much information they received on diabetes prevention and recalled other chronic disease prevention materials such as warning signs of stroke and the ABCs of heart disease. One workgroup member made the following remark:

> "It was great that the church was not only enrolling members but also disseminating information to educate the members about prevention. This makes me feel like the enrollment navigators really cared about helping us with our health issues and not simply checking the box to get us enrolled in insurance."

Still another work group member shared the following experience:

> "I recently participated in an enrollment activity outside of the church and was not provided any literature; this made me feel like the sponsors were not really concerned for the people's health, just the getting them enrolled."

Because the evaluator recognized the comments shared during this discussion to be another developmental encounter, a further exploration of the comments was conducted. Subsequently, the work group was asked to recall what they learned from reading the pamphlets and fact sheets related to the benefits of ACA in the African American community. The evaluator also asked the work group members

who had enrolled in an insurance plan to consider what they had gained as a result of enrollment and to share it. Group members shared a number of accounts regarding what they remembered from reading the resource materials they received. Examples of member comments are provided below:

> "I found out that the ACA materials could help provide more education about caring for diseases like diabetes and other illnesses in our community."

> "The ACA literature I received stated that African American women were now eligible for additional insurance benefits, such as mammograms and prenatal care, at no additional out-of-pocket cost. I am so glad that the ACA requires focus on women's health issues."

> "As I recall, the ACA mandated that Black doctors be hired at a greater number than currently exists. This is great, now I might have a better chance of finding a medical practitioner who I can relate to and can relate to me as an African American."

Action

The researcher recognized a change in the tone of the workgroup members' comments and noticed that group member discussions began to move towards action. Examples of action oriented comments are noted below:

> "The focus on prevention offered in the ACA resource materials could help dispel the myths that exist in our community related to certain health conditions, as well as give us a better understanding of the steps we need to take to treat these health conditions. We could also invite health professionals to come talk with church members about support services and preventive actions we can take to help dispel myths about our health."

Another work group member commented that because of information she found in the ACA literature, she was encouraged to ask questions when visiting the doctor and eager to become more informed about her health status. Someone remarked:

> "We should do more to share this information with our families, neighbors and other church members so they can see what obstacles have been removed by the mandates in the ACA. This could help them possibly take more decisive steps towards visiting a health professional thereby improving their health status."

Still another workgroup member made the following comment:

> "The African-American community has a bad habit of not passing health histories down to family members. As a result, we often do not know what medical conditions have persisted over the years, nor do we know if we are passing negative health conditions on to the next generation. Because of the clarity offered by the ACA we will now made more aware of our health conditions. I think that as we learn more about our health status, we should share more with our family. In the past we had a tradition of placing other pertinent information inside the family bible and passing it along to family members. This is still a tradition in my family and I think by adding health information it could be more meaningful."

The evaluator then shared comments from the focus group discussion held with the men at the church to let the DE group members know that the focus group comments pertaining to getting the word out to the community were very similar to what they were discussing in the workgroup sessions. The evaluator asked the workgroup to reflect on the processes used to get the word out about the ACA rollout. More specifically, the group was asked to comment on what worked well and what did not related to marketing strategy. The workgroup members shared that the activities used were for advertising the health insurance

events were using word of mouth, church bulletins, websites, Facebook, church announcements and flyers. One group member commented that "the church has a list service which contains all the local churches in Clayton County as well as a list of churches that belong to the local county ministers group. The work group members felt that the used of the marketing tools worked well however, they felt that some work needed to be done upgrade sites such as the church Facebook page and the website. Group members also noted that a plan had to be developed to keep continually maintained. The evaluator also pointed out how some comments from the male focus group session were connected to disseminating health information beyond the church. The evaluator also noted that the men talked about what they did to get the word out as well as what resources the church had to market the rollout events. The comments shared during the focus group with the all-male participants were like the following:

> "How do we get outside the walls of the church to make an effort to get that word out that we are having health insurance enrollment programs? It's easy to share the information with the members but it is hard to provide the work to those in the neighborhood."

A response from another member is below which provided some insight on the communications network at their church and how it worked during the past ACA rollouts:

> "Well Brother, I'm glad you asked that question because that, that's the discussion well, one of the topics of discussion that we've been having within the health advisory group meetings. How did we do to get the word out about the insurance enrollment events, how did it work and how do we market going forward? We do have some social media um mechanisms, we have a Facebook page here at the church, and we have a website for the church. In the past we have gone out with members from the men's group to and actually knocked on doors and do community canvasing to say we're having the ACA Navigators come into the church, these flyers, pamphlets have information that you need and we'd like to invite you to this event. These mechanisms worked well, at least, I thought so. We were able to get some neighborhood people in for the rollout events."

Because most of the discussion comments regarding the ACA roll out appeared to be moving in a positive direction and provided insight to how the ACA rollout benefited members of the church, the evaluator determined this to be another turning point and decided to go further by soliciting information from the

group their thoughts on using similar tactics used to roll out the ACA to start a health ministry at the church. The evaluator began this effort by asking the members what they thought the roll of a health ministry at the church would be. The workgroup members described a health ministry's role as monitoring individual health issues such as diabetes and high blood pressure screenings. DE work group members also defined a health ministry as an entity at the church that would host health fairs and sponsor medical professionals to come in and speak at the church about health issues specific to the members of the church. The evaluator continued to probe the members about their perceptions of the role of dedicated health ministry at the church by asking how a health ministry could directly benefit the congregants. The members responded that a health ministry should provide members with the following: resources and messages related to national health observances, assistance for members who become ill during Sunday service, health insurance enrollment events at the church, and visits for the sick and shut-in. Further discussion revealed that these actions were already taking place at the church, therefore, the members commented that they should continue as part of any new health groups established at the church. Although the evaluator recognized that progress was being made, the workgroup member's comments focused on greater benefits at the individual level and not the lager community level. This prompted the evaluator to probe more deeply during the discussion to confirm where the direction the work group was headed and to ensure the members comments were addressing the stated research question regarding the sharing of ACA materials leading to grater equity. Consequently, the researcher decided to go back to the workgroup members to gather additional information on what the group was actually saying about health ministry and health equity.

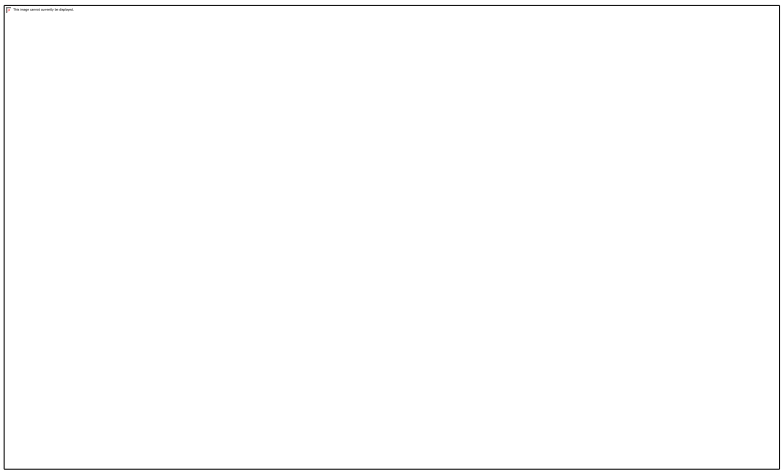
Health Ministry and Health Equity

In contrast to the group member's perceptions about what a health ministry at the church should accomplish, the literature that describes community mobilization efforts to improve equity discusses activities such as partnering with the local NAACP to help eliminate social inequities and hosting

educational initiatives such as high school completion campaigns and college fairs to enhance opportunities for higher educational attainment. This is important because academic achievement is linked with long-term health, and because high school completion programs are commonly implemented in racial and ethnic minority or low-income communities, these programs are likely to improve health equity (Guide to Community Health, 2016). The literature also describes activities such as championing access to care, for example, community efforts to keep local county hospitals from closing can be characterized as activities that increase equity. The case study data to this point revealed little progress toward addressing health equity at the larger community level. The evaluator, therefore, felt it necessary to delve deeper by returning to the workgroup members to hold another meeting to gain information on exactly what the church members were saying about a health equity and health planning at the church. It is important to note that this was the first meeting where men were in attendance. Although the work group members engaged in further analytical reflection resulting in a greater shared understanding of health equity at the individual level, notes recorded how the DE work group members did not appear to look at equity issues that have a broader impact on the community or those linked to social determinants of health.

During the next DE work group meeting, the evaluator shared with the group the gaps in the data between their descriptions of a health ministry and health equity at the community level. The evaluator began this meeting by sharing a definition of *health equity* as the attainment of the highest level of health for all people (Healthy People 2020, 2010). Health equity refers to efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives. In contrast, *health inequities* refer to differences in health that are avoidable, unfair, and unjust. Health inequities are caused by social, economic, and environmental conditions (HEI, 2016). The evaluator shared the image below from Community View (2014) and asked that the group members to pass it around to gain a better understanding of equity by noting that just because all congregants have equal access to health insurance enrollment as well as received ACA resource materials at the church, this did not mean that equity exists.

Figure 2. Health equity image



The evaluator reiterated that social determinants of health refer to the conditions in which an individual is born, lives, works, and worships. It was noted by the facilitator that an overwhelming percentage of our health is influenced or determined by our social and economic environment, including education, housing, food security, employment and working conditions, unemployment and job security, our social safety net, social inclusion/exclusion, and health services (Mikkonen & Raphael, 2010). Therefore, the steps we take to tackle health inequity should address these social determinants and their impact.

Equity at the Community Level

Given that DE is an iterative process, the evaluator took this opportunity to lead the work group members in a discussion that sought to connect activities already occurring at the church and their impact on health equity in the larger population. Previous church activities had included efforts to re-establish and retain the local community transportation service, partnering with the community food pantry to feed the needy, donating bottled water to residents of Flint, Michigan, and working to help keep the local county hospital from closing. After providing the definitions and explanation, the evaluator posed the following questions to the work group:

1. Are we currently addressing health equity issues at our church?
2. How can the health ministry ensure efforts to address health equity in the larger community?
3. Do you think we should be doing this more explicitly or devote greater attention or energy to it? Why or why not?
4. If we should more-specifically address health equity, how can we integrate health equity principles into our planning process now that we have completed the work group's logic model? (Should we revise the logic model?)
5. What are our next steps?

One of the workgroup members who attended all the meetings and was very engaged in the group's activities gave this response:

> "I felt that we were addressing health equity in our efforts to develop a health ministry at the church, because during our planning process we deliberately looked at health issues that disproportionately affected the African-American community. Also, because we were making plans to support this particular population group, I believe were indeed attending to health equity issues".

Another workgroup member in attendance made this statement:

> "We needed to do all we can to serve our internal church population first, and only then can we look at the larger community".

The only male workgroup member at this discussion noted the following:

> "As I recall we did conduct community canvassing during the health insurance enrollment events. We went door to door in the community and knocked and passed out health information and flyers about the enrollment events. Although some church members do come from the surrounding community, there were others in the community who do not attend our church. I believe all church's health ministry should include community outreach activities, such as community canvassing, and invite non-members into our health activities whenever we can. A valuable by product could be to get members to join and not just participate in our health events."

Equity Checklist

Finally, a member of the workgroup who has experience as a public-health practitioner suggested that we develop a checklist of questions the group could consider when designing health interventions, to ensure that health equity remained central to all aspects of the initiatives we undertake. The group discussed possible items to include on the checklist and decided to adopt and adapt an existing health equity checklist from CDC's resource, titled: *A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease* (CDC, 2013), which resulted in a series of questions to ask prior to any health initiative conducted the church. They are: (1) Have we clearly considered and identified the inequities that exist in the target population we are seeking to serve by looking at existing data, collecting input from the community, and assessing the environment? (2) Are we engaging the correct individuals and stakeholders, both internal and external to the church, for this health initiative? (3) Is the intervention targeted to the population that is experiencing the inequities? (4) Is the response to the health issue logical and justified? (5) Have potential barriers to supporting this community been identified? and (6) What is our evaluation and monitoring plan to ensure that health equity-related efforts are measured? The work group agreed to adopt the checklist model instead of going back to revise the logic model. Members felt their efforts to develop the logic model had been so successful that they were not willing to make any changes at this point in the inquiry. Some felt we should reconsider revising the logic model once additional data had been collected, and particularly after the congregational needs assessment was completed and data analyzed. Results from both the needs assessment and logic model are presented later in the study.

Phase II: Stakeholder Participation

Given the multiple research participants involved in this study, the transformational nature of adaptation and the learning and improvement identified by the research, a stakeholder display was developed by the researcher to help expand the field of vision and build a shared understanding of the system that is being influenced. The DE workgroup efforts, along with perspectives provided by other

study participants, provide a clearer picture of the collaborations and partnerships that strengthened the church's capacity to promote learning and become a "learning organization" and are key ingredients in the organization's attempts to make comprehensive systems changes.

Systems Approach

Identifying key aspects of the system (e.g., those parts that contribute to, influence, and/or are affected by the situation) is a key element in developmental evaluation (Dozois et al., 2010). Additionally, Understanding the patterns associated with system behavior, including *how* and *why* each of the critical parts function the way they do, and how they interact to reinforce or disrupt systems will be illuminated in this phase. Representation of all research participants is presented in Figure 3 below, the research systems map at the beginning of this phase to illustrate the process of and inform its members about health, and increase the capacity of the church as a learning organization. This research phase emphasized conclusions and results in support of the second question posed in study.

Figure 3. Research systems map

Systems mapping delivers multiple perspectives from a broader community of interest. Clear mapping is also important for elucidating system components to see how each part is correlated with the others.

Participants' insights were gathered from stakeholders internal and external to the church. The development of health programs at an African-American church was the common theme supported by the he case study's data presented below. The researcher's initial estimations, center on opinions and viewpoints related to the relationship between the development of health programs within an African-American church, that is, programs providing resources to educate

Organization Learning and Leadership Capacity at the Church

According to Peter Senge (2006) learning organizations are organizations where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning together to see the system in its entirety. When communicating with study participants inside the church community, the researcher gave consideration to how they contributed to and detracted from learning at the organizational level. The discussions with study participants at the church resulted in a variety of perceptions and beliefs regarding health planning and organizational learning.

Interview with the Pastor

The initial interview was conducted with the Community Church Pastor. During the interview, the researcher asked him about his role as leader at the church, he stated:

> "I am just a humble servant of God in the community doing my best to help the people at the church find their way and equip them with knowledge to help them add value to their lives."

He went further by saying the following:

> "I am trying to edify my members about Christ and persuade each member to do the right thing so that everyone at the church recognizes that together we are all one body in Christ, holy and acceptable unto God."

At that moment he also shared quote with me:

> "As we used to say years ago, 'everybody is somebody, but Christ is all'."

During the interview, the Pastor remarked that he was very aware of his membership's great need for resources and services to help them address their health. He went further by remarking:

> "Over the years that I have served in a leadership role at the church, I have seen whole families suffer from an illness such as diabetes and could not do anything about it because they did not have the right kind of health insurance or the money to take care of their medical concerns."

He continued:

> "This lack of insurance affects the member spiritually and physically. It affects the member's ability to work in the church and in the community. It affects all aspects of our lives, for example, if you're sitting in church not feeling well, it's hard for you to accept the messages, and it further hinders you from taking an active role at the church."

Finally, he said:

> "It's equally hard to do anything about what's going on in the community if you are not at your best health."

Although he stated that he was very glad the members had taken the initiative to partner with the local community health department to bring insurance resources to the church, he shared that the church still needed to do more work in this area. He reflected that the in the past, the Women for Christ auxiliary conducted health activities at the church. He added that this group had done most of the work over the years to address health issues at the church. He also made this remark:

> "In the past, the Women for Christ invited individuals from the health field to come to the church to speak to the members about health issues such as breast cancer. They also hosted health programs that highlighted physical activity, such as walking in the community. The programs would start with a lot of interest from members but, at some point, they would fizzle."

The pastor went further by saying the following about his wife:

> "My wife oversee the Women for Christ group and I trust her to establish and lead health programs. She keeps me abreast of the health initiatives so I do not question or tell her group what to do. I noticed the women at the church are regularly involved in activities that involve taking better care of their health".

Conversely, he commented that the male involvement in health activities at the church was very limited. He commented that he felt women do more at the church than men in general although he was not certain why.

Focus Group Discussion with the Men and Women at the Church

I asked what the men thought about health planning at the church during the focus group discussion; one participant made this statement:

> "Don't get me wrong, I think talking about health care is very important, but to me it is more important to be educated on particular health issues and measures specifically relevant to men's health. I mean, if I am going to take time to participate in health care events here at the church there needs to be information provided that I can use personally."

Another male focus group member commented in this way:

> "To me, educating men on health issues related to men is key if I'm going to be expected to help carry the health message to other men, because I need to know what to say to other men at the church and in the community about our health. I can tell someone about my health experience but I want to have some information to back up what I am saying."

Another focus group member expressed this thought:

> "You know, we African-American men have a reputation of trying to be macho when it comes to health issues; we do not go to the doctor like we should and get checked regularly like the women do. But if I knew more about what I should be looking for, or what I should expect about checking my prostate, I would do it in a heartbeat."

Some of the feedback gathered during the focus group conducted with the Women for Christ when asked the question why they thought they were struggling to get the men to participate in the health programs at the church, a woman in the group shared this:

> "Our health programs are open to the men; however, now that I think about it, they are mostly focused on health activities that women would be more interested in."

She also stated:

> "This is only because we have always did it that way. Although we have had health events where the topics were both for men and women like heart health, diet and physical nutrition. We have also had some health events specific to the men like prostate cancer awareness talks; they are just not well-attended by the men."

She then expressed a need to engage the men more in conversation and felt that just inviting them to the events was not the answer.

During my interview with the pastor, he mentioned that his job is to empower his members spiritually and help them reach better health. He has been the Pastor at the church for 35 years and said that over the years, he has come to understand that one must be a good follower to be a good leader. When I asked him to comment on the major health challenge faced by the church in those years, he expressed that he had witnessed people at his congregation and in the community who were hungry and could not feed their families. When asked by the researcher what the church did to help address this, the pastor indicated that a member of the church started a food pantry and partnered with the church to get needed food resources to church members and the community. Then he added this:

> "All aspects of what we do as leaders in the church and in the community should be to do the very best we can to get the word out to people to help them with their issues if we can. Letting someone go hungry is not what we do as leaders or as Christians. We need the whole body of Christ to be sanctified, holy and acceptable unto God, which is our whole reason for service."

Interview with Lay Leadership

The lay leaders at the church work with the pastor to fulfill the mission and vision of the congregation. Additional leadership perspectives on organizational learning emerged as a result of interviews with other leaders at the church. One such leader's ancestors helped to establish the original church. She grew up in the church and has been a member all her life. She serves as a member of the trustee board which is the group in the church that is typically in charge of budgetary matters. She is also the CEO of the food pantry that collaborates with the church to offer food items to the needy those at the church and in the community.

She shared her perspective on the change that has taken place at the church over the years, which she characterized as "growth." While she has seen some growth occur at the church, she felt that the much more could be done to embrace change. She said:

> "There were activities taking place at other churches particularly for young people that do not exist here at the Community Church. When I was young girl growing up here, I felt more of a feeling of pride, and fellowship at the church. Now, the young people appear disinterested in the church."

She also stated that she would like to see more interaction between the younger members and the older ones. But she shared that the older members were not likely to be open to change. She thought that this could be accomplished through the food pantry by hosting regular healthy cooking classes that (existing church infrastructure) would engage both the young and the older members. She also, mentioned this:

> "The older church members are very talented and have a lot of knowledge related to gardening; they could share this with the young people with an activity like starting a community garden and teaching the youth about healthy nutritional food."

To the researcher, her comments seemed vital and thought-provoking. In this speaker's leadership role, she recognized that without growth, the church could decline. She further shared that the members could do more to work together, noting the following:

> "In my opinion, there is somewhat of a divide at church. From what I have observed, activities related to health are occurring; however, I do not see much teamwork or bonding during these activities. If the members would get more involved, I think it would help the church more."

She further shared that the members could do more to work together. She indicated that she made an effort to promote teamwork and cohesiveness at the church by bringing the members together around the common cause of regular community food distributions. She mentioned this thought:

> "During these activities I encourage teamwork by setting up teams and fostering a little healthy competition. I designate a team captain, we have team tee shirts and I set a goal for each of them to meet at every event. The team that exceeds the goal gets a gift, something small like a movie ticket. I find this helps to motivate the members to come together as one body and do a good job."

Encouraging teamwork or participating in the health planning activities at the church was not a sentiment shared by all leaders at the church as observed by the evaluator. The president of the trustee board at the Community Church emerged as a key figure because of his lack of responsiveness to request to take part in the health planning at the church. He emerged as a key figure at the church during the DE workgroup meeting that focused on logic model development and health planning. According to a popular African American church blog, the board of trustees plays an important role in supporting the development of new ministries at the church. For example, if a congregation member is interested in starting a Bible study program, he or she must first ask the Pastor and later, if the program requires financial backing, it may be discussed before the board (Laros, 2016). This Blog further stated that in an effort to foster a cohesive environment, the board must understand the philosophy and missionary goals of the church (Laros, 2016). Based on the evaluators observations as well as information gathered from the group members, this individual lacked an understanding of his role and did not appear to be in alignment with the overall vision of the leadership and mission of the church.

This lay leader has been a member of the church for more than 50 years, almost the entire time the church has existed. The researcher approached this member on several occasions to ask if he would

agree to be interviewed; he agreed each time he was asked; however, he would never show up at the agreed-upon place and time, nor would he answer any of the researcher's calls. After avoiding the evaluator for more than two months, he was approached by the evaluator after a service at the church to ask why he refused to meet the requested meetings. This was his response:

> "I do not have anything to do with the health planning at the church; therefore, I do not understand why I am being asked to give my opinion."

This development was viewed by the researcher as an opportunity to capitalize on the continuous loop aspect of the workgroup process; therefore, I shared this outcome with the workgroup chair and the Pastor. They both recommended continued efforts be made to reach out to him, as he could sometimes be obstinate and was not amenable to change at the church. Additionally, the information regarding this member's reaction was also shared with members of the workgroup and they suggested that he be added to the logic model as a critical resource for seeking financial support during health planning at the church. More information regarding logic model development and the elder church leader participation will be shared later in the chapter.

Building long-term adaptive capacity in organizations is best addressed by doing real, urgent work on pressing adaptive challenges (Evans, 2013). Storytelling sessions at the church, along with additional interviews conducted with internal and external stakeholders and the DE workgroup minutes were most helpful in answering the research question "Does the development of health programming result in changes in the organization of leadership within the church (e.g., the formation of a formal health ministry or the ability of the leadership of the church to respond to adaptive challenges related to health); if so, how?"

Storytelling Focus Group Discussion

The researcher observed how stories shared through participation in the longstanding tradition of testimonial service at the Black church supported knowledge exchange between members. In an organizational context, 'knowledge' is frequently defined as 'the capacity for effective action' (Senge, 2006). This knowledge transfer which lead to action was illustrated during a testimonial focus group session emphasizing health. Members shared their experiences regarding enrollment in the healthcare market place during this focus group session. One member stated that:

> "I recently retired from my job and looked at getting COBRA insurance to cover my health care needs until my 65th birthday, which I still had two years to go. I discovered that the price for continuing health coverage through CORRA was extremely high and that I wouldn't have enough money to pay my bills as well as pay for insurance. I decided to risk going without health insurance for a while because I simply could not afford it."

He then began to share his experience with the ACA Navigators that came to the church. He made this declaration:

> "During one enrollment event here at the church, I sat with an enrollment Navigator, and she helped me to maneuver through the health insurance marketplace to find an insurance plan that fit my health needs, my budget, as well as my health habits."

Furthermore, he mentioned that it was very important to look across those three areas when you sit down with the Navigators. He also cautioned against approaching insurance enrollment with what he called "just-getting-some-insurance-for-the–sake-of-having-insurance mindset." He stated this:

> It was helpful to approach enrollment process knowing what you can pay, knowing your health condition, and knowing how often you go to the doctor. That will be very beneficial to help you pick a health insurance plan that is right for you."

He went on to testify that he sat down with the Navigators and found an insurance plan matched his needs. He also made this remark:

> "I found a plan that I was able to get well under the cost of COBRA and because of this I was also able to manage my budget a little better budget while receiving retirement pay."

He finished by commenting that he prayed for relief from his issues with health insurance and that he thanked God for answering his prayer by providing him with health insurance. He further thanked the Pastor for his willingness to help the members with their health insurance needs at the church. He then announced this:

> "It really helped me. I have to say getting enrolled in an insurance plan through the ACA is one of the best things that has happened to me in a long time."

Another church member shared a testimony regarding her mental health status. She explained that when she became an adult, she noticed she began to exhibit some of the same behaviors as her mother did when she was a child. It scared her because by then, she knew her mother had a mental illness and she did not want to share with others because of the stigma in the African-American community regarding mental illness. She further remarked that she eventually shared her story with a woman she met at the church. She made these comments:

> "She encouraged me to see a doctor. She explained to me that a mental illness is nothing more than any other sickness, like breaking a leg, or having diabetes, and that I would be okay to seek help because I was sick."

She added:

> "If you were sick in any other way, you would ask for help."

She said that because of this member's encouragement and prayers, she went to see the doctor and she is now on medications and feeling much better. She also shared that she felt this encounter with her church member was due to divine intervention because it allows her to meet with the Pastor regularly for spiritual counseling, which she remarked has also helped her to feel better about her mental health. She ended her testimony with this:

> "I thank God for his grace and mercy, without the help and inspiration and encouragement of this church member, I am almost certain I would not be here today."

Stakeholder Interviews

Stakeholders are impacted by (or have an impact on) the project; therefore, their perspectives need to be taken into account in order for a project to be successful. When interviewing the pastor, he remarked:

> "Community partnerships are great, but they need to be truly equal."

Stakeholders' influence can help or harm a given project. One state representative interviewed by the researcher, who was very instrumental in identifying additional health care enrollment Navigators for a community wide insurance enrollment event at the church, had identified herself as "the people's advocate who worked for the people". She not only helped to bring health insurance to the church, but she also has quite a few congregants who are constituents. Her comment related to health planning at the

church was that she that she though it was a great way to get the word out about health. She said she was a firm believer in the Bible verse that says:

> "My people are destroyed for lack of knowledge" (Hosea 4:6).

Although she noted that she saw the church as an appropriate venue to address health, she commented that she thought the church could do much more. She went on to say that the ministers she's worked with in Clayton County are faced with impediments that stopped them from getting health information out to the community. She noted that:

> "Well, I think one of the barriers the ministers in Clayton County have is that they are not knowledgeable enough on the health issues that affect their congregants. Specifically, those related to the insurance offered by the Affordable Care Act and what they need to say to their members about it. I think that if we are going to use the church as a place to enroll the community, the pastors need to be educated on what to say to get the people to the events. Yes, they do need to inspire their members, but they also need to provide them with information on what is in the health policy and how it benefits them as well, and I do not see enough of this."

Interviewer comments from another external legislative stakeholder with constituents from the Clayton County community at the church when asked by the researcher what could be done at the church to help the Pastor address the health of his congregation, were:

> "Well, the first thing we can do is implement education and awareness programs, to get the members to go get checkups, and take someone with them. And then report back to the church that they've been obedient to the call. Each one reach one."

When communicating with other external stakeholders regarding health planning and how it could help to increase the leadership's capacity to address adaptive challenges at the church, the concept of storytelling surfaced. One stakeholder felt that it was important to share stories between congregants but she also expressed the need for these stories to be shared at a higher level:

> "Church members can come to the capital and voice their opinions about the not having Medicaid expanded in GA. They can also share their stories about their experiences as a result of not having health insurance; the people that make and pass the laws often do it because they were moved by someone's story. They can share their stories."

She also asserted that church members can be more proactive by spreading the word about the enrollment events at the church, and also share the health resource materials they receive from the local community health center's health insurance enrollment Navigators in their respective communities.

Partnering with the health insurance enrollment Navigators is a key aspect of the health planning activities that occurred at the church. The alliance with health insurance navigators and the church began more than 3 years, ago. The state and local legislatures were instrumental in bringing the two groups together at the launch of the ACA rollout back in 2011. Since that time, the Navigators have assisted more than 30 individuals to sign up for the ACA marketplace health insurance plans at the church; this included people internal and external to the church. Over the years the Navigators have developed a great working relationship with the church members and worked very closely with the DE workgroup members and the Pastor to supply health resource materials such as, pamphlets and fact sheets about health preventative measures and information on the health insurance marketplace enrollment.

A health insurance enrollee revealed during her interview that the same navigator who helped her obtain her first insurance plan also assisted her to find one that was less expensive and met her changing health needs a year later.

The navigators appreciated the partnership with the church as well. When asked to comment on her perception of the relationship with the church she remarked that:

"We try to build strong relationships with the churches; we let them know they can call us at any time to get any information for their congregation, even outside of the open enrollment period. We know that most members share our information because we get calls from people saying, 'I heard about you from my neighbor who attends the Community church'; so we know that they actually disseminate the information. The churches reach out to us--we do not have to contact them. They say, 'Hey, I need help

on this or, I need help on that.' They say, 'Okay, I think I have somebody that I can trust or that can help you with that'. We also work with hair salons, barbershops, and other places in the community, but the church is pretty much our best partnerships."

The interviews with the legislative advocates exposed corresponding definitions of equity; when asked to describe health equity each interviewee said that:

> "Actually equity, I just think it means that everybody has the opportunity to health. But I also see it as delivering and sustaining equal health care in our community. I mean, particularly in Clayton County, we came very close to losing our only hospital in the community, our community hospital. If not for the community coming together to fight the closing; people would have to travel out of the community to seek care. Access to care is very important, so we need to continue to work together as a community to ensure everyone can get to a local doctor when they get sick."

Still another representative shared this:

> "I describe equity as me having the ability and the opportunity to access quality health care, just like you. Oftentimes, equality doesn't always translate to equity in the health field or other fields. To me it's mind-boggling because 5 hospitals were closed down in rural Georgia and many more will close if we don't have Medicaid expansion. Right here in our own community of Clayton County, we had a hospital that was in trouble and about to close. Now someone had to step in to buy the hospital, but the affordable healthcare act could have helped to save it. Also because we are not participating in Medicaid expansion in the state of GA, we still have people who are uninsured."

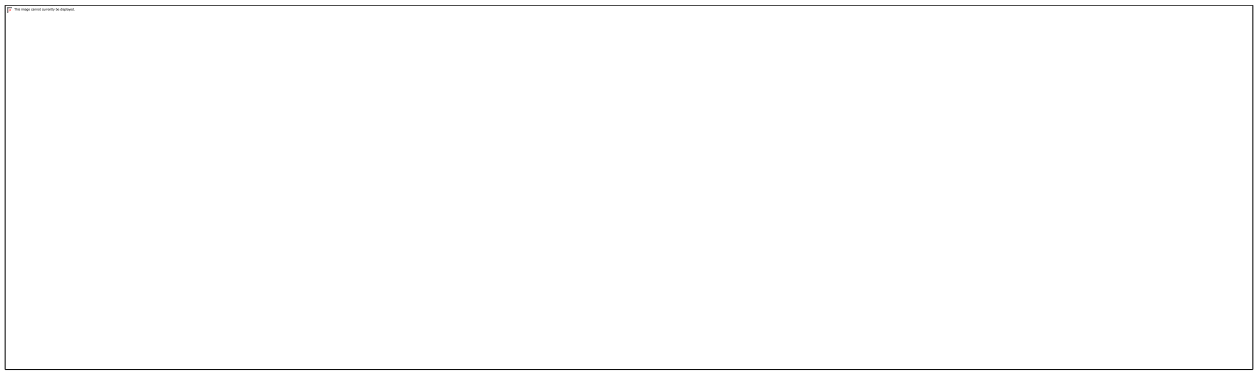
Building Evaluation Capacity

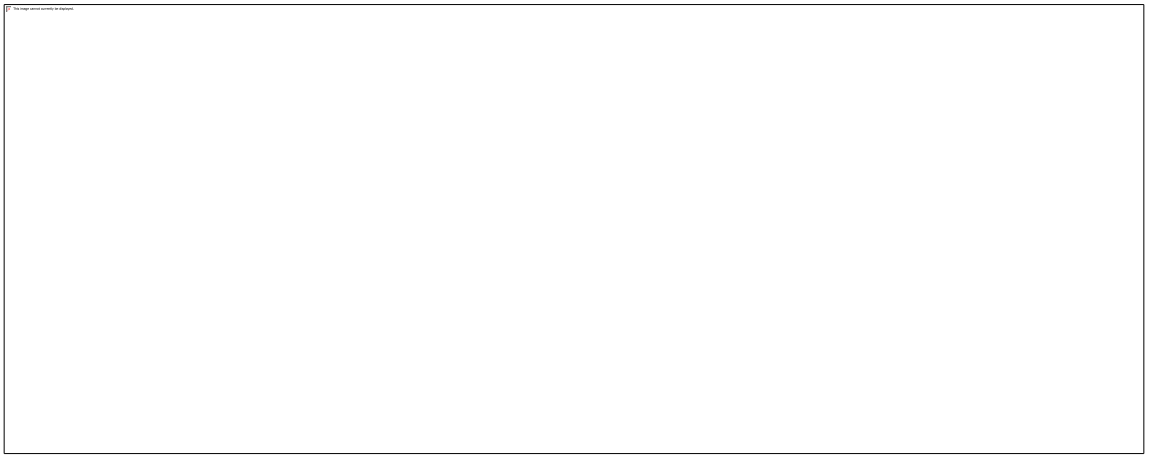
The DE workgroup's efforts to develop and disseminate a congregational needs assessment and their introduction and use of a logic model to assist with health planning at the church were instrumental to building the churches organizational learning capacity. Both evaluation tools helped to advance the churches ability to learn from its work and improve results. The workgroup members

discussed options for disseminating the surveys and to decide on the appropriate questions to ask in the survey, the workgroup conducted a brainstorming session at the beginning of the needs- assessment meeting. During the meeting the evaluator shared the top-ten causes of death for African Americans (CDC, 2016) according to CDC, this was introduced into the discussion as a way to help develop a list of health questions. Several surveys were shared as models for the group to use, they included, the Balm in Gilead, Inc., a faith-based survey, a Presbyterian USA Church congregational health ministry survey and the United Health Ministry Network's "Needs Assessment for Congregations, was also. After more discussion, the group decided to model the survey after a combination of the three, which had a mixture of closed- and open-ended questions that supported the church members including their individual perspectives. Additionally, closed-ended questions based on Likert scale responses, a protocol commonly used in public health evaluations was also included. The workgroup chose this assessment to model because it could be easily tailored for the sorts of questions they decided to ask the congregants. Workgroup members felt that this approach also increased the visibility of the group and provided a measure of assurance and accountability for reaching most of the church members.

One of the group members suggested that the survey not be too long. The group also pondered what would be the right amount of questions to capture the survey respondent's attention. Lastly, all data collected from the church members were analyzed, summarized, and shared with the members of the workgroup. The workgroup members provided their insights on how to share the needs assessment results with the entire congregation. The members provided feedback on whether to use graphs or charts to illustrate the findings from the needs assessment so they could be shared with the lager congregation in plain language. The work group discussed the development of a logic model at the close of this meeting and decided to use the next meeting to discuss it further and engage in a logic model development exercise. All congregational needs assessment survey results are displayed below.

The results of Figures 4-15 below further strengthen the church as a learning organization and illuminates' factors that support building an evaluation capacity? The congregation's needs assessment results are presented below.





Results from the congregational needs assessment results revealed that the predominant age group in the church is 51-68 years old, followed by members in the 31-50 year-old group. The results show more women than men participated in the survey, and the majority of respondents are married. More than 30% of the survey respondents reported having earned some college credit but not completing a college degree, and 58% of the respondents are employed for wages. The response to Question 2 (Do you or a family member currently have health-related issues? If yes, please explain), 99 members responded to this

question and of these, 19% said “no”, and an overwhelming 81% said “yes”. Of the respondents, 34% reported having diabetes and over 60% stated that they have some form of high blood pressure.

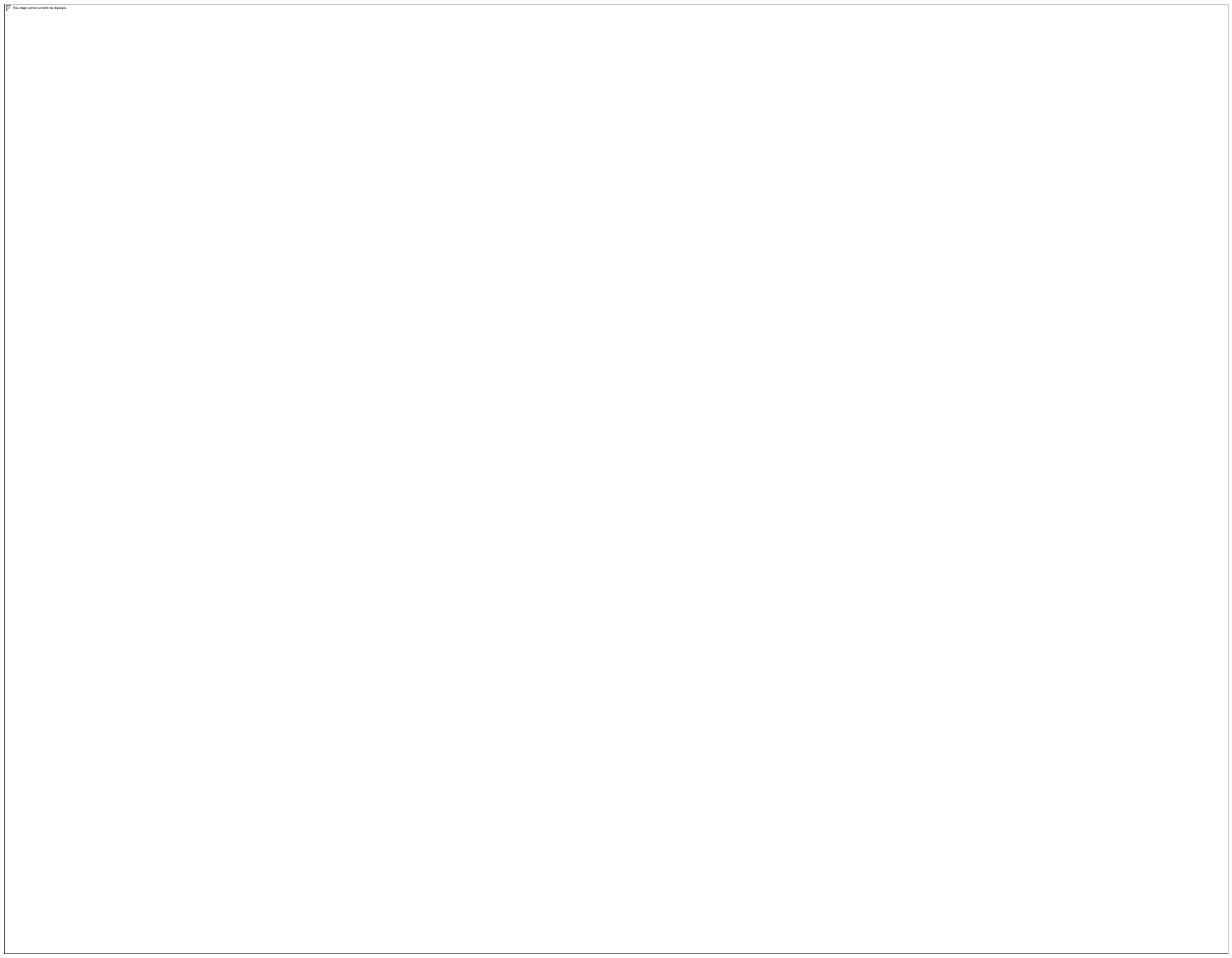
Gender Comparisons

Given the many gender differences that presented themselves during the study, a more detailed evaluation of the needs assessment data was conducted to examine the dichotomy between the two genders. The data analysis showed that of the 105 surveys administered, 41 members didn’t provide their gender however; 37 females and 27 males did indicated their gender. A few key differences are illustrated below. The first divergence in the responses appeared in the survey data results which asked: (a) What is the highest degree or level of school you have completed? If currently enrolled, select highest degree received. The survey results revealed that the women at the community church have 35.14 % as compared to the men who have 25.93 %.

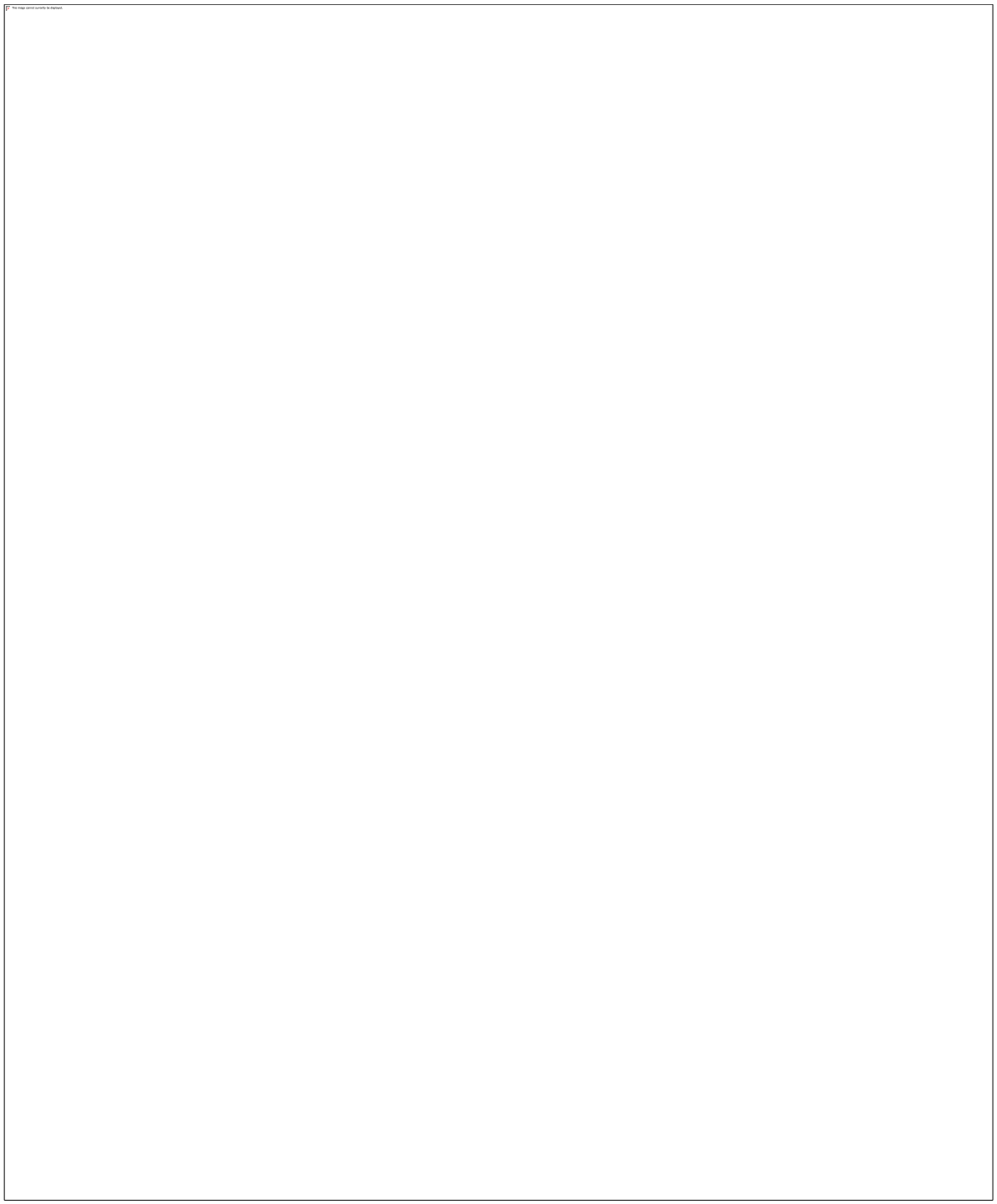
Additionally, the results of the data regarding the data showed that 2.70% of the women have a doctorate degree where the male respondents reported having none. The comparison of the gender data also

indicated that the women have less poor health habits than the men at the church 32.43% when compared to the men at 40.74%. Women reported being less underinsured than the men 21.62% for the women compared to 37.04% of men. Women also appeared to have more financial problems than the men 35.14 compared to the males at 29.63. See Figures 18 and 19 below.

Figures 20 and 21 below, show the results for women at 28.13% for being extremely interested and the men at 10.53% for being extremely interested in learning about and taking active steps to improve their health at the individual level. Although there is not much disparity between the other gender responses as indicated by Figures 22 through 27. In an attempt to ascertain the interest levels between the woman and the men at the community church in learning more and taking some active steps to improve health. The gender difference at each of the following levels: Individual, Family, Congregation and Community were rated (1) Not at All interested (2) Slightly interested, (3) Moderately interested, (4) Very Interested, (5) Extremely interested, reveled the following: See Figures 20 -27 below.



Furthermore, when breaking out the data by gender, responses from the needs assessment survey show how much interest there was between genders in learning more and taking active steps to improve medical care at the same levels as health the survey results revealed the following: Figures 28-35.



Although there was not much difference in the men and women regarding learning and taking active steps about health on all levels there was differences displayed regarding their views on learning and take active steps on medical issues at all levels. On an individual level females revealed a 28% to 9% difference. The gender breakout for learning about family medical issues was very similar 47% to 54 %. The men almost doubled the women in learning and taking active steps for medical issues in the congregation. Lastly, the men were almost twice as very interested as the women in learning about and taking active steps for the community level for the same question 60% to the women 38%. Further information regarding the results of the needs assessment data by gender will be shared in the findings section of chapter five.

The next workgroup meeting was dedicated to developing a logic model. A few workgroup members commented that this would be the first time information on the health of the congregants would be captured in a systematic manner. Another member remarked that they had never heard of or participated in the development of a logic model; however, they were eager to learn more about this evaluation tool. The evaluator shared with the group that a logic model could help provide a framework for the group to assess the overall effectiveness of the health planning efforts and of the various activities, resources, and external factors that play a role in the outcomes of our work.

The evaluator defined the concept of a logic model for the group by providing them with a definition found on the University of Kentucky's Community Tool Box website. The Community Tool Box was used because the resource is accessible to the public which would be a helpful for the group members if they were interested in ganging further information on evaluation information on their own. According to The Community Tool Box (2016), a logic model is defined as "…a picture of how your effort or initiative is supposed to work. It explains why your strategy is a good solution to the problem at hand. Effective logic models make an explicit, often visual, statement of the activities that will bring about change and the results you expect to see for the community and its people. A logic model keeps

participants in the effort moving in the same direction by providing a common language and point of reference."

The evaluator emphasized that a logic model is a very useful tool as it "offers an easily understood, consistent, and visual guide for program planning, implementation, and evaluation" (Dandridge, 2016). The group members agreed to segment the model into inputs, activities, outputs, short-term and long-term goals. The evaluator observed this session as one of the livelier discussions to take place of the DE meetings thus far. A few new church members participated in the logic model session and there were a number emotional responses shared during this group meeting. For example, information regarding the custody and control of equipment was discussed. Someone shared information related to theft of computers at the church. These comments provoked a member to respond this way:

> "I had nothing to do with those computers going missing. During the time, I worked at the church, people were coming and going and using the computers without a written process for use in place. I spoke to the church leadership about security, but nothing was done. No one wanted to spend the money on security."

This led to further discussions regarding the emergency preparedness at the church. A nurse participating on the workgroup shared that she was under constant pressure to be available in the event of a health emergency occurring during service. However, she noted that there is no protocol for her to do so and that she has no permission from church members or leaders to take charge during a medical emergency. She also stated that a medical response plan should be developed and shared with the members. Another member indicated that she felt the church needed to obtain medical equipment, such as defibrillators, smelling salts, bandages and other first-aid equipment, because of the frequency of adverse health events and the older population at the church. Paralleling these comments were sentiments shared during the male focus group discussion. One member responded that he felt the usher board should be used to support any emergency response that occurred at the church. He said:

> "The ushers are on duty every Sunday, if an emergency occurs during the services they should be the first responders."

Another male focus group member commented that not all the ushers have medical training or skills. The other member responded, that they could get trained in CPR and have a written action plan to contact responders which included emergency phone numbers, such as local police and sheriff. Yet another focus group member stated this:

> "We do not have an emergency operations plan here at the church. There has been so many things happening at the church these days. Look at what happen to the members at that church in Charleston, SC. We need to be able to take care of our members in the event of an emergency."

Comparatively, a DE group member suggested using the existing infrastructure at the church by recruiting other members with skills in CPR and emergency response to help. The emergency planning information uncovered at the focus group meeting held with the men at the church was later shared with the workgroup members and they felt it was vital enough to be place it on the logic model as part of the health planning going forward. Results from the logic model are shared below in Table V below.

TABLE V

Phase III

Transferability

The aim of phase three is to determine if the actions that occurred in phases one and two are transferable to other similar churches. While, generalizability and transferability are important elements of any research methodology, transferability implies that results of the research study can be applicable to similar situations or individuals. Transferability can also be defined as the degree to which the results of the research can be applied beyond the boundaries of the research (Universal Teacher (2016). Results from phases one and two were captured in the form of lessons learned. The resulting lessons learned were given to an eleven-member ministerial association in the Clayton County, GA area in the form of a survey

to test the transferability of this research study. These lessons will be shared in greater detail in Chapter 5 in the results section of the research. Although eleven churches were provided the survey, only eight surveys were collected and analyzed. While the survey responses were provided by eight pastors from the minsters consortium, each minister was asked to provide their perspectives on their respective membership which when combined, totaled approximately two thousand members. It is also important to note that although the churches that responded to the survey are located in the same geographical boundaries as the church central to this research study, these churches also have a comparable membership of predominantly African Americans, and they are alike in organizational structure and functions; each differ in complexity. Much like that of the Community Church, complexity exists in the demographics, values and beliefs related to health care and planning in these external churches. Given the diversity that exists within and between these congregations, the researcher placed an emphasis on context which was essential to achieve scale of this research project using the developmental evaluation framework.

Although all results from the external minister's survey are presented in Appendix G of the study, this chapter provides an overview of survey results pertinent to the analysis and finding for phase 3 of the research. Please see Table VI below for an overview of the external's church demographic and data.

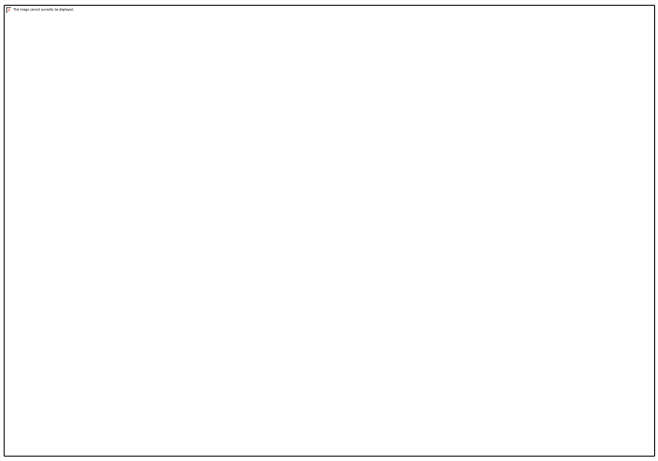
TABLE VI. External Church Demographic Data		%
Age	51-68	50%
	31-50	26%
	81+	12.60%
	18-30	12.60%
	69-80	0%

More Males or Females at the Church	Female	100%	
	Male	0%	
Marital Status	Married or domestic partnership	62.50%	
	Single, never married	25%	
	Widowed	25%	
	Divorced	0%	
Education	Bachelor's degree	37.50%	
	Doctoral degree	25%	
	High school graduate, diploma or equivalent	25%	
	Associate's degree		12.50%
	Master's degree		12.50%
	Employed for wages		57.1%
Employment Status	Retired		57.1%
	Unable to work		20%

	Health Data	**%**
Please check any of the health related issues below that concern at least 20% of your congregation.	Diabetes (Sugar in the blood)	75.00%
	Hypertension (High blood pressure)	62.50%
	Arthritis	25.00%
	Cancer	62.50%
	Mental health	12.50%
	Access to care	25.00%
	Fair and equal treatment from the doctor	12.50%
	Other community issues	12.50%
	Lack of insurance	12.50%
	Healthy Behavior (eating, exercising, smoking, etc.)	62.50%

An additional exploration of the results showed that 42.8% of external survey respondents reported that they were very interested in health improvement for the community which is very similar to the 41.33% reported by the needs assessment respondents as seen in Figure 30 below

Figure 36. External survey results community health improvement



These results were also authenticated by the study's theoretical constructs and the narrative data gathered from interviews with the pastor, the leadership and the external stakeholders all which stated that the church is a vehicle for meeting the needs of community. The action of visiting the sick and shut-in, participating in testimony services as well as employing prayer or support groups for sick members ranked very high on the external survey. This was also noted to be extremely important to the members of the Community Church as well. These activities provided further insights into existing methods and practices in the Black church that easily support the implementation of health planning and health initiatives in this environment,

Additionally, the external survey respondents also stated that they were interested in inviting health professionals to come speak at the church which was also expressed by members in both gender specific focus groups as well and by the pastor at the community church which is evidence for this activity working well across churches. Additional comparable activities shown to work across

congregations were, distributing health information to the congregation via pamphlets/resources which found to be a method used during the health enrollment events highlighted in the early analysis of this case study. Furthermore, community outreach (e.g. feeding the hungry, volunteering at a shelter) also corresponds the with the health endeavors revealed by the DE workgroup meeting notes and were remarked on by both the pastor and the lay leader's regarding other actions the church could take to address the health of its members.

More notably, some external responders commented that they have other ministries that help the community such as prison support, giving to the missions, and Wounded Warrior projects. The comments shared by the external churches about other ministries indicated efforts closely linked to broader community health equity initiatives, much like those noted by the DE workgroup members. The survey showed 50% of the respondents had worked to improve county bus service, 16.67% volunteered to provide bottled water to residents of Flint, Michigan, while another 50.00% reported other efforts such as helping the metro-area homeless once a month.

Half of the external survey respondents said that they had taken part in hosting an Affordable Health Care (ACA) Market Place insurance enrollment event at their church. The external churches revealed that they had external help to host these enrollments as did the Community Church. Some reported that a company by the of named Enroll America; assisted, while others stated that the information on affordable health care was obtained from a representative that spoke to members who had questions but they did not provide exactly where this individual worked. There were a few external churches that reported that activities related to the ACA were conducted on individual levels with a qualified consultants and other still stated that they did not conducted any of these activities in church or during church time. The external churches reported using marketing strategies to announce the enrollment events similar to those used by the Community Church. They reported using church bulletins, websites, Facebook, church announcements and flyers. They also confirmed that they sponsored national

health observance (e.g. American Heart Month, Prostate Cancer Awareness Month) much like that of the Community Church. The external survey showed that four of the churches reported yes, to currently having an existing health ministry, one church stated that although they no not currently have a health ministry they were working on a grant to obtain defibrillators for the members. Examples of the mission of the health ministries provided were:

1. To inform the congregation on the various health issues. To provide information and resources regarding these issues.
2. Our church provides holistic care for the entire year. Spirit, soul and body.
3. To fulfill the mission of Jesus Christ by making faithful disciples; reaching and teaching the gospel of Jesus Christ and teaching people that they can start where they are and by changing their thinking, they can change their lives. Our purpose is to glorify God and allow His people the opportunity to come in and worship Him. By equipping the saints, we aim to take this ministry to a higher level of service, praise and worship and education which will enhance individuals as well our collective body and communities. Reach out in our communities with ministry.

Furthermore, the tradition of testimony service, a widely used practice of the Community Church that proved to be a means for knowledge transfers and helped the pastor to address the adaptive health of his members was also validated by the results reported from the external survey. The survey revealed that 83% of the respondents used testimony service to share stories about their health at the external churches. A few of the health stories noted as shared on the survey were breast and prostate cancer survivors, healing, a deacon's discussion of his equilibrium problem and how it had been tested, another deacon's discussion of his recent prostate cancer diagnosis. The external respondents also reported how these testimonial services affected the other church members. Examples provided were:

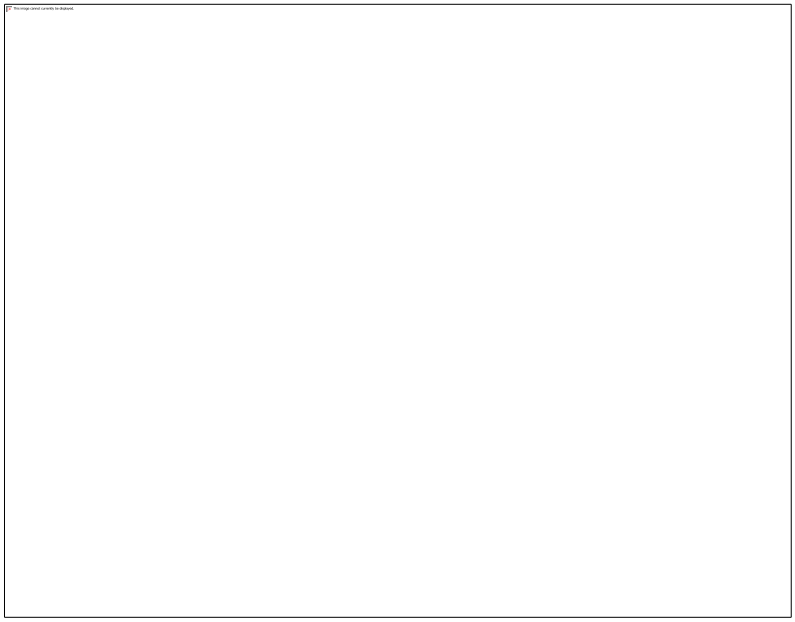
1. Inspirational
2. Increased awareness
3. These testimonials enlighten our congregants about their health and encourage us to pray for one another, and support one another. The bible says "we overcome by our testimony." Revelation 12:11.
4. It gives hope, peace, love and ability to go on when tragedy strikes.

Additionally, gender preference for health planning and for health delivery was reported as existing in the external churches. Although, the survey revealed that 83% of both genders participated equally in the above ministries compared to reporting only 17 % of women unlike that of the Community church, and there was also slightly little difference in health preference format presentation between women and men as reported by the survey; the survey narrative for this questions corroborated the findings from the Community church that indicated men were interested in gender specific health education. The narratives offered by the external churches for this question were:

1. men are certainly more private with issues
2. Men need more prompting about health issues. Especially, Afro-American men concerning all health issues. Nevertheless, men would prefer talking to another man or male doctor concerning their health issues.
3. Women are more open, otherwise, preference is same.

These statements are much the same as those that emerged from my case study observations, the DE workgroup meeting note, the pastor's comments and the gender specific focus groups that took place at the Community Church. This further highlights the importance of placing emphasis on gender specific approaches when planning for health interventions. The external ministers also provided a glimpse of which church leaders or groups were actively engaged in furthering a health agenda, meaning they spend time on it at least once a month at their churches. The majority of respondents reported sisters at the church with the pastor coming in next at 20% which further confirms the gender difference related to work of any kind at the church. This mirror's the comments made by the Community Church pastor that women seem to do more work than men at the church. See Figure 31 below for members actively engaged in work as reported by the external minister's survey.

Figure 37 External survey results members actively engaged in work at the church



Much like the Community Church the external surveys also reported that health planning at the churches was conducted on a monthly basis and that the churches that did not report having a health ministry was interested in learning more about what they could do to engage in health planning at their churches.

Finally, an interesting finding that emerged from the external churches surveyed showed that 100% of the external churches reported not having a partnership with a health related organization. While there were no partnerships reported one church did indicate that they would be reaching out to the Associate Dean of Diversity & Inclusion Academic Vice Chairman for one of the local university's family medicine department however; there was no other information reported for why. The narrative

data provided in the external surveys indicated an awareness and understanding by the respondents as to the definition of a partnership examples provided were:

1. Common interest and goals
2. Partnership on community events and resources
3. A working collaboration with a liaison who gives data to help inform an organization and the organization provides support and cooperates to advice their mutual interests.
4. When different organizations work together for same cause.
5. Will need information about this.

Given, the cogent descriptions provided by the external ministers in the preliminary survey analysis on what they believed a partnership was, as well as the degree of stakeholder involvement addressed in the case study which appeared to facilitate health planning at the church, this did not correspond. Therefore, much like the iterative process found in developmental evaluation framework, the researcher sought out a few of the external ministers that participated in the survey to get additional information on why they had reported not having a partnership with a health related organization. The responses I received were that:

> "Although we have gotten help from the local hospital and health department when we needed pamphlets, factsheets and other resources; we never signed any documentation stating we had a formal partnership."

> "We work together off and on with health organizations however, there is no long standing commitment with any particular agency. They contact us when they need the help from the church and we contact them when we need their assistance."

> "We want to be long-term partnerships with health organizations but we really do not know how to go about it. Anytime, we needed assistance with activities like the ACA insurance enrollment, one of the sisters in the church that works at the hospital makes the connections for us."

The comments shared by the ministers were very revealing and indicated a further need to communicate a shared language that everyone could agree upon for describing what a partnership truly is. The remarks also suggested that there is further need for exploration and cross connecting innovative models and best practices related to health planning in the African American Church.

CHAPTER 5: QUALITATIVE DATA ANALYSIS AND RESULTS

Introduction

This study explored how an African American church supported greater use of the resources provided by the Patient Protection and Affordable Care Act (ACA) among its members and potentially the wider African-American community, and in so doing, built the capacity of the church to address social determinants of health and promote health equity. A particular aim of the study was to investigate how this particular African-American church linked a government program with the people it serves, as one of many ways it could minister to their health. The research questions guiding this study derive from a pre-selected framework as well as grounded, emergent concepts.

Although an emphasis was placed on the a priori theoretical questions of this research, via qualitative content analysis supporting through Atlas.ti, emergent constructs were discovered upon further examination of connections between various quotes, themes, collected documents, and memos. Examinations of these relationships lead to new questions, used as queries to address the data. Once answered, the questions identified additional key factors that served to expand understanding of the initial research questions (e.g., regarding the church as a learning organization and building its capacity), integrating analysis from Phases 1, 2, and 3 of the study. These constructs thus helped determine and understand the progress made during the evaluative inquiry at the church and guided efforts to answer the overall research questions. Table VII below shows the a priori theory and, emerging from it, related questions that need to be resolved through the study analysis.

TABLE VII. Research Study Questions

Research Phase	A Priori Research Study Questions/ Emergent Questions (a)
Phase I	1. How does an African American church connect its membership to resources offered by the ACA in a way that increases health equity?
	1. Are there any differences by gender preference for health care and health planning at the church?
Phase II	2. What is the relationship between the development of health programs within an African American church—that is, programs providing resources to educate and inform its members about health—and increasing the capacity of the church as a learning organization?
	1. Do church based social networks influence learning?
	1. Does the development of health programming result in changes in the organization of leadership within the church (e.g., the formation of a formal health ministry or the ability of church leaders to respond to adaptive challenges related to health)? If so, how?
	1. Is the involvement and participation in the church between men and women different related to health activities?
	2. Does the development of health programming build the capacity of church leaders and members to engage in evaluation and reflection? If so, how? What factors support building an evaluation capacity?
	1. What data gathering techniques and discussion promote a commitment to health equity related work among church members?
	2. What are the unique assets of the church that inform organizational learning? (Prayer, sick and shut in, marketing, encouragement).
	1. How do external stakeholders influence and partnerships affect learning about

resources related to health?

Phase III	3. What lessons learned from this process can be transferred to other African American churches?

Similar to the study's methodological approach for data collection, the findings from the analysis given in this chapter also are presented in three phases: (a) exploring the activities taken by Community Church to roll out and introduce ACA resources to the entire congregation and individuals in the surrounding community, (b) examining the results from the first phase to leverage the church's readiness and the organizational learning capacity to develop and implement a health ministry, and (c) identifying and capturing lessons learned throughout the process to transfer the findings in other African American churches in a way that adds value and benefit to their congregations. Presentation of the results of the analysis will also be organized here by research question. Information regarding the lessons learned from this research study will presented in chapter 6. Additional information such as study limitations, leadership implications an executive summary providing steps for health ministry development in an African American church are also presented in chapter 6.

Analysis

The researcher examined the data and coded this information to show the connections between the as in the data, how it supported the analysis and how this analysis impacted the research findings of

the study. This coding exercise resulted in a code list which the researcher segmented into two categories, apriori and emergent. This code list is presented in Table VIII below.

TABLE VIII Research Code List

A priori	Emergent
Organizational Learning	**Gender**
ACA	**Accompanying love ones to the doctor**
ACA law	**Acting like family**
Awareness	**Administrative**
Better Access	**Advantages**
Change in outcome	**Advertisement**
Changes in process	**Advisory Committee**
Church Assets	**Advocates for our own health issues**

Community partnerships

Encouragement

Equal

Equal rights

Equity

Evaluating

Expansion

Experimentation in the black community

Facilitator

Faith

Georgia

Greater understanding

Healing

Health Behavior

Health choices

Healthy Life

Hearing the message in church

History

Human rights

Inequity

Information

Information transfer

Insurance

Knowledge

Awareness of individual health

Being done well

Branding

Challenges with the health ministry

Church Announcements

Comfortable

Communicating

Communicating vision

Community Canvassing

Community examples

Communicating

Competing priorities

Confidentiality

Consensus

Control

Cost

Creating

Decisions

Enthusiasm

Exploration committees

Externally

Fair Treatment

Fairness

Family

Lack of insurance	**Fear**
Leadership	**Fellowship**
Learning Organization	**Followership**
Lessons learned	**Follow-up**
Medicaid	**Food pantry**
Organizational learning	**Formal**
Other church health ministries	**Friendships**
Other examples of health minis...	**Gaps**
Pamphlets	**Gender**
Participation	**Family**
Policy	**Fear**
Prevention	**Fellowship**
Process	**Followership**
Process health matters	**Follow-up**
Reasons for participating	**Food pantry**
Reflection	**Formal**
Resource	**Friendships**
Resource materials	**Gaps**
Roles	**Guidance**
Serving people	**Health Advisory Committee**
Sharing information	**Health Fairs**
Sharing stories	**Help**
Skills in the church	**Hinder access**
Social Media	**Improvement**

Specific solutions for African Americans	**Influence**
Stakeholders	**Informal**
Survey	**Internally**
Telling our stories	**Kinships**
Your concepts of a health ministry	**Legislative**
	Love
	Males vs. Females
	Marketing
	Measuring progress
	Love
	Men
	Men on a Mission
	Mental health
	Mentorship
	Messaging
	Mission
	Movies
	Not
	Not being done well
	Partnerships
	Pastor sermons
	Plans for training
	Power
	Prayer

Previous activities

Questioning the work

Recognition

Recruitment

Medical screening on the

Relationships

Resistance

Respectful

Response

Retired

Rewards

Risk

Routine

Rules

Safety

Schedule

Scheduling

Secrets

Sensitive information

Silence

Similar stories

So you got to communicate

Strategy for education

Stigma

Structure

Thank God

The group commented that men…

The messenger

The norm

The Pastor is in favor of

The pastor obviously,

Thinking back, do you remember…?

Trust

Trust issues

Understanding

Volunteerism

Voting

Website

What else can be done?

What I think I heard today…

Wisdom

Women

Women, women do it. I mean the women do it…

Written reports

Thank God

The group commented that men…

The messenger

Quotes were used extensively in the study to support researcher claims, illuminate experience, evoke emotion, and provoke response. The researcher also coded on quotations from various participants collected during the inquiry. Frequency or rate of occurrence can help identify relevant information to support findings when coding data. During this coding process 73 quotations were found when querying

for "Equity", 85 quotations were found when querying for "Organizational Learning" and 45 quotations were found when querying for "Gender". The query lists of coded quotations is included in the Appendix F section of the study.

Data analysis in phase one centered on the DE work group meetings, the congregational needs assessment, and the DE work group's efforts to develop a logic model. Furthermore, because of the retrospective character of the data collected in this phase of the study and the exploratory nature of the facilitator's questions, a sequential table displaying observed issues that

emerged during the workgroup meetings, the new directions that resulted from a detailed discussion of the questions and actions that included the implementation of new ideas, new perspectives on communication practices in the church, and new approaches to program

development are presented below. Emergent or open coding can be ordinal or nominal; counting the number of occurrences, relationships and categories in a document is a simple type of

evaluation. Counting words via word processing software was employed by the researcher as a way to assemble patterns quickly that were emerging from the repeated review of the documents. During this review and evaluation of the data, an echoing of specific words and phrases began to occur. The emergent word cloud in figure 36 below depicts this repetition, capturing the words that appeared most often in larger, darker type.

Figure 38 Emergent word cloud

The key themes that surfaced from the word cloud were trust, men, women, leadership, safety, family, fear, church and health. These themes emerged while examining data from various modes of data in the study. The concept of trust first appeared during the early DE workgroup sessions on health equity. The workgroup members were reflecting on their past experiences with health professionals and medical

care which opened up a deeper discussion about feelings of trust. Trust was also noted as a factor that supported the researcher's ability to serve as an embedded member of the workgroup. It was noted in one of the workgroup session's meeting noted the researcher stated that there had to be to mutual trust between the evaluator and the group members in order to build and cultivate a working relationship that could result in sharing decision making information. Trust also appeared as part of the testimonial story telling sessions during the focus group testimonial session church members commented that they had faith and trusted in God to see them through their health issues. This was shared by both members of the community church and responses from the external church in the survey. One story shared by a member during the testimonial focus group contained several words that appeared in the word cloud. For example a member shared her story regarding her experience with breast cancer. She commented that:

> "I was diagnosed with breast cancer at 28 years old. What happened was, I was at home and I was taking a shower and I noticed a lump. I ignored it for some time because I was not really certain what it was and I thought maybe it would go away. I recognized after a couple of weeks that it didn't.
>
> I went to the doctor and the doctor did a breast exam. After they did the breast exam they called me back with news that they wanted to biopsy it or actually before I left the doctor's office, the doctor wanted to biopsy it. Then they called me back with the news that it was cancer. I went to the doctor by myself initially and I kept it to myself. I didn't even share it with my mom. I waited and waited until I felt like I couldn't wait anymore, and then I finally broke down and went to my family. What kept me from going to my family to talk about it was fear.
>
> I was even afraid to come up here and testify this morning in front of everybody. That's why I asked my cousin to come up with me, because I was afraid. Fear can stop you from doing things, even things that you know you should be doing, and things that you know that will help take care of yourself. My mother is a praying woman and because she trusts in God, she helped me through this ordeal. She went to the doctor with me. She was with me through my mastectomy. She rallied the family and they all came around me to help me as a result of my mom.
>
> It's because of her that I'm up here sharing my story. Don't think that because you are young that you cannot get breast cancer because that's not true. I was going along living my life not thinking about anything and all of a sudden, boom it happened to me. I want

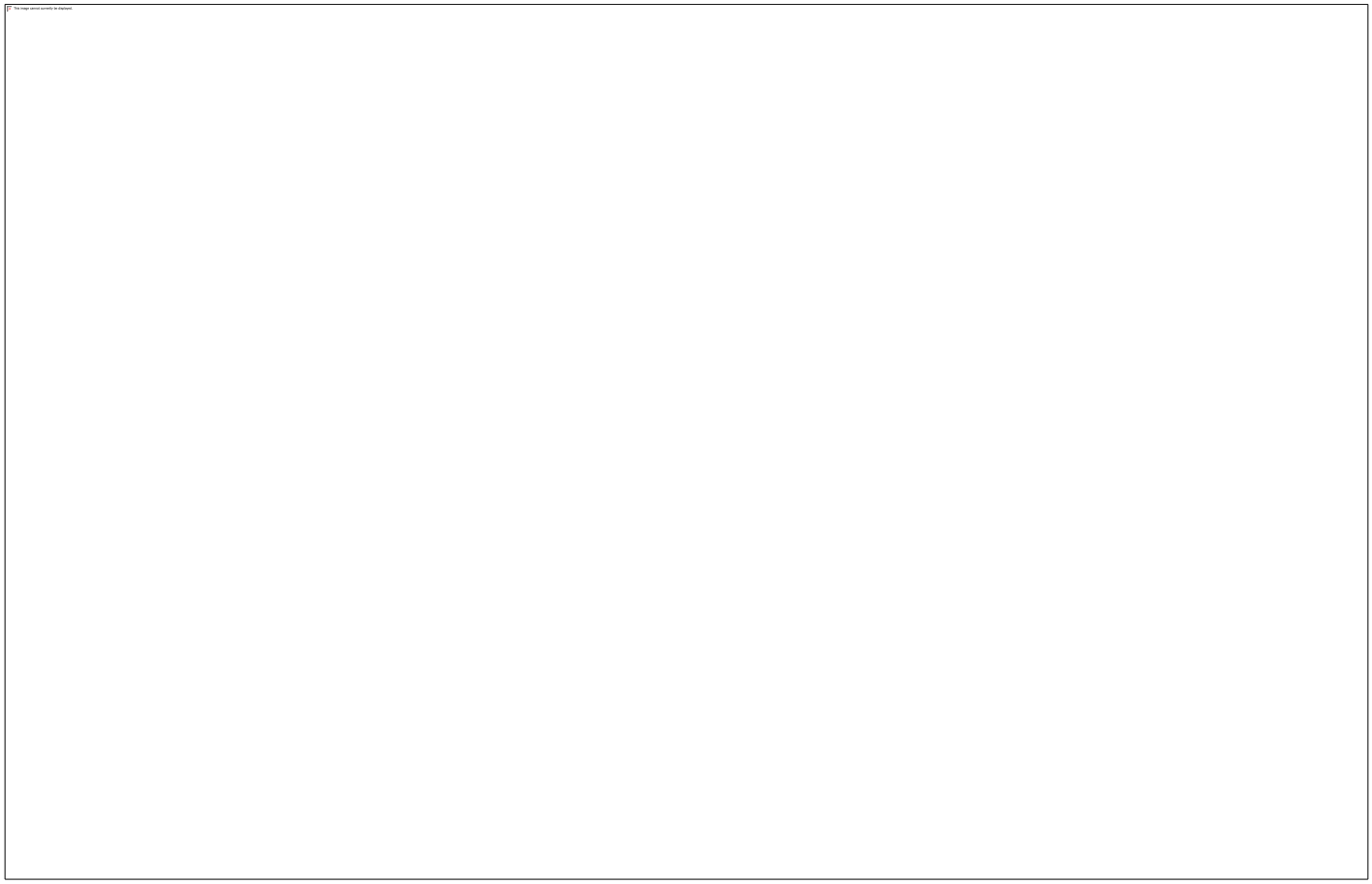
> to share that with most young women and I also want to share that you need to check yourself. Do your own self breast examinations because you never know. Had I have checked it earlier and didn't happen to kind of stumble on it during the shower, it may have fared better for me if I would have gotten it done a little earlier.
>
> I want to tell you don't let fear paralyze you. I again was afraid and I waited a long time before I shared it with anybody. Once I did, I got help. People rallied around me, people in my family, people at the church, people went to the doctor with me, even here at the church after they found out what was going on with me. I just want to stand and say I appreciate it. I'm doing much better now. I'm still going through my chemo. I had to get all my hair cut off because my hair started falling out. I had people here at the church rally around me and get their hair cut too, just in support of what I'm going through. I want to make certain that everyone knows, you don't have to go through things by yourself. If you trust in God and you believe in him, you have friends at the church and people that will help you through whatever situation, health and/or otherwise. Thank you."

The testimony above indicated a desire to share for the member to share her story with other women at the church which shows evidence of a divergence between men and women regarding health issues. Furthermore, this testimony provides evidence of the close relationships between members at the church. Leadership was mentioned several times throughout the study however, the phrase occurred more frequently during the external stakeholders interviews. The interview respondents provided comments on ways to partner with the church leadership in health planning activities at the church such as conducting ACA insurance enrollment events. Leadership was also displayed in the way the women at the Community church stepped up to take part in putting on health events at the church such as breast cancer and prostate cancer awareness programs.

During the open coding process, the researcher began to identify relationships, commonalities, differences and patterns between words and phrases. For example, a review of the participant quotations collected from the interview data revealed categories such as education and training, health

behavior, men and women. The researcher further cross-categorized these codes with quotations taken from the DE work groups and the focus groups and identified consistencies leading to the recognition of patterns and themes. The following illustrations provide an overview of patterns and themes that emerged directly from quoted data captured through various collection modes.

Figure 39. Overview of Emergent Patterns and Themes



This was also suggested in the male specific focus group where the members commented that they were interested in being educated about health issues specific to their gender group. Other gender specific issues were displayed when coding in Atlas.ti such as the DE workgroup's efforts to be purposeful about male health issues at the start when planning for health events at the church.

Research Questions and Results of Analysis

Phase I:

1. How does an African American church connect its membership to resources offered by the ACA in a way that increases health equity?

ACA Resources and Equity

Trust -

Findings from the data gathered to inform the church group's efforts to roll-out the ACA and provided answers to the first research question: how an African American church connected its membership to resources offered by the ACA in a way that increased health equity were revealed during the DE workgroup meetings. The evaluator used reflective practice techniques to uncover encounters which helped member's re-evaluate their thought patterns and utilize what emerged as tipping points for action. The developmental encounters also helped to guide future discussions, spur dialogues with the church pastor, develop agendas, and plan for the next DE work group meetings. Table IX below provides an overview of the encounters which occurred during the span of the developmental intervention, as well as the resulting tipping points that helped drive the DE workgroup.

TABLE IX. DE Workgroup Developmental Encounters Overview		
Emergent Themes	**Turning Points**	**Action**
Trust	Sharing information through group reflection.	Educating members about new provisions in the ACA.
Developmental Evaluator	Recognizing reflections that needed to be shaped and guided.	Bringing the workgroup back to a more focused discussion.
Refection on ACA Rollout	Increased education and awareness liked to the resource materials provided during church health events and enrollment campaigns e.g., facts sheets, toolkits, handouts, statistics and preventative care brochures	Sharing the information with neighbors, family and church members.
Equity	Shared reflections of member perceptions on health equity at the individual and community levels.	Education on, development of and implementation of a health equity checklist to be used in planning all health events.
Myths	Shared information through group	Inviting health professionals who

	reflection.	can help refute the myths.
Family health history	Shared information through group reflection.	Develop tools and processes to pass information down generationally.
Limited male participation	Observations, workgroup member comments and leadership influence	Stronger marketing and information sharing among male church members.
Gender preference for medical care.	Capturing this information to use as a part of health planning at the church.	Ensure information is utilized in all health planning going forward.
Leadership	Understanding the connection between leadership influence and resources at the church.	Continue to educate leadership and members on the connection between resources and health planning (help educate them to see the big picture).
Evaluation tools (needs assessment and logic model)	Introduction and use of tools needed to determine baseline information and strategically examining the churches organizational structure to support health planning.	Conducting activities to better gauge internal and external needs. Utilizing the assets in the organization as a way to further health planning.

Trust

An inherent lack of trust for medical professionals emerged when reviewing the data. Evidence of this can be found in the quotes from participants of the DE workgroup meetings. The data also showed that the work group members had personal connections with individuals who had unethical experiments conducted on them i.e., the Tuskegee experiment. One could assume that because the workgroup members were personally acquainted with these individuals, they regarded the experiments to be more personal, which deepened their sense of distrust. The case study data also suggested that growing up with the knowledge of these experiments created an environment of distrust of medical professionals in their community. The language used by the workgroup members indicated that they took these experiments personally as they repeatedly stated, "They did this to us" while sharing their stories in the workgroup meetings. The workgroup member's comments about the doctor's misdiagnosis and dismissive behavior towards them appeared to be taken personally; the animosity displayed by the workgroup member when sharing her story also showed evidence of this. Furthermore, the workgroup member's limited knowledge of the benefits of legitimate clinical trial research also indicated a lack of trust as one group member commented "one could not trust that the medical practitioner would do what they said they would when participating in this sort of research." Finally, a few of workgroup member's actually stated that they did not trust the medical professionals for several reasons which only confirmed the above mentioned perceptions of distrust. Based on workgroup member comments an assumption could be made that the members were engaging in negative or poor health behaviors as a result of what they learned from their families regarding healthcare behavior. It also suggested that the members were continuing to pass down this misinformation to other generations.

The data also revealed that the leadership saw the importance in having a heterogeneous group participate by his willingness to help recruit more men to the group. Based on the results of the discussion

taking place in the meetings it became apparent to the researcher that workgroup members had steered away from a focus on equity; therefore, the evaluator made an effort to guide the group back to that issue.

This redirection prompted a deeper reflection and guided the group to recall their experiences with the ACA rollout. The data from the ACA rollout meetings suggested that members were empowered by both the notions of getting members enrolled into the health insurance exchange and also receiving information that educated them about prevention and chronic disease. One could assume that the workgroup members wanted to take some measure of informed control over alleviating adverse health conditions by the way they reacted to receiving literature about preventative health. The ACA rollout discussions showed that health education was important to work group members, which parallels reports in the literature on how ACA could benefit African Americans in numerous ways. Additionally, there was some evidence that members wanted some measure of connections with those providing the health information as well as with those enrolling them into the health insurance. This was recorded in the workgroup meeting data, where participants mentioned that there were enrollment activities that they participated in external to the church where the interactions with some Navigators made them feel as though they were just "a check in the box" or a quota to fill at health enrollment events. A huge revelation that emerged from the ACA rollout discussions showed that actually reading the pamphlets and not simply picking them up was of upmost importance. This is evident by a member's comments that they learned ACA mandated access to preventive care at no additional cost and focused on specific gender health issues. The data revealed the importance of having a doctor of the same ethic background was important as evident by a workgroup members reflections when asked by the evaluator to discuss on what they recalled from reading the ACA material. The ACE rollout motivated the group members to think about the organizational processes and practices at the church. This can be found in the focus group discussion regarding receiving health insurance information at the enrollment events as well as providing resources outside of the walls of the church and into the community. This discussion also focused on the importance of having social media at the church to assist in marketing these enrollment activities. Comments from the ACA rollout discussion

also corroborated earlier workgroup member reflections that poor health behaviors were being passed down generationally. This suggested the need to introduce new tools to the church members that would help to break this cycle. For example, using measures such as placing health information inside the family bible and passing it along to family members much like they did in the past to share other pertinent family information was a tool familiar to all the other group members and offered a familiar, tested approach for sharing health information generationally.

Equity

The act of engaging the group in more critical reflection regarding how the ACA resources were provided at the church and whether this led to an increase in equity, provoked the group members to examine their own assumptions about health and their beliefs about health inequities in a way that provided them with a new shared understanding. The stories and accounts shared by the members of the DE work group helped them to see that they were not alone in their misgivings about their individual health and health behaviors. Additionally, challenging the work group to reflect critically on the ACA resource materials helped the group learn more about health equity at the individual level from each other. More specifically, their exchange of personal accounts of unfair treatment helped the group to gain awareness about why mistrust exists in the African American community and motivated the group to develop actions at the church to address their perceptions of unfair treatment. This exchange of information altered their thinking about the inequities they experienced in the past, motivating the group to share this information with the congregation. Furthermore, the transformation of the work group's views on health inequities and their increased understanding of health prevention that resulted from their reflection on the ACA resource helped to spur further exploration of a dedicated health ministry. The work group members were transformed through learning in a way that motivated them to greater action. Finally, one could conclude the work group members' decision to share the information with a broader audience at the church and to the community as collective action the members decided to take which helped to increase health equity at

the church. Although the researcher recognized a transformation occurring, further insight was needed to make a more explicit connection between the studies first research question of how the materials offered at the church lead to increased equity. Upon further analysis, the data also provided evidence of a disconnection between equity at the individual level and at the larger community level. This will be discussed below in further detail under the section on how critical reflection moves members to action.

Phase II:

2. What is the relationship between the development of health programs within an African American church—that is, programs providing resources to educate and inform its members about health—and increasing the capacity of the church as a learning organization?

Increased Capacity for Organizational Learning

Phase two confirmed the increased capacity of the church as a learning organization and addressed the second question (and its associated sub-inquiries) regarding leadership organization in the church and how it responded to adaptive challenges related to health. This phase also verified how health program planning in the church increased capacity for church leadership and membership to engage in evaluation and reflection as well as illustrates factors that support building an evaluation capacity. Greenleaf, R. K. (1977) described servant leadership as "…servant first…It begins with a natural feeling that one wants to serve, to serve first. A true servant leader puts others needs above his own and makes certain that people's needs are their highest priority." Data gathered from the discussion with the pastor of the church showed how he was a servant-leader with transformational tendencies. His comments suggested a clear concern for the welfare of his church's members; however, he also expressed having a real interest in moving the church forward by testing new ideas. This was further exhibited by his enthusiastic approval for the establishment and implementation of the developmental evaluation

workgroup at the church. His willingness to go ahead with this study coincided with his leadership vision; from the pulpit during his weekly sermons, his message of growth for the church was a common theme. But by placing such importance on the people around him, he truly was acting as a servant-leader. He was keenly aware that his church had to keep providing new and useful resources to the congregation and that members' health was one large area needing attention. During the interview, he made many remarks about knowing church members had this need and that the church was an avenue for addressing these needs. To the pastor, only healthy church members would be able to serve to their full potential. Further, in order to stay healthy, church members need to have individual health insurance coverage and the church needed to help as many people as it could achieve this goal—and that through collaboration and growth, the church can continue to help more and more people. This is a key research finding, as it provides support for partnering with external stakeholders who can bring additional services and resources into the church.

Lastly, the pastor at the church demonstrated a knowledge of the social determinants of health related to equity (mentioned by the researcher in the first phase of the research). This was demonstrated in his reflections about feeding the hungry and the start of the food pantry at the church. His knowledge and awareness of how environmental conditions, such as lack of food to keep people properly nourished, affects his congregants. In other words, members of this congregation share the same common needs as the general US population, that is, to have access to healthy food, safe living conditions, regular physical activity, and dependable medical care. But the obstacles they encounter in getting what they need reflect their own common history--and the church can help them find solutions.

1. Does the development of health programming result in changes in the organization of leadership within the church (e.g., the formation of a formal health ministry or the ability of church leaders to respond to adaptive challenges related to health)? If so, how?

The interview of the lay leadership at the church suggested that the church was indeed a life-long, family institution. But one woman's reflections about her long-term membership suggested that a great deal of change had occurred at the church and that this change was not positive. Her comments also suggested that as new members joined the church, it would then have to find new ways to keep everyone involved and motivated. The lay leader's comments presented options for growth and capacity building through and intergenerational projects. She, like the pastor, was a visionary. And she had suggestions that could make use of the existing assets at the church in the form of young and older members working together to shift the culture at the church. Although she implied the older members may not be open to her ideas, there is potential for innovation around food and nutrition activities that fit directly into the tenets of healthy behavior and making an effort to feed the hungry similar to that mentioned earlier by the church pastor. Her comments were vital and thought provoking because in her leadership role, she recognized that without growth, the church has potential to decline. Her responses suggest a belief that greater cohesion and teamwork can encourage new relationships and enhance existing ones, which in turn, supports a greater learning environment. This leader's perspective implies that teamwork fosters greater cohesion and the more this approach could be adopted by the church during the health planning, the better off the organization would be. Furthermore, her example could be used as a model by the health planning committee and shows that leadership can have a positive effect on teamwork and enhance organizational growth and leaning. Conversely, anecdotes from the leadership responses warn that leadership influence can hinder growth and innovation; therefore, leaders must be supportive in the right ways when working with teams toward achieving set goals.

Leadership reactions related to the trustee's behavior implied they were already aware of his negative attitude related to change at the church. Request by the workgroup members to add this leader to the logic model suggested that the workgroup members were aware of the need to educate the leadership

about the connections between the resources and health planning. Researcher interactions with the lay leader confirmed a disparity in his perception of the philosophy, goals and mission of the church. An assumption could be made from this that not all leadership at the church was in cooperation with each other, which has potential for an increase in their ability to respond to adaptive challenges related to health at the church.

Findings from the data showed evidence of the impact of storytelling on other church members and how the likely application of the knowledge shared through these stories contributed to the leadership's capacity to address adaptive challenges at the church. Additionally, an argument could be made that because the member who shared his story regarding his health enrollment experience, articulated his encounter in a way that demonstrated a clear and precise understanding of the enrollment process and was extremely adept at conveying how enrollment improved his situation from his own perspective he was able to move others toward enrollment, which conceivably improved their health circumstance much like the turning points and the resulting actions taken by the DE workgroup members in phase I of this research analysis. Findings also suggested that sharing stories allowed the identification of unintended consequences which helped the pastor to address adaptive health challenges at the church. This was found in the data where the member shared her testimony about her fears and experiences with mental health. She developed a close friendship with the church member she mentioned, and the ensuing relationship helped build trust that that has potential to support organizational sustainability. This member sharing her story at the testimonial focus group also led to unintended consequences such as the pastor finding out about his member's mental health condition which led to a routine meeting with the member. The more-significant finding here is that is it gave the pastor the opportunity to address a particular health of one of his members as a result of the member sharing her story.

2. Does the development of health programming build the capacity of church leaders and members to engage in evaluation and reflection? If so, how? What factors support building an evaluation capacity?

Developmental Evaluator

The case study data also revealed insights into the evaluator's skills to lead a workgroup in the developmental innovation. The evaluator guided the inquiry on how to ameliorate the issues described in the problem statement. The evaluator's primary functions on the team were to elucidate team discussions with evaluative data and logic, and to facilitate data-based decision making in the developmental process (Patton, 2011).

The fact that the evaluator sought to confer with the note taker and the workgroup chair verified the evaluators the attempts to make the work session truly a shared process. The evaluator's use of preexisting tools such as videos, movies and equity tools revealed an interest to appeal to the group members in an objective manner. This is important to note because of the evaluator's close relationship with the group members. The findings further demonstrated that the leadership was very supportive of the workgroup's efforts to be engage members in the DE process. Researcher observations indicated that the DE workgroup members were excited and encouraged as they prepared the questions for the congregational needs assessment and discussed the strategy for developing the logic model. Additionally, findings from the congregational needs assessment provide evidence that members from the Community Church maybe experiencing higher rates of chronic disease as the literature reflects that African Americans ages 50 and older are living with more chronic illnesses when compared to other Americans (Community Tool Box, 2016). This assessment result shows the need for health interventions that address chronic related issues at the church. The assessment results also corroborate a running theme that has surfaced in most of the data collected throughout the study that suggests greater participation from the women at the church than men, this further strengthens the need for gender specific delivering in health education at the church and provides a stronger argument for why women are viewed as doing more than men when it comes to health activities at the church. This assessment finding could also be used as a talking point for recruiting men when engaged in health planning at the church. Employment status was

also an important finding of the assessment data as it is a determining factor in the cost of insurance enrollment in to the health care market place. Additionally, findings from the assessment indicate a need for activities that not only addresses individuals but that also address health issues concerning their families which is evident by the response to the assessment questions "do you or your family members have health conditions". A significant finding from the needs assessment was that congregants was the level of disclosure regarding what health and medical problems they had; in my opinion, this level of disclosure suggested a desire for assistance with their health issues, which provided more evidence of the need for a health ministry at to help ameliorate the health concerns of the congregants. Furthermore, the assessment responses provided information with regards to specific health conditions of the membership. This can be seen in the assessment data the shows a breakdown of the chronic related illness suffered by the church members. Having information about diseases as diabetes and hypertension also helped with health planning because those were common ones that many members had themselves or had in their families. Inviting certified diabetes educators to deliver to facilitate the events would be a logical (and practical) way to address a need for health literacy. It is important to note that the respondents wrote different descriptions for these chronic conditions such as high blood pressure, hypertension, sugar diabetes and diabetes, this finding shows a need for the diversity in language among the African American community and it also confirms that African Americans are not a monolithic group, which strengthens the need for understanding of this diversity when conducting further health planning at the church. The logic model helped to develop an inventory of assets available in the church and provided an understanding of relationships among available resources to operate programs.

3. What are the unique assets of the church that inform organizational learning? (Prayer, sick and shut in, marketing, encouragement).

The data presented numerous examples of assets unique to the church that inform organizational learning. Workgroup members views on what a dedicated health ministry should provide

members with highlighted the following: resources and messages related to national health observances, assistance for members who become ill during Sunday service, health insurance enrollment events at the church, and visits for the sick and shut-in. Further discussion revealed that these actions were already taking place at the church, therefore, the members commented that they should continue as part of any new health groups established at the church. Additional assets include various auxiliaries and other ministries at the church, leadership connections, relationships and networks and members. These church ministries are responsible for teaching and training congregants in a variety of areas from Sunday School that provide a host of life lessons associated with the teachings of the bible, youth ministry which assists in training the youth in life lessons and preparing them to become adults. These same training and techniques can be used to provide congregants with information regarding health and health behavior, which was a theme presented in several areas of the data collected in the research study. This finding suggests that the existing organizational infrastructure related to other ministries and education and training is suited for health ministry and health education. Additionally, there is value and opportunity in the older population engaging with the younger church members working together with the older members to from each other which has potential for increasing organizational learning that could shift the culture at the church.

Lastly, the researcher's first attempt at data segmentation uncovered assets at the Community church such as meeting rooms, member skills and expertise, funding, specific leader and greater access to the community. These can all be viewed as strengths found in the church that support organizational learning. These assets were mentioned in the notes from a DE workgroup meeting. Several comments were made by work group members during the logic model development meeting. One member in particular mentioned that we should tap into the existing expertise at the church when planning events such as CPR training and safety awareness as we had people in the church with these skill sets.

Resources and assets such as testimonial service, love, trust, family and faith in prayers for healing can be found in the data throughout the study. More specifically, the testimony provided by the church member who shared her story about her experience with breast cancer touched on all if not most of aforementioned assets. She shared that she wanted to tell her story to help educate the young adult women in the church to be aware of the signs of breast cancer. Accompanying members to the doctor, providing encouragement and the empowering sermons from the pastor regarding health are all benefits unique to the church that help to act as influencing messages for the members

Emergent Constructs

1a). Are there any differences by gender preference for health care and health planning at the church?

Gender Preference for Health Care and Health Planning

The workgroup member's comments revealed issues related to gender biases and health. The initial lack of male participation in the DE work groups and the comments made by workgroup members in the meetings regarding a member's husband's desire to be treated by a medical doctor of the same gender indicated differences in gender preference for health care and health planning at the church. Additionally, the workgroup sessions on the ACA rollout also showed evidence of the importance of the males at the church taking an active role in health events. This assumption was confirmed by the group

member's discussion regarding community canvasing and the comments made regarding the men recruited to help with this effort. The feedback the researcher received from both the men and women at the church who participated in the focus groups conducted corroborates the pastor's sentiments expressed during his interview. One could conclude that the men at the church were interested in participating in a smaller formal learning environments that addressed particular health issues specific to their gender. This was evident when they responded to interview questions about their limited participation in the DE workgroup meetings as well as the pastor's interview comments concerning more work on health activities were done by the women in the church. Additionally, when the researcher examined the data from the women's focus group regarding the limited male participation in the health events and activities at the church the finding showed that they were under the impression the topics focused on male health. This could lead one to conclude that there needs to be more discussions with the men about health topics that they feel are to pertinent to them. It was apparent from the focus group discussions that the men and women had different views regarding health planning at the church. This was further confirmed when the researcher compared the emerging themes from the DE workgroup meetings regarding gender preference in learning. As noted in the DE workgroup meeting data earlier males preferred to receive their medical care from male medical providers and their views about health conditions and the treatment of these conditions were really not based on fact but mostly conjecture. This could be viewed as an opportunity for the leadership at the church to work together with the DE workgroup members to infuse change into the culture of the church relative to health and gender preference—this could be further facilitated with a dedicated planning discussion that bring the two groups together to work toward better health.

Additionally, when examining the needs assessment responses by gender there are a few difference noted, the survey findings show that women are more educated than the men at the community

church. The needs assessment survey revealed that some women have a doctorate degree where the male respondents reported having none. This difference in education levels suggests that women have more potential for being more knowledgeable about health issues. This information corroborates what was discussed in the DE workgroup meeting regarding the education and training, these discussions reveled that women were more competent about health issues and were more willing to share their knowledge with family and friends. Although there was little disparity between the other gender responses as indicated by the needs assessment responses related to health the comparison of the gender data indicated that the women have less poor health habits when compared to the men. This finding was also confirmed by comments made during the all-male focus group when one group members stated that "women are better at taking care of themselves than men". It also sheds light on the Pastors comment that women are more active in health planning and health events at the Community Church. The data also shows evidence that women have more financial problems and that men. Additionally, the results of the congregational needs assessment indicated that men reported being more underinsured that the women. This finding suggest that women have a better sense of the importance of going to the doctor than their male counter parts. This could also account for the more female involvement with the ACA health insurance enrollment as observed by the researcher during the ACA rollout events at the church. Although the data revealed women as having slightly more financial problems than the men both groups are able to meet the financial requirements associated with health insurance eligibility which states that individuals must show financial income of some measure to enroll.

Although there was not much difference in the men and women regarding learning and taking active steps about health on all levels there was differences displayed regarding their views on learning and take active steps on medical issues at all levels. Females were more interested in the individual level than men which strengthens the evidence that women are more involved in health activities at the church. Lastly, the men were almost twice more interested than the women in learning about and taking active steps for the medical care of the community which presents an opportunity for men to engage in health

planning at the community level as opposed to health activities at the church. This finding is very important to note when planning for health events that involve the community, it also mirrors the comments made by the only male participant in the DE work group who commented that men were engaged in the ACA health insurance enrollment events by conducting community canvassing.

2a) **Do church based social networks influence learning?**

Critical Reflection Moving Members to Action

Going back to the workgroup members to engage them in more critical reflection allowed them the opportunity to receive more education about equity at the community level. It also provided them with a framework for a greater understanding of the equity work they were already engaged in at the church. Given the comments made by the workgroup members an assumption could be made that attending to the individual health of the internal congregation was actually addressing the community members because members from the surrounding community attended the church. Additionally, it appeared that members were conflating the concept of equality with equity because one member suggested that the workgroup was making an effort to address health issues specific to the African American community, therefore, it was leveling the playing field by attempting to reach this specific population group at the church. An important finding to note is that members continually learned from each other during the workgroup meetings as well as coming to mutual agreements within the workgroup sessions. This can be substantiated by the comments made by the male workgroup member who stated that he was personally involved with community canvasing and he knew first hand that individuals from the surrounding community did not necessarily attend the church. He also confirmed that an engaging the larger community could be a value added benefit for the church because an

unintended consequence could be an increase in membership which the group had not considered up until that point. Furthermore, this second look into the equity discussion reveled that one had to be purposeful in efforts to introduce it into the health planning activities which let the members know that they had to do some work to get results. Because of a workgroup member sharing knowledge of an existing tool to ensure equity in planning, the other group members were able to engage in the use of another preexisting tool to help with introducing equity into their health activities. This proved to the group that they did not have to reinvent the wheel when conducting health-planning activities; it also makes them aware of tested tools and instruments available that can be tailored to meet their needs. Further, this suggests that given the opportunity to explore and share information with each other the workgroup members learned an evidence based approach for increasing equity by taking part in an intervention that supported sharing and learning new ideas from each other.

2b). Is the involvement and participation in the church between men and women different related to health activities?

What is the leadership culture in the church? (Men vs. women).

Additionally, observations of his leadership style suggested that the pastor is very open to partnering with experienced individuals who can assist him in achieving goals he has for the church. Furthermore, based on the conversation with the Pastor, it was clear that he recognized his limitations: he knows he is not capable of leading and implementing health programs at the church by himself and that he needs to delegate specific tasks to others, particularly to those within the church infrastructure. He seemed to demonstrate support of smaller learning communities because of the way he responded to the researcher's questions regarding past health initiatives at the church. He mentioned that

although there were some efforts to host health programs and health related activities at the church, they were not sustained. Most notable in his comments were that he allowed others to take the lead and was supportive of small group activities conducted by the women at the church. The comments shared by the pastor related to productivity and differences in gender at the church bared a subtle resemblance to the observations made by the DE workgroup member's comments that male participation in work at the church is limited. It was evident from the data that the leadership culture related to health planning at the church is one where women take the initiative to conduct heath events and health activities. Although the data suggests that the women are more active in that role at the Community church conversely the external survey data presented a different case in that men and women were equally involved in the health planning activities. This could indicate a variance in leadership culture between the external churches and the Community church and could stem from the Community churches pastor comfort level with allowing the women groups to conduct the health activities.

2c). What data gathering techniques and discussion promote a commitment to health equity related work among church members?

Testimonial Story Telling

Findings from the data showed evidence of the impact of storytelling on other church members and how the likely application of the knowledge shared through these stories contributed to the leadership's capacity to address adaptive challenges at the church. Additionally, an argument could be made that because the member who shared his story regarding his health enrollment experience, articulated his encounter in a way that demonstrated a clear and precise understanding of the enrollment process and was extremely adept at conveying how enrollment improved his situation from

his own perspective he was able to move others toward enrollment, which conceivably improved their health circumstance much like the turning points and the resulting actions taken by the DE workgroup members in phase I of this research analysis. Findings also suggested that sharing stories allowed the identification of unintended consequences which helped the pastor to address adaptive health challenges at the church. This was found in the data where the member shared her testimony about her fears and experiences with mental health. Although a she commented that a close friendship developed between her and the church member she spoke of, the ensuing relationship that resulted between the two members helped to build trust that that has potential to support organizational sustainability, the more significant finding here is that is it gave the pastor the opportunity to address a particular health of one of his members as a result.

2d). Stakeholder Influence and Partnerships in Health Planning

Oftentimes the pastor needs help from external partners to assist him to address challenges facing the church membership, however, comments during the pastor's interview support that he has had past experiences with stakeholders that were not so fruitful. Data provided during stakeholder interviews regarding the need for pastors to be more educated about the ACA health insurance market place appeared to mirror comments provided by the pastor, who noted several times during his interview that he relied on others to help where his expertise and knowledge are limited. An additional external legislative stakeholder interviewed by the researcher who severs constituents at the church from the local community comments echoed the aforementioned comments and added further validly to the study given that he is also the minister of a church in the community. Findings indicated that his remarks were not only a call to action for the members to get regular checkups but he also expressed the need for education as well,

which were very closely aligned to the male focus group respondent's comments describing their desire for more focused education about men's health.

Similar to the findings from the storytelling focus group session, when communicating with other external stakeholders regarding health planning and how it could help to increase the leadership's capacity to address adaptive challenges at the church, the concept of storytelling surfaced. When interviewing an external local law maker her comments corroborated the importance of sharing stories between congregants but she also expressed the need for these stories to be shared at a higher level. Her comments also confirmed that these same stories regarding health care enrollment events at the church, and the health resource materials they receive from the local community health center's health insurance enrollment navigators would further provide proof of the church capacity to become a learning organization both internally and externally. Findings from the marketplace enrollment navigator's interview revealed that having a relationship with the church and being given permission to visit the church during health insurance open enrollment season was very helpful for getting people signed up. Observations of their enrollment efforts at the church also indicated that because they were seen by the church members as trusted agents from the community health center they were more easily accepted by the church. This conclusion is based on observations and well as comments made by ACA enrollees interviewed at the church. Additionally, these Navigators, lived in the community, occasionally attended services at the church and followed up with the congregants by calling them outside of the registration events.

Lastly, when examining information across phases I and II to determine whether health planning at the church has the potential to increase health equity at the larger community level, I noticed a contrast in the way the DE workgroup members were defining health equity and the definition of the external stakeholders. The stakeholders were addressing equity in much broader terms than that of the workgroup members as found in the data resulting from the stakeholder interview question asking for

their definition of equity. When comparing the comments with those from the DE work group members, there was a noticeable difference. Findings indicated a lack of communication between the workgroup members and the local representatives regarding what health equity issues exits at the community level. These findings also implied a need to engage the stakeholders in health planning at the church. The stakeholders in this research study offered a unique opportunity for both the church leadership and membership to share their stories outside the boundaries of the church; they also possessed information regarding equity unique to that found at the church that could further the efforts of the DE workgroup member to address equity at the lager community level. Likewise, this information together with the other perspectives on health planning at the church discussed previously helped to improve the knowledge of individuals at the church and supported building an evaluation capacity.

Phase III:

4. What lessons learned from this process can be transferred to other African American Churches?

Transferability Findings

Researcher analysis of the results of the external minister's survey revealed some resemblances in demographics to that of the Community Church. For example, similarly, to the needs assessment results, the ages of the external churches range from 51 to 68. Also, the external survey data showed a greater number of married people as well as a majority of members with higher education. This information is important when developing targeted health messages, as the messages should align with the audience's level of understanding and experience. While the survey from the Community Church revealed a greater number of members still working, the external survey showed an equal number of employed members as retired congregants. This suggests the need for a variety of approaches to health insurance delivery for

example, ACA enrollment and Medicare information are both needed. According to the external survey results, diabetes was the number-one health issue of the congregations with hypertension and cancer stated as the next prevalent ailments respectively, this is also very similar to the needs assessment results that pointed to diabetes and hypertension as the leading health issues. The survey also uncovered a desire for health programs at the external churches. There was an overwhelming affirmation from the external respondents that more women than men attended their congregations. This finding parallels the information disclosed in the needs assessment and provides a possible explanation for why health planning is more of an activity undertaken by females at the church which was a finding revealed earlier in this research. Survey responses also suggested that although there was no formal effort to conduct enrollment events at the church there was an awareness that members were interested in enrolling and shared that information with the church leaders at some level. The external members interests in the ACA Health Care Market place is an indicator that the ACA could be used by other churches to further health planning that leads to the development of a formal health ministry. The external churches reported using marketing strategies to announce the enrollment events similar to those used by the Community Church. They reported using church bulletins, websites, Facebook, church announcements and flyers. Based on researcher observations, these marketing strategies were also used by the church central to the case study. Use of similar marketing strategies implies a common infrastructure that has shown merit for getting the word out to congregants and individuals external to the church. This further demonstrates the potential for transferring methods to for health planning to other churches. The external responders also confirmed that they sponsored national health observance (e.g. American Heart Month, Prostate Cancer Awareness Month) much like that of the Community Church. This was a very strong indicator of transferability of procedures used by the Community Church to support health planning, particularly because these were methods foundational to this case study.

A few of the external ministers reported not having a health ministry; however, they did report having analogous ministries to that of the Community Church such as: usher board, choir/music Dept.,

Deacon/Deaconess Board, food committee, hospitality committee, adult Sunday school, children Sunday school, fiscal and trustee ministry, pastor's aid, supper saints - 55 and up support group, prison ministry, young adult ministry, dance ministry, and women's ministry; further substantiated the cross sharing of best practices as the organizational structures of the churches are much the same. Furthermore, the mission of these other ministers described by the external church implied an association between healing and spirituality. They also infer a sense of empowering members to make informed decisions regarding their health and the health of the greater community. Again, as noted above, this is a distinction that only exists in the church which helps to further health interventions in a way that cannot be found in other organizations seeking to address the health of its members.

Lastly, findings from the external survey regarding leadership, organizational structure and partnerships uncovered correlations to the Community church that further validates the transfer of research methods used in this case study. Particularly the survey findings that show a limited knowledge of what is involved in a formal partnership as well as the lack of existing partnerships as at the external congregations. This revelation suggested the need for more education regarding partnerships and how they can impact health, similar to the recommendations made for the members from the Community Church. The above health ministry missions are inspiring and provide a nuance of education and the need to address the member's health from a universal approach that provides an array of health information and materials. Moreover, this strengthens the case for employing strategies amongst the ministries at the church to assist with health planning much like what occurred during the case study. These statements are much the same as those that emerged during the researcher's case study observations, the DE workgroup meeting notes, the pastor's comments and the gender specific focus groups that took place at the Community Church. This further highlights the importance of placing emphasis on gender-specific approaches when planning for health interventions.

There was an overwhelming affirmation from the external respondents that more women than men attended their congregations. This finding parallels the information disclosed in the needs assessment and provides a possible explanation for why health planning is more of an activity undertaken by females at the church which was a finding revealed earlier in this research. Findings from the external survey also indicated that story telling was also a common practice at their churches. The external survey comments related to testimony service and health is yet another example of what enabled this research study to be effective in the boundaries of the church that would not be plausible in other organizational settings. The overwhelming positive responses received by all research participants confirming use of these practices at their church illuminated a unique aspect of the church and supports transference of methods in a way that would not be effective in other settings. As noted in the findings, the aforementioned activities substantiated continued fellowship with family members and further builds relationships with individuals both internal and external to the church which can be challenging for other organizations. More specifically, the external survey responses, as well as the data gathered internal to the church touted an association between prayer, faith and healing. This was validated by the examples of testimonial stories shared by the congregants of the external survey which revealed how they progressed through sickness as well as reports of someone who had been healed or had a report from the doctor.

CHAPTER 6: STEPS, APPROACHES AND TOOLS NEEDED TO IMPLEMENT A DEDICATED HEALTH MINISTRY

Introduction

This chapter provides greater detail about the important steps taken when the Community Church underwent an internal process of community health planning. The findings from this process then present public health leadership a realistic approach toward increasing access to care and reducing health disparities, ultimately leading to improved health for African Americans. Insights are presented from this intervention that demonstrate an increase in health equity and support self-directed change occurring in the health of African Americans. The evaluative context of this research shows that sharing personal experiences related to health and investigating existing organizational resources to drive health planning ultimately lead to the implementation of a dedicated health ministry at the church.

Steps

Health Ministry at the Church

The DE workgroup voted to institute a dedicated health ministry at the church as a result of the intervention they co-conducted. This research study increased the evaluation capacity at the church which in turn empowered the membership through the introduction of new tools such as logic models, needs assessments and surveys. Currently, the workgroup planned to use the increased capacity to gather additional data to develop an action plan for the health ministry to implement during the upcoming calendar year at the church. The additional knowledge exchanged via storytelling, focus groups and interviews that examined the internal processes at the church, also helped to drive change. The church also learned the importance of building relationships that sustain membership and organizational growth.

As well as implemented a real world approach to ensuring equity measures are a routine part of their health programming at the church and in the surrounding community.

It is clear to see that the church has made progress since taking part in this intervention at the church. The members are now taking more of an active role regarding health programs and events at the church. For example a member of the workgroup committee donated an informational pamphlet and resource stand so that health information could be displayed more prominently at the church. Additionally, the leadership is more aware of the health status of the membership at the church as a result of a summary of the data findings from the intervention that took place at the church. The church leadership is also interested in utilizing methods employed in this case study to such as the needs assessment and the health equity checklist to determine gaps in services and resources at a higher church organizational level. The church has re-tooled its website and has offered the health committee members space to market and advertise upcoming events at the church. Church are seeking out information about health insurance enrollment and are looking forward to open enrollment season. Leaders from one of the external churches has requested help with assessing their capacity for health planning at their congregations. Most notably members have expressed how much they enjoyed taking part in the DE process and commented that although they it was a time consuming intensive proves they enjoyed learning from each other and the comradery shared by the group. They commented that even though the work was hard is was beneficial because it gave them a sense of accomplishment to know that they tackled the development of the health ministry at the church. Most notable is that members are taking a more active role to address health on an interpersonal level as well as a community level thereby engaging in health equity. Evidence of this can be found in that a member of the DE workgroup committee has taken part in a PSA for Breast Cancer awareness that is being aired not only in the church but also being shared by different media outlets in the community thereby helping to increase health equity.

This case study presented valuable information on successfully engaging a Black church when implementing health interventions geared for the African-American population. Study results identified the processes and steps members of the church were able to take for themselves as they were guided through a way to innovate church structure and practices for health program planning and implementation in a way that fosters lasting systemic change representing collective views, beliefs, and tenets of the church. To the professional literature, this study contributes strategies and tools that can be used to raise awareness of social determinants of health in the African American community and ways to work toward health equity. The research also equipped the church members to come together to design health interventions that helped them make informed decisions about their individual health and support health decision-making of individuals within their community.

Reflecting on practices and process inherent to the church provided a framework for the Community Church members to conceptualize the actions they needed to take to address health planning at their church. The research participants shared their past experiences related to their health and performed newly acquired evaluation techniques that helped drive sustainable change regarding programming at the church. The study participants engaged in data collection and program planning such as logic model development, which helped determine existing assets for short and long-term goal-setting. The study recorded the process through systematic data collection and analysis of a numerous sets of feedback, insights, and perspectives. The process also helped to characterize the church as a learning organization, whose members can address adaptive challenges related to improving their health. Findings also revealed the benefits and value of engaging internal and external stakeholders (relative to the church), in terms of achieving a sense of personal interest and investment needed to help improve the health of church members. Moreover, lessons learned proved to be transferable to

other churches through a detailed comparison of survey data collected and analyzed from other similar churches.

Lessons Learned

Given the exploratory nature of this investigation, lessons of best-practice were developed that have the potential for adaptation by similar churches. While the best practices described below are specific to the efforts conducted at the Community Church, they also provided a guide for others engaging in innovation and change in similar community settings. The act of gathering baseline information on the church's membership before attempting to engage in health planning or health interventions was a valuable lesson learned at the outset of the research study. Examples of useful demographic data acquired from the congregational needs assessment revealed that there are more female members than males with most having some level of college or technical training. Additionally, most of the members at the Community Church are married and currently working for wages. The needs assessment also revealed that most of the survey respondents were eligible to enroll in health insurance through the ACA Marketplace because they were working and had some form of income during the year prior to enrollment, which is a requirement for receiving health insurance through the ACA Marketplace. Because the majority of the members of the church were married, their health decisions affected their entire family. Additionally, the information we gathered showed that the most widespread chronic illnesses are diabetes and high blood pressure. Another lesson found that members described high blood pressure in various ways, some wrote, high blood, high blood pressure, while others reported it as hypertension. Understanding the variations in the language used to describe these sicknesses as well as determining the most pervasive chronic related illness amongst the membership was important because it helped to tailor health interventions planned by the members of the church.

As a result of the DE workgroup member's comment and meeting notes, we learned that there was a need for gender-specific delivery in health information. A more specific-finding was that men wanted precise education about male health issues in all settings; women, on the other hand, seemed

slightly more health-conscious overall than the men and more involved in health programming at the church. The study concludes that a key lesson here is to take the male perspective into consideration when planning health programs. The needs assessment data showed that most survey respondents were interested in health education for themselves as well as for the congregation and that small workgroup teams appear to be the best approach to health delivery at the church. Moreover, the members wanted to get their health information from subject matter experts and preferred receiving evidence-based resource materials, such as fact sheets and health brochures.

We found that strong leadership involvement such as the pastor's participation along with other leaders at the church was critical to the implementation of health planning. The analysis revealed that the pastor relied heavily on his spouse to get information regarding health initiatives at the church. Also, most members involved in the inquiry were already working on some other auxiliary at the church. This outcome revealed cross-learning among groups at the church were occurring, which helped to further guide information about health planning throughout the church. It is important to note that everyone, particularly those on the leadership team, needed to be made aware of the health planning activities so that they could serve as informed ambassadors for the church with the ability to communicate a consistent message to help individuals in the church and in the community in a way that will further the capacity of the church to become a learning organization. This could further disseminate and spread the word about the health events occurring at the church.

Another essential lesson that resulted from this exercise was to capitalize on the existing organizational infrastructure at the church such as testimony service to share relevant experiences related to health and use of the current church infrastructure such as its other ministries and auxiliaries; doing so helped to get the word out about health planning. The members of the church learned that partnerships were a crucial aspect of health planning at the church. Partners were instrumental in introducing current, relevant information on preventative health initiatives as well as providing the most updated health

insurance enrollment resources. Partners were also very influential in helping to get individuals enrolled in health insurance at the church, they found the church to be a comfortable environment, and because they frequently participated in enrollment events, they developed a rapport with the church members and the enrollees. Use of evaluative tools such as surveys, focus groups, interviews and observations helped to leverage the assets available within the church and the community to respond to adaptive leadership challenges. Additionally, preexisting tools such as the equity check list not only serves to enhance the church members practices that potentially impact equity and address social determinates of health at the church, use of such tools also help with unintended consequences related to attrition of health ministry members, the check list can be easily used by new members joining the ministry and also quickly adopted by other ministries in the church such as the food pantry Additionally, a useful lesson that resulted from this partnership was the documentation of the number of individuals that obtained insurance through the ACA Health Care Marketplace. This information helped shed light on the success of the enrolment events. Furthermore, we learned that collaborations with external partners such as the community legislators helped bring important health- related information into the church while it returned to the partners' important feedback, such as church member desire to participate in health insurance enrollment. Information for health planning flowed in and out of the church, between members and community leaders in the same way, such as when the community mobilized to prevent a local community hospital from closing. For details, see Figure 36 below depicting the flow of information in the system.

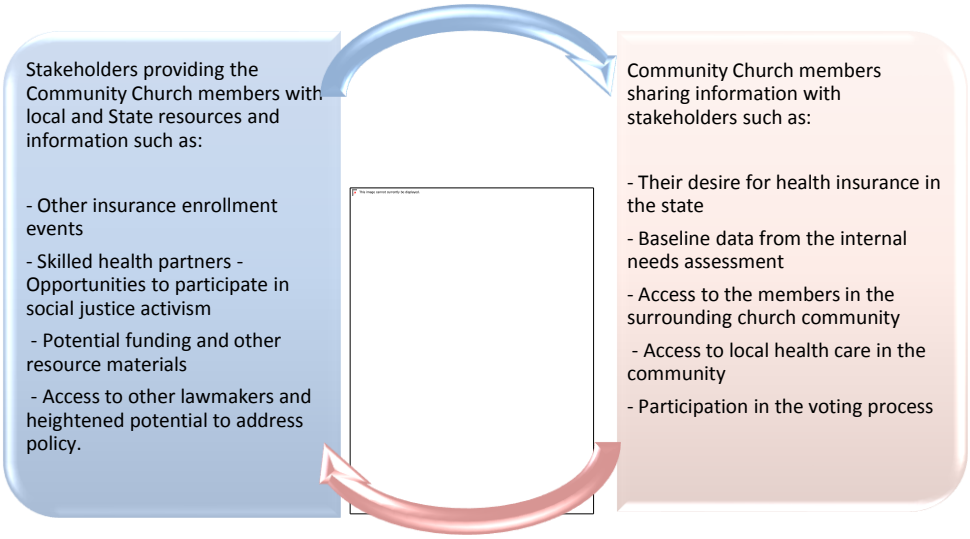


Figure 40. Internal and external heath information flow diagram

Minister's Survey

The use of an external minister's survey was extremely valuable to this research. Obtaining external perspectives from similar churches corroborated the research study's results as well as strengthened the innovative approaches taken by the Community Church. Engaging other local pastors in the study could encourage their membership to attempt similar activities undertaken by the Community Church to engage its members in health planning, to institute (or fortify) a health ministry in a systematic way, it also provided proof that the assets characteristic to the African American Church, such as church ministries/auxiliaries and the long-standing practice of testimonial service can be used to assist a pastor trying to face adaptive challenges related to the health of a congregation, as well as the larger health of the community. The accounts shared by members from the Community church were further substantiated by the external survey respondents regarding how prayer and encouragement for the sick and shut-in and sharing of experiences through testimonials motivated members to take action

to address their health issues.

The Bible, states, “And they overcame him by the blood of the Lamb, and by the word of their testimony; and they loved not their lives unto the death (Revelations 12:11, King James). Findings from the data in this study suggest that the church members hold a collective belief that sharing their experiences through spoken word assisted in elevating health issues that they did not have control over; thereby validating the concept of the impact of spirituality on health. Through testimony, some church members even found the encouragement to address their health problems in ways they at first did not realize they could, thus achieving more control than they may have thought they had as illustrated by the member who shared she had mental health issues. The use of testimonial service shown both in the external and Community church, also suggested an expansion to the paradigm of living a well-balanced life: members need to think about healthy living, which requires more than just a regular checkup and report from the doctor. Furthermore, the idea of learning and sharing new concepts and practices--as demonstrated in the study and particularly in the results of the external survey--should include developing formal partnerships. Doing so has potential to empower the external churches to collaborate with entities that have a level of expertise to assist them to grow such as the health departments and lawmakers. This empowerment in turn helps to build capacity, both within the church and in its neighboring community.

Developmental Evaluation in the Research

Developmental evaluation in this research provided evaluative information that met the needs of the Community Church. DE was more suited to the dynamics of the social intervention undertaken by the church members because of their limited involvement and awareness of traditional and more dominant approaches of program evaluation. DE allowed the members to engage in evaluation in a manner that not only fit their circumstance but also supported their organizational environment. Given

that there was no previously accepted model for solving the problem of addressing health issues and health planning specific to the Community Church, DE evaluation served to fill this gap. Use of DE in this research study assisted in increasing knowledge capacity and skill building at the church. This approach helped to develop new partnerships and supported change in the practices at the church. Advantages to using DE in this research were numerous: it helped to develop new improved policies and programs at the church. DE also fostered continuous learning which was also a critical aspect of the improvement process that took place at the church central to this research study. An additional advantage was the emergent and adaptive evaluation design ensured that the intervention conducted by the church members had purpose and could respond in a rapid way to support the emerging issues and questions that occurred during the DE workgroup meetings.

The DE approach did have its challenges. It brought a continual need to meet with the workgroup members and other stakeholders in a climate of competing priorities. Unfortunately, the researcher found that many of the Community Church members participating in the study were also very involved with other activities at the church; therefore, attendance and scheduling could be difficult. Another challenge posed by the use of DE in this research is the volume of data needing to be managed by the evaluator. This was ameliorated in the study by the use of a note taker.

Role of Evaluator as Researcher and Practitioner

The researcher served as the developmental evaluator during this study. The researcher also acted as a strategic learning partner and facilitator, which differed from the traditional roles of most evaluators. In the role of evaluator, the researcher brought a complex systems orientation to the evaluation through engagement of other stakeholders and the introduction of evaluative tools that were new to the workgroup members. In this role, the researcher conducted sound strategic decisions that

involved all stakeholders and creative data collection such as the use of movies to spur discussion to determine the potential for development of a sustainable health ministry.

Relationship

The researcher's relationship with the Community Church began more than 10 years ago. The researcher's leadership philosophy entails having a vision that results in action. Helping the members of Community Church build their capacity to address health challenges both individually and collectively was also accomplished as a result of researcher participation. Her role as evaluator empowered others to involve themselves in health initiatives as well as reach out to members at the church in need of help in enrolling in the ACA Market Place Insurance. The researcher's role as the evaluator made a tremendous difference at the Community church. As evaluator the researcher took great strides to be objective and open minded and not drive her own agenda. Given the pre-existing relationships at the church and the positive results of the research, church leaders and members have asked the researcher to lead other initiatives at the church and in the larger community. These requests demonstrate the congregation sees the changes made as something positive and that they want these changes to continue. The researcher feels, however, that the congregation members have developed skills to take on new challenges themselves, with or without the researcher acting in a facilitating role.

Guiding Change

The researcher sought to facilitate the evaluative inquiry in a systematic and on-going way that resulted in better health outcomes for church members and helped them examine past and present organizational practices that fostered sustainable program development and implementation in the church. Attending key meetings at the church was an integral part of the process of guiding change. Additionally, during the second phase of the research study attending regular meetings with the pastor

and other church members was a necessary aspect to help guide change. The additional work of developing the needs assessments, attending trainings, drafting the logic model and the external minister's surveys for research participants to help guide the process was all instrumental in helping to guide the intervention at the church. Listening intently to the discussions in an effort to capture and document the emergent precepts was also and key part of managing and guiding change in the group. Conducting key informant interviews at critical junctures such as the interviewing the president of the trustee board as a result of the emergence of his role perceived as a critical one by the DE workgroup members. Regular document review of the workgroup meeting notes was a regular part of the evaluator's efforts to guide the workgroup members. Capturing Lesson learned was also a vital part of this research study used as a foundation for the development of phase three of the research but to also provide evidence of the transferability of the research findings in the study. Lastly, DE was extremely useful for developing a health ministry at the church because it supported the church member's efforts to discuss the personal experiences and share stories regarding their health in a way that moved them to take action regarding their health status. It supported organizational learning through shared information and experiences that allowed the very people with the issues to address it.

Leadership Implications and Recommendations

Leadership could potentially benefit from identification of the key formal and informal leadership structure in the Black church as a way to leveraging collaborative partnerships that work to address health issues in the African American Communities. Additionally, understanding the linkages among groups within the Black church and their assumptions about relevant health practices and their knowledge and education about health care services systems are plausible methods for addressing leadership challenges. Furthermore, engaging in processes to learn about past and current efforts to

engage church membership around health or related issues, understanding what worked and did not work — and why — as well as how those efforts might influence their readiness or willingness to become involved in future efforts again is a leadership challenge. Developing an increased understanding of the norms and values that exist in a faith congregation and how they may influence African Americans to participation in the health decision-making processes and their health behaviors can enhance leadership's ability to make a difference in other communities of color. Finally, public health leaders have a role to promote equity in communities through a greater awareness of how environment and living conditions effect health. It is important for public health practitioners to have real world examples of approaches to eliminating health disparities and inequities from individuals affected by these conditions. Use of DE as a means to increase equity and to conduct health planning that leads to a dedicated health ministry is important to public health leaders. Providing public health leadership with real world examples such as lessons learned for building a health ministry is essential. Below is a template for public health practitioners to use if interested in establishing a health ministry.

TABLE X. Useful Tools for Public Health Practitioners Supporting a Health Ministry

	Action		Reasons for taking action
1.	Recognition of the problem	1.	Acknowledgement that there is an interest to address the health issues of the congregation.
2.	Gain leadership buy-in	2.	Ensure leadership at the church are onboard with the process.
		3.	Make certain that the intervention fits with the mission and vision of the church.
3.	Recruitment of volunteers to participate in the intervention	1.	Develop flyers and letters requesting volunteers from the organization to participate in the exploration of health planning at the church.
4.	Discussion of the issues related to health	2.	Explain the context of what is being accomplished, share the schedule of planned activities.
5.	Collection of baseline data	3.	Develop and employ evaluative tools to assist with data collection such as a needs assessment or logic model.
6.	Discussion of gaps in services	4.	Hold ongoing discussions regarding the needs that result from the survey and began to explore how to address the gaps.
7.	Build a partnership with and evaluator	5.	Look for evaluation expertise from among the congregation as well as in the community external to the church.
8.	Contemplate the evaluation approaches carefully	6.	It is important to note that evaluation methods may not work well for all churches. Consideration should be given to the stage the church is in regarding their thoughts about a building a health ministry. Also given the role trust played in this study it should be given attention when considering evaluation models; for example, other participatory models might be the right fit, use of other empowerment evaluation models might be more suitable.
9.	Emphasize use of practical tools	7.	Use of a tested evidence based equity checklist to help guide implementation of increased equity engagement.
10.	Seek and utilized external partnerships	8.	Development relationships with individuals and organizations that can assist with health planning efforts. Begin to recognize planning from a systems perspective.
11.	Ability to analyze data, capture lessons learned	9.	Develop findings from the data collected to use as lessons learned to share with external churched.
12.	(Data Party)	10.	Share information and results with those involved in and affected by the intervention.

Recommendations

Given that data from this study presented views and insights from church leaders and their congregants on ways to implement health planning and health activities in the African American church that further promoted heath equity, these recommendations are geared toward two primary audiences: the public health practitioner and the church leadership.

For Public Health Practitioners

The findings from this research strengthen the need for public health practitioners to have a greater understanding of innovative evaluative approaches that provide direct access to data from the population in which they intend to serve. Unfortunately, because of the overwhelming need to address chronic related illnesses in the African American Community and because of the complexity that exists within this population, approaches to health planning for this population need to be novel and provide immediate tangible benefits for those it is intended for. Because of this, greater emphasis is placed on public health practitioners to explore health interventions that are atypical to those currently in use. In this case study the findings demonstrated that health planning occurred in the context of uncertainty. Although, decisions were made without having a clear picture of the outcome, the affected group was able to provide input on what health planning worked best in the past, the nature of their current state of health and what action they could take for improvement. This research study supported change in an

environment specific to the African American who participate in this organization in a way that public health leadership could learn from and use in future health interventions.

Public health practitioners could benefit from knowing that in there is connection between storytelling and inspirational healing. As noted in the results from the Community Churches data analysis and the reported data in the external minister's survey; story telling was found to be an extremely valuable and effective technique for sharing health information among the congregants. The sharing of information increased the member's knowledge and awareness as well as encouraged inspirational healing. Equipping public health practitioners with the insights gained from this research related to using the power of relationships and connections between the powers of testimonial help strengthened the church members. Use of this information by health professionals could provide a guide for building inspirational healing action steps into their health interventions particularly in those interventions implemented in the African American church. The findings in this research add to the limited information that exists aimed at explaining gender differences in health in the African American community. This research supplies public health practitioners with a greater understanding of gender preference related to health and health planning. This study showed that men have a preference in the way they are educated about health issues as well as the health topics that will be presented to them. Additionally, as noted in the study, women were more flexible about health education and are more apt to work on health planning in the church. This is important for public health practitioners designing targeted health interventions for individuals in the church. The results of this study also has potential to provide health professionals with knowledge that by reaching out to the women in the African American church they are more likely to get health activities implemented as well as have some assurance that the men will engage in those activities.

Finally, a recommendation for health practitioners that resulted from this research is that stakeholder engagement is important when developing evaluation capacity at the church. As evident in the research findings having a collaboration with entities such as the ACA healthcare navigators and the local elected officials furthered the flow of information both internal to the church and external from the church. This cooperation fostered a connection between the personal health aspects of the church members and the very lawmakers that helped to develop and further health and equity policies. The research demonstrated that engagement of the legislatures with the church members connected the personal to the political in a way that validates and confirms the need for comprehensive health planning and interventions in public health practice.

For African American Church Leaders

The findings from this study provide a starting point for the Black Church to increase its engagement in long-term strategic planning. The results of the study demonstrated that the Community Church benefitted from learning new tools and techniques to perform evaluation and process building. Engaging the members in the use of a pre-existing tool such as the equity checklist helped to keep members focused on the community they are engaging and helps with sustainability of the practices and processes around health conducted by the members. The members of the church were able to use the needs assessment to collect data that provided a clear picture of the health state of the congregants as well as obtain collective feedback for moving forward with health planning in a way that addressed their needs individually and as a larger church body. Their engagement in logic model development provided them with a tool that assisted in evaluating the resources at the church and how they could capitalize on these resources to support long- and short-term health planning. Additionally, based on the information resulting for this research related to the organizational structure, the leadership could capitalize on this format further to deal with adaptive challenges related to the health of its members and health planning

at church. This could be accomplished through project delegation much like that suggested earlier in the study for the ushers to serve as first responders in the event of an emergency. Strategic planning could assist with the church leadership with the number of competing priorities that exist at the church.

Finally, I recommend the church leadership use these findings to facilitate a larger discussion on what it means to engage in partnerships with health organizations in order to sustain long-term formal partnerships that set goals, achieve them, and do what is necessary to be sustainable. Exploring the role and depth of good partnerships could serve as an opportunity for church leadership to come together with other leaders and public health practitioners to have a more detailed discussion on what this mean and how to accomplish it. Furthermore, this also offers

public health practitioners a chance to shed their systemic assumptions about partnerships and gain greater understanding about what partnerships are in a real world setting. Below is a table of steps to help leaders of African American Congregations form a health ministry.

TABLE XI. Useful Tools for Church Leadership Forming a Health M

inistry

Actions	Justification for taking the actions
1. Hold internal discussion with congregation about health	2. To allow the congregants to share their perspectives about health and to talk about how the church can address the health issues of its members.
3. Gain the by-in from the church leaders	4. Ensure the Pastor and other leaders are in agreement with the activities to support a ministry at the church. 5. Make certain that the intervention fits with the mission, vision and goals of the church. This also identify what evaluation approach to employ. 6. Allows the Pastor as a trusted messenger use the pulpit to deliver health messaging.
7. Establish a sense of trust for the project	8. Trust needs to be established early in the process because of the sensitive nature of health issues. 9. Articulate that you are looking to build on existing church resources and activities to maintain a sense of familiarly such

			as, visit the sick and shut in, testimony service, praying for member. Also gives those members if any, already engaged with health activates a sense of assurance that their work is still important.
10.	Seek out evaluative expertise in the church or local community	11.	Bringing a subject matter expert to guide the evaluation process. This will ensure that the work to implement the project will be accomplished by someone who has a background in helping lead change.
12.	Conduct an assessment	13.	This will allow the church to examine the gaps in service and help inventory resources at the church that can be used to assist with health planning.
14.	Educate the congregation on gaps in services future steps	15.	Hold ongoing discussions regarding the needs that resulted from the assessment and began to explore how to address the gaps. Ensure that regular updates are share with the members of the church about the progress (look at using existing assets at the church such as: newsletters, church announcements and church website)
16.	Build relationships with external stakeholder partnership	17.	Understand how formal partnership with external stake holder can support health planning at the church.
		18.	Seek out additional resources and services to help support the health planning project.
19.	Emphasize use of practical tools	20.	Educate church leadership on the use of preexisting tools to help guide the evaluative process such as the equity checklist used by the DE work group.
21.	Seek and utilized external partnerships	22.	Development relationships with individuals and organizations that can assist with health planning efforts. Begin to recognize planning from a systems perspective.
23.	(Data Party)	24.	Share information and results with those involved in and affected by the intervention.

Limitations

Each research method is a different way of collecting and analyzing empirical data, and each has its own advantages and disadvantages (Yin, 2009). A limitation of this study was the limited participation of church ministers in the external survey which yielded only nine congregational perspectives from the external churches. Although, the nine congregational survey results consisted of perspectives of more than 500 congregants, future studies should consider other sampling choices as it could assist with providing a larger survey respondent pool and help to strengthen the transferability of the research findings.

Because of the dual roles serving as researcher and DE facilitator, bias is an issue of concern for this particular research study. Opportunities for researchers to involve themselves in continued professional development related, for instance, to determining what is a substantive emergent occurrence and what is unnecessary within group facilitation as well as an expansions of qualitative data collections skills such as interviewing and leading focus groups is essential to producing quality action research dedicated to improving program development and change. This study, as a dissertation project, does represent a professional development opportunity for the researcher; however, that means that her skills improved over the course of the project, and this may have affected the results of earlier as compared to later data collection efforts and DE reflective sessions. However, given the researcher's positions as the evaluator as well as a congregant allowed access to information that may not have been otherwise provided. A noted disadvantage to the DE also serving as a congregant potentially increased input from some members taking part in the case study while possibly decreasing others. An additional drawback to also consider is given the formal male leadership role that exist in most African American churches gender may also be challenging when conducting similar research.

Conducting developmental evaluation in the Black church was a limitation of this study because of the competing priorities that existed. Developmental evaluation entails repeated group facilitation and because it is an iterative process the workgroup central to this study was constantly meeting and coming together even outside of the designated agreed upon schedule. Given, the constant challenges placed on the Black church to address the hopes and aspirations of the congregants as well as the community, it is important for researchers participating in comparable research studies to be cognizant of schedule demands.

Lastly, a limitation in this study is that transferability is only explicit to the churches where data is being collected from. Given that most African American Churches are not monolithic obtaining data from churches specific to the case study is needed. Additionally, the extent to which this study's conclusions provide evidence of transferability to the external church was predicated on data collection from the two churches in the boundaries of this particular research study. Therefore, this should be taken into consideration when attempting the methods outlined by this research.

Conclusion

Empowering underserved communities to take their health care needs into their own hands requires amplifying the voices of consumers while simplifying paths to obtaining and using health insurance. The concepts of participation, empowerment, equity, voice, sustainability, local ownership, and partnership are prevalent in the development and evaluation of organizational programs. DE is an emerging approach that is gaining the attention of funders and philanthropic foundations, nonprofit organizations, and traditional evaluators who are engaged in developing and testing new solutions to complex and persistent challenges in unpredictable environments (United Way of Calgary, 2013).

DE addressed the leadership challenges confronting the Community Church as it sought to adapt to the changing situation offered by the ACA, to highlight health disparities and health inequities in the African American community, and to propose meaningful program implementation to address these disparities. The use of the DE evaluative approach at the Community church unearthed the impact trust had on the intervention conducted at the church. The workgroup members identified trust as an impediment to engaging in beneficial health behaviors and recognized that trust was also factor in sharing health experiences that lead to decisions about changes to processes and practices at the church regarding the health of the congregants and the community. An increase in knowledge and awareness was acquired by church members as to difference in equality and equity and procedures adopted by the church to purposefully engage promoting equity at the community level through a simple assessment equity checklist tool. The evaluative inquiry conducted at the Community church revealed of gender differences that proved to helpful in providing evidence of what worked best for the men and what was more beneficial to the women regarding health planning. Examining this situation through a systems thinking lens, the researcher was able to provide an overview of the research participants and the

processes used for collecting thoughts and actions is real time which helped to provide a rich illustration of how the different parts came together to support this endeavor. The DE approach helped to integrate the elements of a case study approach e.g. multiple modes of data gathering with an action research approach using data analysis as an evidence base for action and facilitating desired change.

This researcher confirmed the church member's proven impact on self-directed, problem identification and subsequent knowledge generation which lead to the development of solutions based on their experiences is analogous to the process of action learning and action research. Through the use of DE, the congregants implemented change in and across organizational boundaries. Their work required iterative and reflective processes that supported new discoveries and sustainable change. Finally, the church leadership's value system was critical to the success of this research study. From start to finish the leadership at the church was very supportive and extremely interested in the research project. It is very important to note that the head pastor's influence and his desire to empower his congregants to make informed choices about their health was a factor that proved to be very important to the completion of this work and furthering health equity in the church and the surrounding community. Given the possibility of such support in other African American churches, as indicated by the results of the minister's survey, the process undertaken by the Community Church in this study offers public health and church leadership pragmatic strategies for health planning and introducing health interventions that can be transferred to African American churches in other communities and ultimately can lead to improved population health for African Americans.

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APPENDICES

APPENDIX A: TABLES AND FIGURES

TABLE A.I. *Clayton County Georgia Population Demographics*

Report area	Total population age 18	Estimated population with poor or fair health	Crude %	Age-adjusted %
Clayton County, GA	184,299	28,935	15.70%	16.90%
Georgia	7,121,933	1,111,022	15.60%	15.80%
United States	232,556,016	37,766,703	16.24%	15.74%

Community Commons, 2014.

TABLE A.II. *Evaluation Overview*

	Situation
Summative evaluation	A review of the effectiveness at the end of a program or initiative; useful when key decisions are to be made with regard to continuation or upscaling.
Formative evaluation	Useful when fine-tuning a model, or when baseline data are needed for future summative evaluation.
Developmental evaluation	Useful when working in situations of high complexity, e.g. early-stage social innovations (rural innovation).

Patton, 2011

TABLE A.III. *Overview of Socioecological Model and CBHP*

Level of change	Theoretical approaches and targets	Examples of CBHP strategies
Intrapersonal	Individual characteristics that influence health behavior such as knowledge, attitudes, beliefs, affect, and past experiences	Tailored communications Motivational interviewing
Interpersonal/social network	Interpersonal and group influences including formal and informal social networks and social support from family, friends, and church members to support healthy behaviors	Family programs Lay health advisors Support groups Witnessing/group testimonials
Organizational	Policies, facilities, and organizational structures, e.g., standing committees such as health ministry, which may help promote/maintain recommended behaviors within the church	Pastor leadership Church-sponsored education/events Bulletin inserts Policy changes, e.g., foods served Committees
Environment/policy	Neighborhood, community, or governmental resources, institutions, policies, advocacy, media activities, or other activities that improve the supportiveness and availability of healthy options for church members	Farmer's markets Produce discounts, gleaning Victory gardens Walking trails Community coalitions Increasing access to health care and low-cost screening/follow-up

Campbell, M., et al., 2007

TABLE A.IV. Survey Methods

Survey Methods Phase 3

Steps	Action	Resources	Analysis
1	Develop survey questions	Test survey questions and design during focus group with internal community church leadership	Triangulation /Atlas.ti software
2	Determine sample size	Purposeful sample	Spreadsheet
3	Determine the date and time the external minister organization in Clayton County GA will be available to take part in	Introduction letter, phone calls and emails to the external minister's	

	the survey	President.	
4	Attend external ministers' meeting	Disseminate paper survey face to face	Collect survey instruments
5	Collect results		Spreadsheets/Atlas.ti software

TABLE A.V. Summary of Data Sources

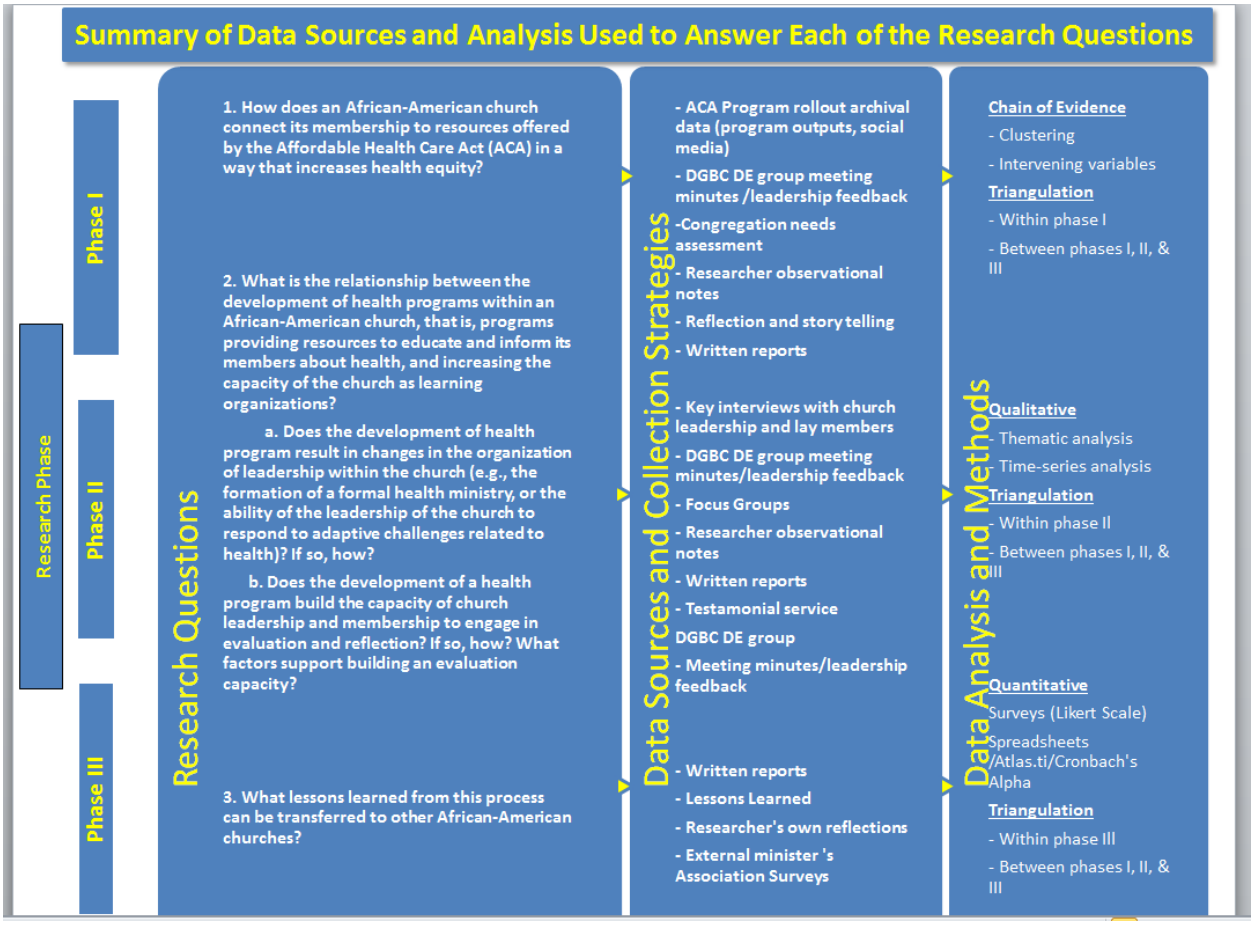


Figure D1. Conceptual framework

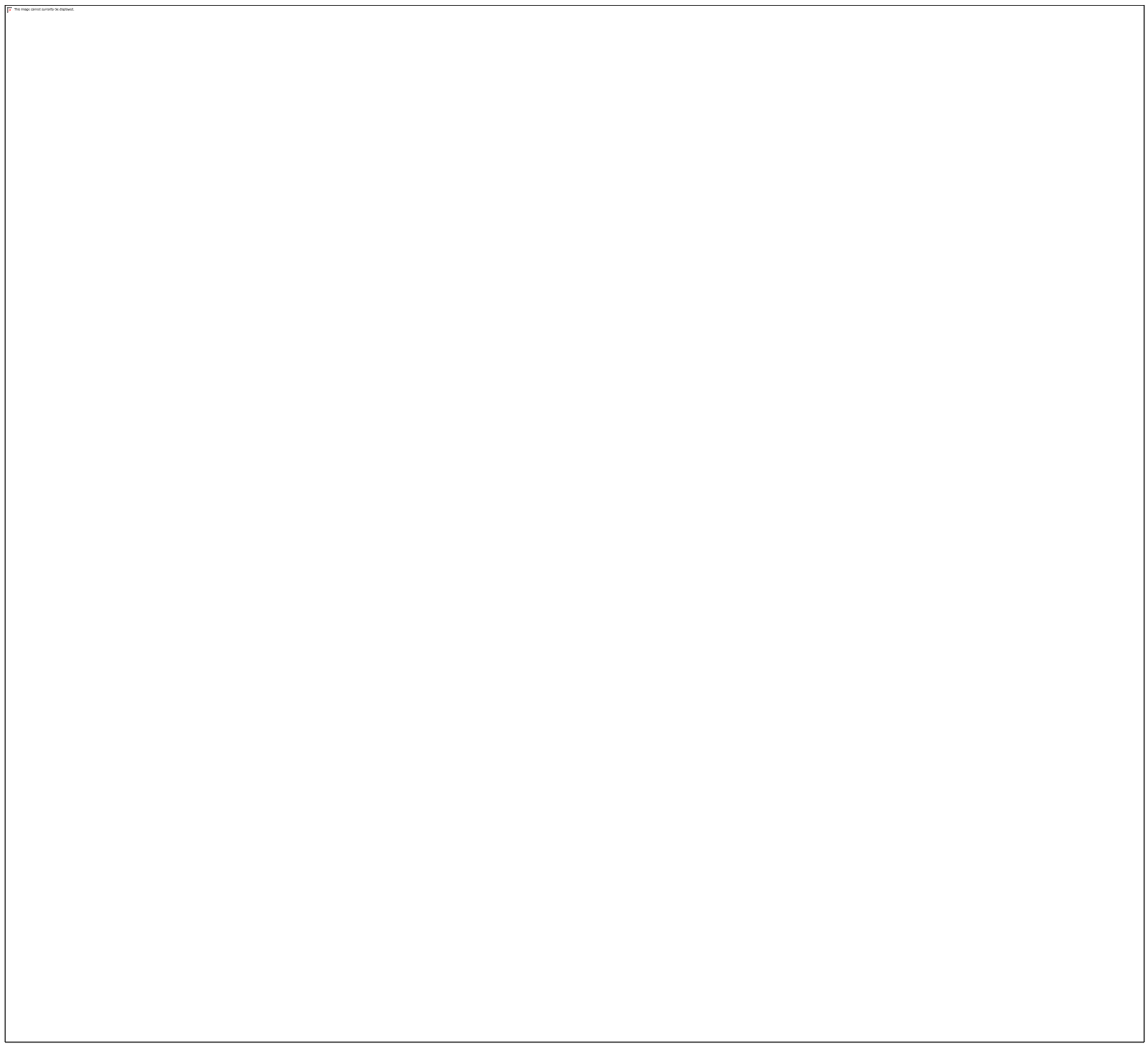


Figure D2. Developmental evaluation logic model.

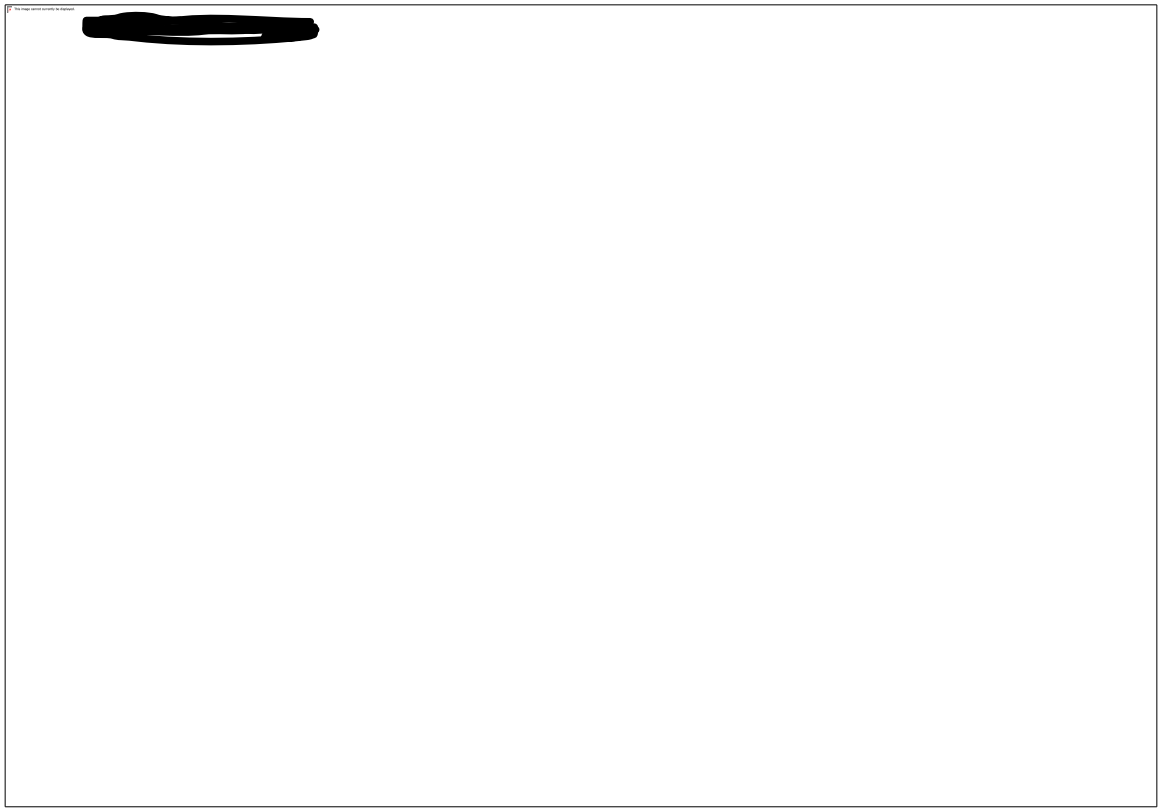
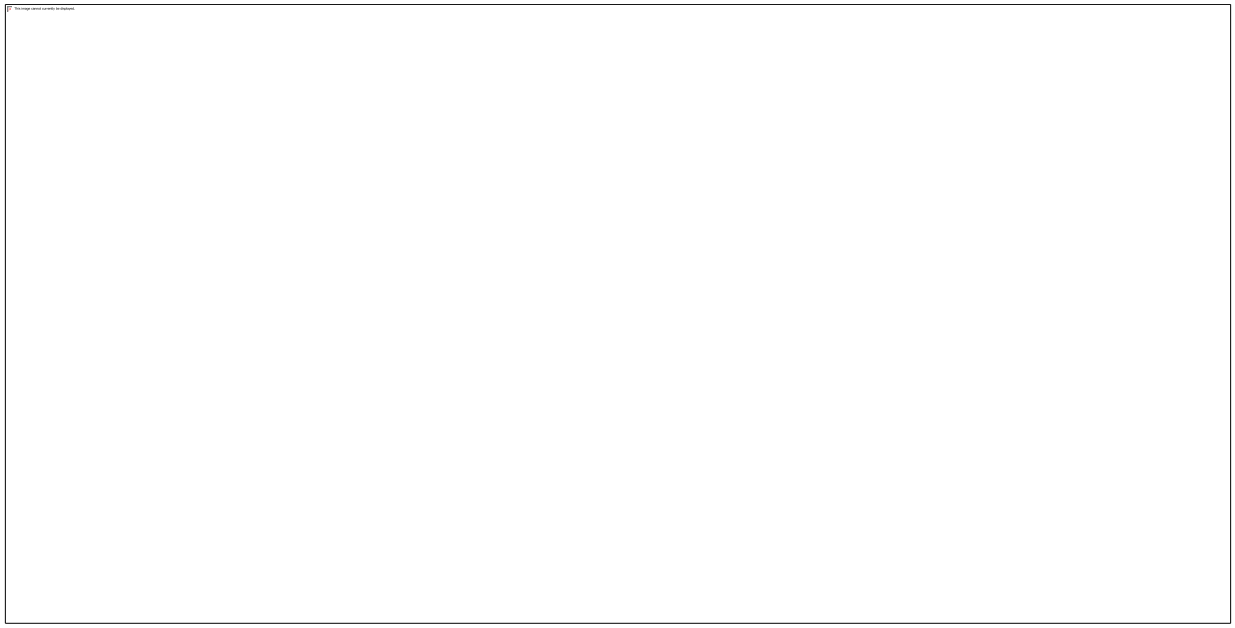


Figure D3. Systems thinking word cloud



APPENDIX B: LETTER OF SUPPORT

April 25, 2015

Dear Sister Rosalyn Bell,

May God bless you and keep you as you go through the process to obtain your doctoral degree from the University of Chicago at Illinois (UIC). I am proud of you for endeavoring to lift up your fellow church members in spirit and in health by offering to partner with the Dixon Grove Baptist Church (DGBC) in this effort. Your dedication to the church's mission to love God unconditionally, worship together on a regular basis, and advance Christian education is evident in your passion to empower church members to make informed decisions about their health.

I'm writing to let you know that the DGBC would be delighted to collaborate with you on your research study. We understand the need to develop tested approaches to address the serious health care needs faced by our community and we are committed to working with you to help address this deficit.

We are aware that you will be recruiting church members and others from the surrounding Clayton County, GA community to volunteer as research participants and we offer you our assistance in every way. The Book of Luke states: that the harvest is plentiful but the labors are few; God has opened the door for Dixon Grove to assist in this undertaking and we are thankful for the opportunity. Thank you for considering DGBC, we pray for a successful outcome. You are a blessing to the church.

In Him,

Reverend James E. Harris,

Pastor, Dixon Grove Baptist Church

APPENDIX C: WORK PLAN

1. How does an African American church connect its membership to resources offered by the Affordable Care Act (ACA) in a way that increases health equity? **<u>Activities</u>:** **Discuss health disparities/inequalities in our communities**	**<u>Week One (1)</u>** 1. Introductions • Themes from introductions: African American community, education, trust, internal expertise, relationships, history. • Watch health disparities video (breast cancer, asthma, heart disease, diabetes, obesity, and HIV). Action items – Share overall work plan Forward video, request everyone to watch parts one, two and three.	**<u>Week Two (2)</u>** 1. Group discussion on health disparities video and themes from introduction. (Were there any similarities? If so, what were they?) 2. Questions to be answered about health disparities • Did you know about health disparities before watching this video? • What did you learn today about health inequalities? • How can we apply what we learned from watching the videos? • What immediate steps/actions can we take at Community Church as a result of watching the videos? • What goals can we set as a committee, if any, based on watching today's video?	**<u>Week Three (3)</u>** 1. Evaluator collaborates with the work group to develop a needs assessment questionnaire for the church members (congregational survey). 2. Committee chair reports to the pastor and leadership on progress made thus far and get feedback from the pastor. 3. Chair and evaluator hold discussion on leadership input and plan for next meeting. ***1. Evaluator develops semi-structured interview questionnaire for the pastor, and three church members***	**<u>Week Four (4)</u>** 1. Group discussion on logic model for program development. 2. Evaluator works with work group to develop a logic model based on work done to roll out the ACA. 3. Evaluator works with work group to develop a logic model for advisory group. **2.** ***Evaluator drafts needs assessment survey for congregation.***
2. What is the relationship between the developments of health programs within an African	**<u>Week Five (5)</u>** 1. Reflect on what	**<u>Week Six (6)</u>** 1. Hold discussion to	**<u>Week Eight (7)</u>** 1. Advisory group holds a	**<u>Week Nine (8)</u>** 1. Prioritize the health-

American church--that is, programs providing resources to educate and inform its members about health--and increasing the capacity of the church as a learning organization?

a) Does the development of health programming result in changes in the organization of leadership within the church (e.g., the formation of a formal health ministry, or the ability of the leadership of the church to respond to adaptive challenges related to health)? If so, how?

b) Does the development of health programming build the capacity of church leadership and membership to engage in evaluation and reflection? If so, how? What factors support building an evaluation capacity?

Activities:

the church did to roll out the ACA at the church.

2. Reflect on what worked well and what did not.

3. Determine how we can do better the next time.

1. Evaluator shares final congregation needs assessment with advisory group.

look at prior health and wellness activities/events at Community Church.

2. Reflect on what worked well and what did not.

3. Determine how we can do better the next time.

4. Chair communicates with pastor and leadership on the progress of the work group and gets feedback.

5. Chair and evaluator hold discussion on input from leadership.

2. Evaluator conducts a congregational needs assessment. Evaluator conducts interview with South Side Community Health worker.

discussion on the 10 leading causes of death for African Americans.

2. Determines which of the causes are priorities in the church (Causes of Death from 2010). Source: National Vital Statistics Reports, Vol. 62, No. 6, December 20, 2013, Table I, Page 31)

(• Heart Disease Facts Prevention • Cancer Health Disparities in Cancer CDC Feature, Health Disparities in Cancer Reducing Health Disparities in Cancer • Stroke Facts Prevention • Diabetes Prevention Fact Sheets • Unintentional Injuries WISQARS Data & Statistics • Nephritis, Nephrotic Syndrome, & Nephrosis (Kidney Diseases) • Chronic Kidney Disease Fact Sheets Protecting Kidney Health Fact Sheet • Chronic Lower Respiratory Disease Data & Statistics • Homicide WISQARS Data & Statistics • Youth Violence Prevention • Septicemia • Preventing Healthcare-associated Infections • Alzheimer's Disease Healthy Aging Data & Statistics

related activities we want to tackle at the church. (How do we want to think about health? What language do we want to use? Do we have questions related to age? Adolescent and middle-age related questions?)

2. Evaluator develops a report to be shared with the group at next meeting.

3. Evaluator develops report from committee's progress, meeting notes, leadership interview results, and congregational survey results along with other health and wellness activities at the church.

4. Chair communicates with pastor and leadership on the progress of the work group and gets feedback.

5. Chair and evaluator hold discussion on input from leadership.

1. Evaluator takes part in a

Discuss ACA rollout and items related to a health ministry			Others: (• Life-cycle related issues • Infant mortality • Nutrition • Mental health • Pregnancy/prenatal care • Health insurance access) ***1. Evaluator conducts interview with pastor***	***testimonial service at the church to collect members' stories regarding their health experiences and the ACA roll out at the church***
	Week Nine (9)	**Week Ten (10)**	**Week Eleven (11)**	**Week Twelve (12)**
Activities:				
Discuss items related to a health ministry	1. Evaluator shares report with committee members 2. Evaluator invites two established church based health miniseries in to Advisory group to present overview of their ministries 3. Evaluator will share examples of other health ministries in African American churches and hold discussion 2. ***Evaluator conducts***	1. What is our church's mission statement? 2. Advisory group discussion what the church already offers that is related to health and healthy lifestyle? (meals, visiting shut-ins, hospital visits, prayer chain, prayer shawl ministry, support groups, health fairs, hand sanitizer available, blood pressure screening, other) 3. Hold group discussion on what we think a health ministry should look like and how it fits with existing mission	1. Discuss who will benefit from the health ministry services being developed—members, the community, or both? 2. Decide how the ministry should be organized, spiritually branded and who should take part 4. Examine information collected from the congregation regarding their health needs and priorities ***3. Evaluator conducts 2 focus groups with Women for Christ and Men***	1. Advisory chair communicates with pastor and leadership on the progress of the work group and gets feedback. 2. Chair and evaluator hold discussion on input from leadership. Conduct interview with pastor and other church leaders.

	interview with Sen. Gail Davenport, District 44	4. Determine whether a health ministry is a good fit for the church.	***on a Mission ministry***	
3. What lessons learned from this process can be transferred to other African American churches? How can health professionals work effectively with these churches and support their capacity? **Activities** ***Discuss surveying other churches in Clayton County***	**Week Thirteen (13)** 1. Evaluator will develop a final comprehensive report of all activities accomplished to include lessons learned. Evaluator shares the report with the health committee, pastor, and congregation.	**Week Fourteen (14)** 1. Evaluator and work group will develop a survey questionnaire which includes lessons learned from the overall DE advisory group's activities at Community Church.	**Week Fifteen (15)** 1. Evaluator analyzes survey data. 2. Evaluator drafts a report on survey findings.	**Week Sixteen (16)** **1.**Evaluator shares data with Community Church members.

APPENDIX D: WORK STRUCTURE

DE Health Advisory Group Structure and Workflow

The Community Church Health Advisory Committee decided to meet twice a month on the second and fourth Sundays immediately following service. The committee decided to revisit this schedule once everyone in the group are all in agreement that the group has started to gel and everyone feels comfortable moving forward; this will be determined by a majority vote after four meetings have been held.

The committee will consist of a chair and co-chair, an evaluator/facilitator, and a note taker. I will serve as evaluator. The chair is responsible for convening the meetings and conducting other necessary business, including receiving and discussing written reports from the evaluator, providing the committee with information on any other meeting conflicts that may arise, and adjourning the committee meetings. The evaluator will provide the overall plan for the committee and serve as facilitator, helping to shape the work by asking questions, facilitating discussion, sourcing or providing information, demonstrating, pausing the action, reminding the chair, note taker and the participants, and connecting similarities found in the discussion. The evaluator will also share written reports from other data sources, such as key leadership interviews, congregational surveys, focus groups, and storytelling testimonial sessions. The note taker will capture all pertinent information being discussed in writing or via audio, provided the DE group agrees to be recorded. The note taker will be required to have some training in confidentiality issues. Lastly, the group will be responsible for engaging in discussions and occasionally presenting on a specific topic of interest.

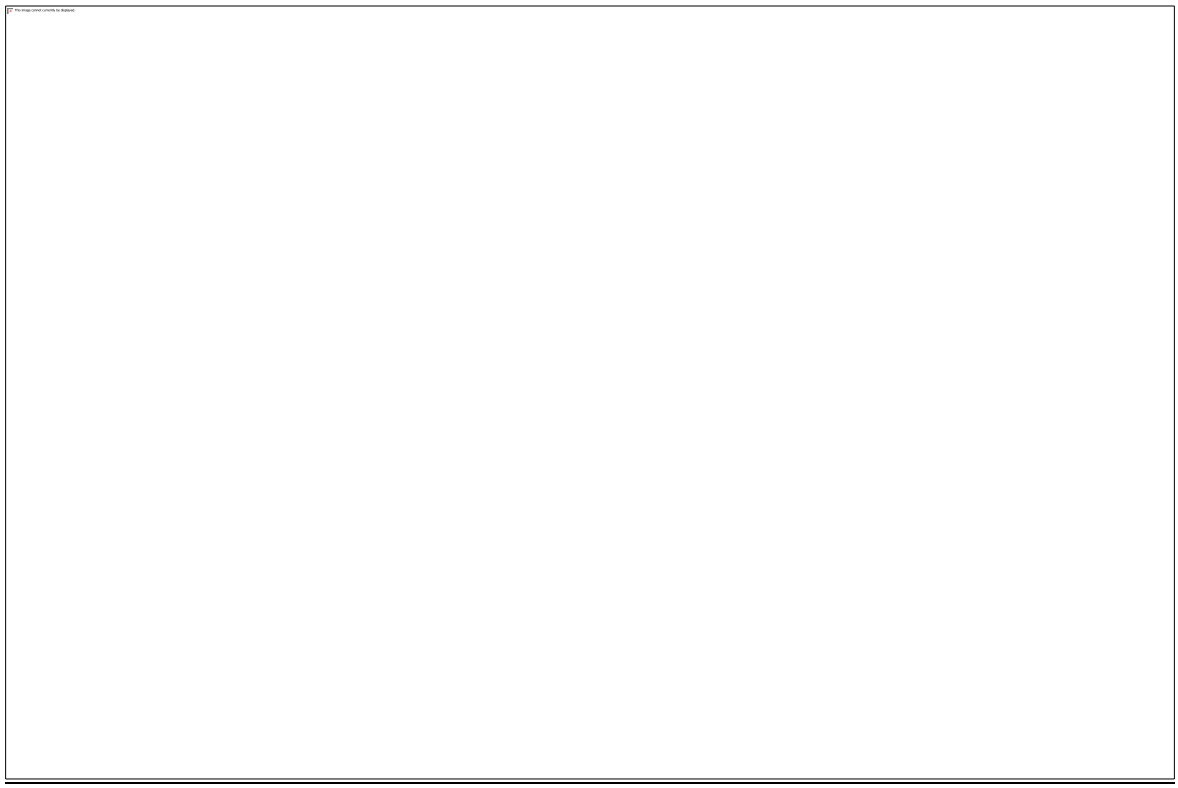
The proposed work structure for carrying out the functions of the health advisory committee is that the evaluator will provide the committee with information and topics for the group discussions, and the committee will discuss the featured topics. The evaluator will also facilitate the group discussion by asking questions and moving the

discussion along. The chair will serve as leader of the group and carry the information to the pastor and other executive leadership in the church.

The pastor will provide his feedback to the chair and he may occasionally use the pulpit to share information with the congregation about the committee's progress. In an effort to include the leadership's input in the work group discussion, the chair will meet separately with the evaluator to share the pastor's feedback. The evaluator and chair will meet regularly to ensure that changes are timely and that continuous feedback will be incorporated into future DE group discussions. The evaluator will introduce this feedback to the work group and, depending on what emerges from group discussion, the group will vote to decide whether mid-course adjustments or decisions are needed.

The evaluator will also consider other data collected from the congregation—such as focus groups, survey input, key leadership interviews, and storytelling—when developing written reports. All contributions will be taken into consideration as the group makes decisions about the path the health ministry should take going forward. The above process is iterative and aligns with the work group meeting schedule developed for the overall work plan throughout all three phases of the study. The illustration below presents the workflow and reporting process.

Figure. D4 Health Advisory Workflow and Reporting Process



APPENDIX E: DATA COLLECTION MODES

Table D6. Data Collection Modes

Focus Group Questions
1. Tell me about how information is communicated to the church's membership?
2. What sorts of information would you like to receive as a member of the church?
3. What are some of the ways you would like to receive this information?
4. Give me a few examples of the ways you would like to receive this information.
5. Tell me a little about the information you feel is vital to receive from the church.
6. Please tell me about any information sharing barriers that exist.
7. What do you think can be done to enhance information sharing?
8. What would you recommend to the church leadership to make it better?
9 What are your thoughts about health ministries in the church?
10. Please provide your input on the role of the church to address the health of its membership.
11. What sorts of activities do you think a church-based health ministry should conduct?
12. What is your role and responsibility to support the health ministry in your congregation?
13. How do health ministries benefit the members of your congregation?
14. In what ways can you help to further the education of the church membership regarding better health behaviors?
15.. How do you feel about the church partnering with outside entities, such as the local health department, to provide education and awareness activities to the members of the church?
16. Does the church have a role to further health policies that affect its membership, such as Medicaid expansion or the cost of prescriptions?
Key Informant Interview Questions
1. What are your thoughts about health ministries in the church?

2. Please provide your input on the role of the church to address the health of its membership.

3. What sorts of activities do you think a church-based health ministry should conduct?

4. What is your role and responsibility to support the health ministry in your congregation?

5. How do health ministries benefit members of your congregation?

6. In what ways can you help to further the education of the church membership regarding better health behaviors?

7. How do you feel about the church partnering with outside entities, such as the local health department, to provide education and awareness activities to the members of the church?

8. Does the church have a role to further health policies that affect its membership, such as Medicaid expansion or the cost of prescriptions?

9. Does the church have a role to further health policies that affect its membership such as Medicaid expansion or the cost of prescriptions?

Congregational Needs Assessment Questions

Check All that apply

1.Your age: ☐18-30 ☐31-50 ☐51-68 ☐69-80 ☐81+ Your gender: ☐Male ☐Female

1. Your education: What is the highest degree or level of school you have completed? If currently enrolled, highest degree received.

- ☐ No schooling completed
- ☐ Nursery school to 8th grade
- ☐ Some high school, no diploma
- ☐ High school graduate, diploma or the equivalent (for example: GED)
- ☐ Some college credit, no degree
- ☐ Trade/technical/vocational training

2. Marital Status: What is your marital status?

- ☐ Single, never married
- ☐ Married or domestic partnership
- ☐ Widowed
- ☐ Divorced
- ☐ Separated

(c) Employment Status: Are you currently…?

- ☐ Employed for wages
- ☐ Self-employed
- ☐ Out of work and looking for work
- ☐ Out of work but not currently looking for work

- Associate degree
- Bachelor's degree
- Master's degree
- Professional degree
- Doctorate degree

- A homemaker
- A student
- Military
- Retired
- Unable to work

2. Do you or a family member currently have health-related issues? Yes No

If yes, please explain: _____

_____

3. What health and medical problems do you have, or do you know of in your family, congregation, and community? (Please check below all that apply).

Individual and Family

___Barriers to raising healthy children

___Can't afford medical care

___Need for spiritual renewal and focus

___Problems with stress

___Chronic illness or disability

___Persons ill at home

___Primary caregiver for another person

___Substance abuse problems

___Need for personal counseling

___Problems with sexuality

___Financial problems

___Under/uninsured persons

___Legal issues

___Poor health habits

___Housing problems

___Loneliness, isolation

___Job problems

___Grief and/or loss

___End of life issues

___Physical/emotional abuse or neglect

___Other

___Problems in relationships with others

Please list:

_____

Use the back of the form if more room is needed.

4. How much interest do you and your congregation have in learning more and taking some active steps to improve health at each of these levels? Please check all that apply. Please rate each as:

(1) not at all interested (2) slightly interested (3) moderately interested (4) very interested (5) extremely interested

Myself	Not at all interested	Slightly interested	Moderately interested	Very interested	Extremely interested
Individual health issues					
Family health issues					
Congregational health					
Health in our community					

5. How much interest is there in learning more and taking active steps to improve medical care at the same levels? Please rate each as:

(1) not at all interested (2) slightly interested (3) moderately interested (4) very interested (5) extremely

Survey Questions for External Ministers Group					
1. Snapshot of your congregation's Demographics					

Myself	Not at all interested	Slightly interested	Moderately interested	Very interested	Extremely interested
Individual health issues					
Family health issues					
Congregational health					
Health in our community					

1. What would you say is the average age of the members of your church?

1. 18-30
2. 31-50
3. 51-68
4. 69-80
5. 81+

2. Would you say you have more males' ___ or females___ in your congregation? Other_____ (Please check)

a) Education: What would you say is the highest degree or level of education in your congregation? If currently enrolled, highest degree received. (Please check below)

1. No schooling completed
2. Nursery school to 8th grade
3. Some high school, no diploma
4. High school graduate, diploma or the equivalent (e.g., GED)
5. Some college credit, no degree
6. Trade/technical/vocational training
7. Associate's degree
8. Bachelor's degree
9. Master's degree
10. Professional degree
11. Doctoral degree

(b) How would you characterize the marital status of most of your members?

1. Single, never married
2. Married or domestic partnership
3. Widowed
4. Divorced
5. Separated

(c) In each of the following boxes, please rank the employment status of your congregation from 1 to 10: (1 being the highest and 10 being the lowest).

1. Employed for wages
2. Self-employed
3. Out of work and looking for work
4. Out of work not currently looking for work
5. A homemaker
6. A student
7. Military
8. Retired
9. Unable to work
10. Other

11. Interest in Health and Health-Related Issues

3. Please check any of the health-related issues below that concern at least 20% of your congregation:

12. Diabetes (Sugar in the blood)
13. Hypertension (High blood pressure)
14. Arthritis
15. Cancer
16. Mental health
17. Access to care
18. Fair and equal treatment from the doctor
19. Other community issues
20. Lack of insurance
21. Healthy Behavior (eating, exercising, smoking etc.)

4. How much interest do you and your congregation have in learning more and taking some active steps toward improving health at each of these levels? Please check all that apply by indicating whether you or your members are: (1) Not at all interested, (2) Slightly interested, (3) Moderately interested, (4) Very Interested, (5) Extremely interested

Comments:

Myself	Not at all	Slightly	Moderately	Very	Extremely
Individual health issues					
Family health issues					
Congregational health					
Health in your community					
Congregation	Not at All	Slightly	Moderately	Very	Extremely
Individual health issues					
Family health issues					
Congregational health					
Health in your community					

23. Congregational Health Ministry

5. Please check all health-related activities conducted at your church.

- ☐ Inviting health professionals to speak at the church
- ☐ Distributing health information to the congregation (pamphlets/resources)
- ☐ Community outreach (e.g., feeding the hungry, volunteering at a shelter)
- ☐ Hosting Affordable Health Care (ACA) Market Place insurance enrollment events at the church
- ☐ Visiting the sick and shut-in
- ☐ Prayer or support groups
- ☐ Participating in testimony services
- ☐ Sponsoring national health observance activities (e.g., American Heart Month, Prostate Cancer Awareness Month)

Underlying community activities related to health such as:

- ☐ Working to improve county bus service
- ☐ Strategizing to keep the local hospital open
- ☐ Volunteering to help provide bottled water to residents of Flint, Michigan
- ☐ Other (s)_____

6. Does your church currently have a health ministry? If so, please give the mission of the health ministry, who leads it, what it does and how often does it meet. If you do not have a mission statement please describe what you think the mission is.

7. If you do not have a formal health ministry, please list the ministries at your church. Please list others.

24. Gender Roles and Health Activities

8. Are women or men more active in the above groups you checked, or do both genders participate equally? Please comment. _____

9. What has been your experience in your congregation regarding how members prefer to have health issues addressed?

1. Sermons, presentations or general discussion with the whole congregation, e.g. during services or testimonial sessions
2. One-on-one mentoring or sharing with another congregation member, coordinated by a health ministry or church leadership
3. Small group discussions or classes
4. Other (please describe)_____

10. Have you observed any differences in format preference between women and men? (Please describe.)_____

9. Sharing Stories via Testimony Service

11. Please check whether the following church leaders or groups are actively engaged in furthering a health agenda, meaning they spend time on it at least once a month. (Check all that apply):

1. Pastor
2. Pastor's wife or spouse
3. Health ministry leader or committee
4. Brothers at the church
5. Sisters at the church
6. Other ministry (ies) or recognized group(s) within church, please specify._____
7. Informal group--for example, are there persons or a group of people within the church who are furthering health-related activities but are not an official part of the church organizational structure (e.g. congregants who are doctors or nurses who informally counsel others); Please describe below.

   _____

8. NA--doesn't exist in your church

12. Do your members share stories about their health during testimonial service?

1. Yes
2. No

If yes, please give an example: _____

13. How do these testimonials affect the person and others? _____

3. Community Health Partnerships

14. Do you presently have community partnerships with any health-related organizations?

a. If so, who are they:

_____

b. If not, would you like to partner with health agencies?

1. Yes
2. No

c. Please explain in your opinion, what makes a partnership?

15. If you checked ACA related activities in question #7, then please answer the following:

a. Have you conducted any Affordable Health Care insurance enrollment activities at your church? If so, please describe briefly:
_____

b. How did you advertise it to participants? (e.g. church website, Facebook, or other forms)

c. Did you invite community members from outside of your church to attend?

1. Yes
2. No

d. Did you or your membership learn anything about health or health behavior as a result? If so, please explain. _____

IV. Evaluation

16. How do you plan, implement, and evaluate initiatives in your church? (Check all that apply, if other add comment)

1. During monthly meetings
2. At annual church planning sessions
3. By designating a new committee
4. In a congregational needs assessment
5. In surveys
6. At church conferences
7. In a congregational workgroup

17. How are health issues part of that planning?

18. If you are interested in learning more about ways to start a health ministry or how to conduct assessments and evaluations of activities at your church, please check what resources would be most helpful, or contact me via the information listed below.

- Fact sheets
- Meetings
- Training sessions
- Web resources

- Phone conferences
- With facilitation of church leaders

Other _____

Comments:_____

Thank you for your time. Please feel free to contact me regarding any questions or concerns you have related to this survey. ***Rosalyn Bell,*** Bellroslayn@gmail.com , 678-614-2990

APPENDIX F: CODING QUOTATION QUERY REPORT

Query Report **73 Quotations found for query: "Equity"**

_____

1:1 Um, you know I, I don't have a... (33:33)

1:2 Um, well I can give, I can give... (34:34)

1:4 my question has been is that w... (36:36)

1:6 let me ask you about Obamacare... (41:41)

1:8 if you don't have any other in... (47:47)

1:9 even if you have other insurance... (48:49)

1:10 You can qualify for Medicare? (49:49)

1:11 Cannot qualify for Medicaid? (39:39)

1:12 Medicare, Medicare (44:44)

1:15 And I said that's what you got... (61:61)

1:24 Health Advisory Comm/Mental He... (79:79)

1:31 Right, well you know that's a g... (86:86)

1:37 Health Advisory Comm / Adverting... (102:102)

1:39 Men talking to me (107:107)

1:41 Men/ Health Behavior (109:109)

1:43 Male Participation (114:114)

1:44 Change in Process (115:115)

1:45 Knowing Skills in the church (117:117)

1:47 Change in Process/ Response (120:120)

1:49 And I had to go convince my ot.. (124:124)

1:51 You know what I found out thou.. (126:126)

1:55 Taking it back, or taking it f.. (130:130)

1:56 Health issue so I think, but e.. (132:132)

1:60 Okay so, you, you're uh one of.. (140:143)

1:66 Well, what I wanted to say was .. (151:151)

1:68 We got people here at the church.. (160:160)

1:70 I mean just based off of what .. (163:164)

1:73 The ministry can go as far as .. (176:176)

1:80 Well I've been listening here .. (190:190)

1:85 Well I think men on a mission .. (201:201)

1:86 Okay, time for leadership, the.. (204:204)

1:87 I guess what she's looking around.. (208:208)

1:88 Right. And represent the deacons.. (211:212)

1:89 They picked this person up and.. (215:215)

1:90 The usher needs to say okay th.. (221:221)

1:91 What it is, it's not so much.. (225:225)

1:92 What is my contact person's na.. (227:227)

1:93 Not the group. The group is no.. (229:229)

1:94 You know, this is the person t.. (233:233)

1:96 The main thing I been asking q.. (239:241)

1:98 In terms of setting up the web.. (253:253)

1:100 So, I guess I'm just simply say.. (257:257)

1:101 We're not communicating correct.. (260:260)

1:104 And the website to me is a cri.. (270:271)

1:109 Right. Well you know what I, I.. (282:284)

1:110 I think you're headed in the w.. (291:291)

1:111 Well that's where the ministry.. (296:296)

1:113 Okay, then people can start re.. (300:300)

2:1 I think it is wonderful that w.. (5:5)

2:2 I think we should have more di.. (5:5)

2:3 When I was a little girl, I no.. (8:8)

2:4 did not want to share my story.. (9:9)

2:5 Later on, I became friends, la.. (10:10)

2:6 With her encouragement and pra.. (11:11)

2:7 I do not have any fear about m.. (13:13)

2:8 think it is wonderful that we .. (5:5)

2:9 I do not have any fear about m.. (13:13)

2:10 Health insurance enrollment. I.. (16:16)

2:11 I think it is wonderful that w.. (5:5)

2:12 When I was a little girl, I no.. (8:11)

2:13 Prostate cancer. I'm here to s.. (24:26)

11:6 9. The group explored utilizing.. (13:13)

11:7 The group talked about the pro.. (14:14)

11:8 The workgroup discussed the pr.. (15:15)

12:3 Reasons for participating: (ed.. (6:6)

13:4 The question was asked and dis.. (18:21)

13:5 We had a discussion about how .. (22:22)

13:7 The group discussed how our co.. (23:27)

15:1 The session discussion opened.. (4:4)

15:8 There was a discussion held ar.. (17:17)

19:1 Leadership Buy-in 2. Time 3. E.. (17:33)

19:2 Invite Leadership to meetings.. (36:50)

Query Report: **45 Quotations found for query: "Gender"**

1:13 Now uh, a question I have is u.. (57:57)

1:14 For twenty years and I found o.. (59:59)

1:15 And I said that's what you got.. (61:61)

1:16 When I was first diagnosed 20 .. (63:63)

1:18 Telling Stories / Male Specific.. (66:66)

1:19 Mental Health / Black Males (69:69)

1:30 Leadership visibility (93:93)

1:32 Now I think, the, the critical.. (87:87)

1:33 Point Person/getting the word o.. (95:95)

1:39 Men talking to me (107:107)

1:41 Men/ Health Behavior (109:109)

1:42 Exercise/Men (113:113)

1:43 Male Participation (114:114)

1:49 And I had to go convince my ot.. (124:124)

1:51 You know what I found out thou.. (126:126)

1:55 Taking it back, or taking it f.. (130:130)

1:56 Health issue so I think, but e.. (132:132)

1:57 Women, women do it. I mean the.. (134:134)

1:59 ell I'm just saying, woman are.. (136:136)

1:66 ell, what I wanted to say was .. (151:151)

1:70 I mean just based off of what .. (163:164)

1:71 Okay well if somebody misdiagnose.. (170:170)

1:76 One con is, we have to have a .. (182:182)

1:77 So police, you know when a pol.. (184:184)

1:78 So that's a risk. We gotta have.. (186:186)

1:91 What it is, it's not so much.. (225:225)

1:95 My thing is uh, what about uh,.. (235:235)

1:102 So, I guess I'm just simply sa.. (257:257)

1:104 And the website to me is a cri.. (270:271)

~1:108 But I think Deacon Ford hit it.. (281:281)

1:109 Right. Well you know what I, I.. (282:284)

1:112 All the [00:56:00] resources, .. (298:298)

1:113 Okay, then people can start re.. (300:300)

2:6 With her encouragement and pra.. (11:11)

2:7 I do not have any fear about m.. (13:13)

2:10 Health insurance enrollment. I.. (16:16)

2:11 I think it is wonderful that w.. (5:5)

2:12 When I was a little girl, I no.. (8:11)

2:13 Prostate cancer. I'm here to s.. (24:26)

13:4 The question was asked and dis.. (18:21)

13:5 We had a discussion about how .. (22:22)

15:2 Roz stated that scripts were d.. (7:7)

15:8 There was a discussion held ar.. (17:17)

19:1 Leadership Buy-in 2. Time 3. E.. (17:33)

19:2 Invite Leadership to meetings.. (36:50)

Query Report 85 Quotations found for query: "Organizational Learning"

1:2 Um, well I can give, I can giv.. (34:34)

1:4 My question has been is that w.. (36:36)

1:13 Now uh, a question I have is u.. (57:57)

1:14 For twenty years and I found o.. (59:59)

1:15 And I said that's what you got.. (61:61)

1:16 When I was first diagnosed 20 .. (63:63)

1:18 Telling Stories / Male Specif.. (66:66)

1:19 Mental Health / Black Males (69:69)

1:23 Social Media/Community Canvass.. (78:78)

1:30 Leadership visibility (93:93)

1:32 Now I think, the, the critical.. (87:87)

1:33 Point Person/getting the word o.. (95:95)

1:34 Advertisement /Repetition (97:97)

1:37 Health Advisory Comm / Adverti.. (102:102)

1:39 Men talking to me (107:107)

1:41 Men/ Health Behavior (109:109)

1:42 Exercise/Men (113:113)

1:43 Male Participation (114:114)

1:44 Change in Process (115:115)

1:45 Knowing Skills in the church (117:117)

1:47 Change in Process/ Response (120:120)

1:49 And I had to go convince my ot.. (124:124)

1:51 You know what I found out thou.. (126:126)

1:55 Taking it back, or taking it f.. (130:130)

1:56 Health issue so I think, but e.. (132:132)

1:57 Women, women do it. I mean the.. (134:134)

1:59 ell I'm just saying, woman are.. (136:136)

1:60 Okay so, you, you're uh one of.. (140:143)

1:61 Right. So I mean the partnersh.. (145:146)

1:62 Free medical screening on the .. (147:147)

1:65 She, is a a part of the ad.. (150:150)

1:66 ell, what I wanted to say was .. (151:151)

1:68 We got people here at the chur.. (160:160)

1:70 I mean just based off of what .. (163:164)

1:71 Okay well if somebody misdiagn.. (170:170)

1:73 The ministry can go as far as .. (176:176)

1:74 What I think I heard today, an.. (179:179)

1:75 So that's going to be on our agen.. (181:181)

1:76 One con is, we have to have a .. (182:182)

1:77 So police, you know when a pol.. (184:184)

1:78 So that's a risk. We gotta hav.. (186:186)

1:79 So that's a risk. We gotta hav.. (186:186)

1:81 I was just saying they group p.. (188:188)

1:84 the pastor obviously, I mean, .. (197:197)

1:85 Well I think men on a mission ... (201:201)

1:86 Okay, time for leadership, the.. (204:204)

1:88 Right. And represent the deaco.. (211:212)

1:89 They picked this person up and.. (215:215)

1:90 The usher needs to say okay th.. (221:221)

1:91 What it is is, it's not so muc.. (225:225)

1:92 What is my contact person's na.. (227:227)

~1:94 You know, this is the person t.. (233:233)

1:95 My thing is uh, what about uh,.. (235:235)

1:96 The main thing I been asking q.. (239:241)

1:100 So, I guess I'm just simply sa.. (257:257)

1:101 We're not communicating correc.. (260:260)

1:102 So, I guess I'm just simply sa.. (257:257)

1:103 [inaudible 00:49:38] those thr.. (265:266)

1:104 And the website to me is a cri.. (270:271)

1:105 You give a person that's visit.. (270:270)

~1:108 But I think Deacon Ford hit it.. (281:281)

1:109 Right. Well you know what I, I.. (282:284)

1:110 I think you're headed in the w.. (291:291)

1:111 Well that's where the ministry.. (296:296)

1:112 All the [00:56:00] resources, .. (298:298)

1:113 Okay, then people can start re.. (300:300)

2:2 I think we should have more di.. (5:5)

2:6 With her encouragement and pra.. (11:11)

2:7 I do not have any fear about m.. (13:13)

2:10 Health insurance enrollment. I.. (16:16)

2:11 I think it is wonderful that w.. (5:5)

2:12 When I was a little girl, I no.. (8:11)

2:13 Prostate cancer. I'm here to s.. (24:26)

11:5 It was discussed that the meet.. (12:12)

11:6 9. The group explored utilizin.. (13:13)

11:8 The workgroup discussed the pr.. (15:15)

13:1 The committee selected Health .. (3:3)

13:4 The question was asked and dis.. (18:21)

13:5 We had a discussion about how .. (22:22)

15:1 The session discussion opened .. (4:4)

15:2 She stated that scripts were d.. (7:7)

15:8 There was a discussion held ar.. (17:17)

15:10 § Second Phase (Week 5) o Look.. (26:32)

19:1 Leadership Buy-in 2. Time 3. E.. (17:33)

19:2 Invite Leadership to meetings .. (36:50)

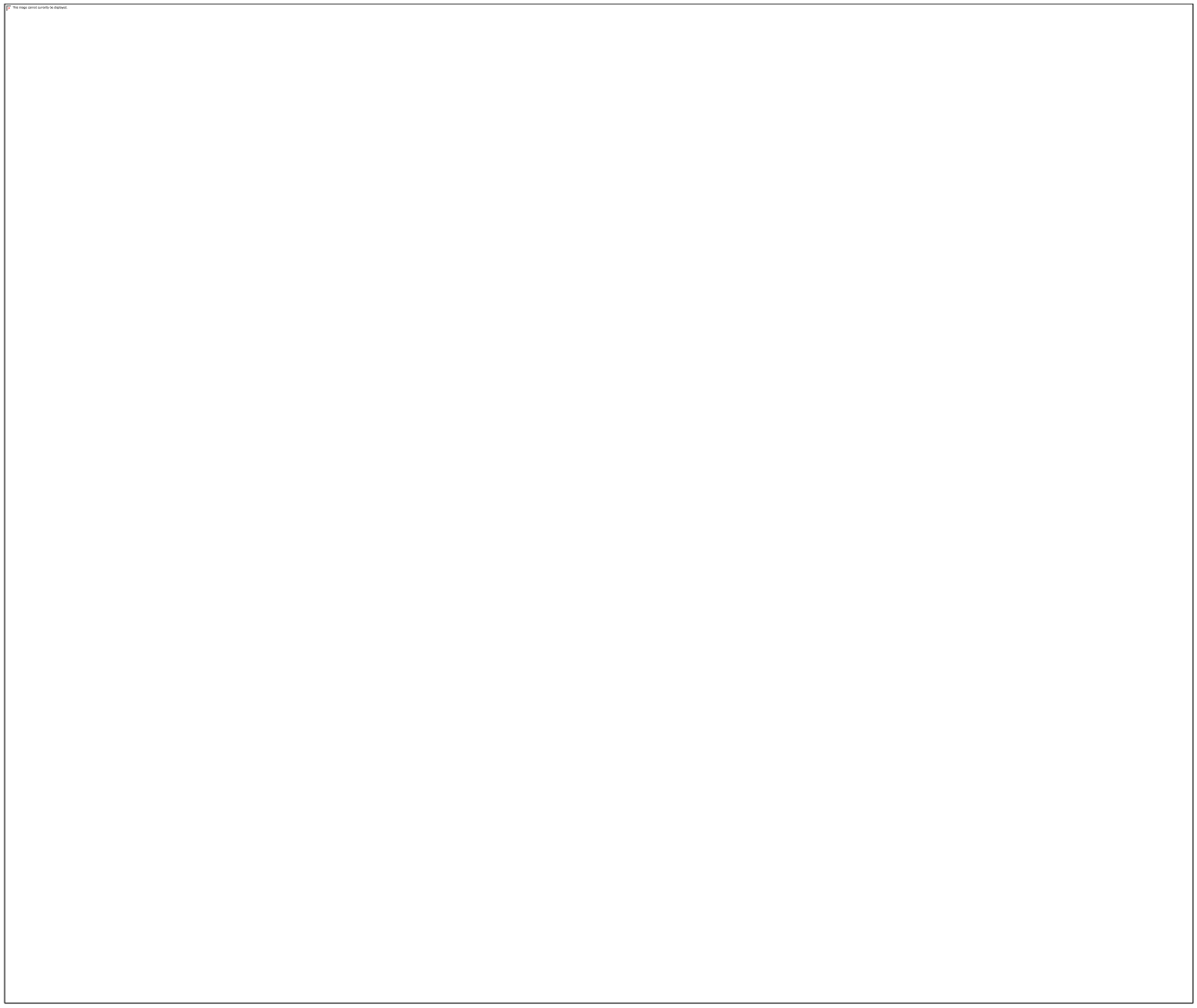
APPENDIX G. EXTERNAL MINISTER'S SURVEY RESULTS

Q1 - What would you say is the average age of the members of your church?

Answer	%	Count
18-30	12.50%	1
31-50	25.00%	2
51-68	50.00%	4
69-80	0.00%	0

81+	12.50%	1
Total	100%	8

Q3 - Education: What would you say is the highest degree or level of education in your congregation? If currently enrolled, highest degree received.



Answer	%	Count
No schooling completed	0.00%	0
Nursery school to 8th grade	0.00%	0
Some high school, no diploma	0.00%	0

High school graduate, diploma or the equivalent (e.g., GED)	25.00%	2
Some college credit, no degree	0.00%	0
Trade/technical/vocational training	0.00%	0
Associate's degree	12.50%	1
Bachelor's degree	37.50%	3
Master's degree	12.50%	1
Professional degree	0.00%	0
Doctoral degree	25.00%	2

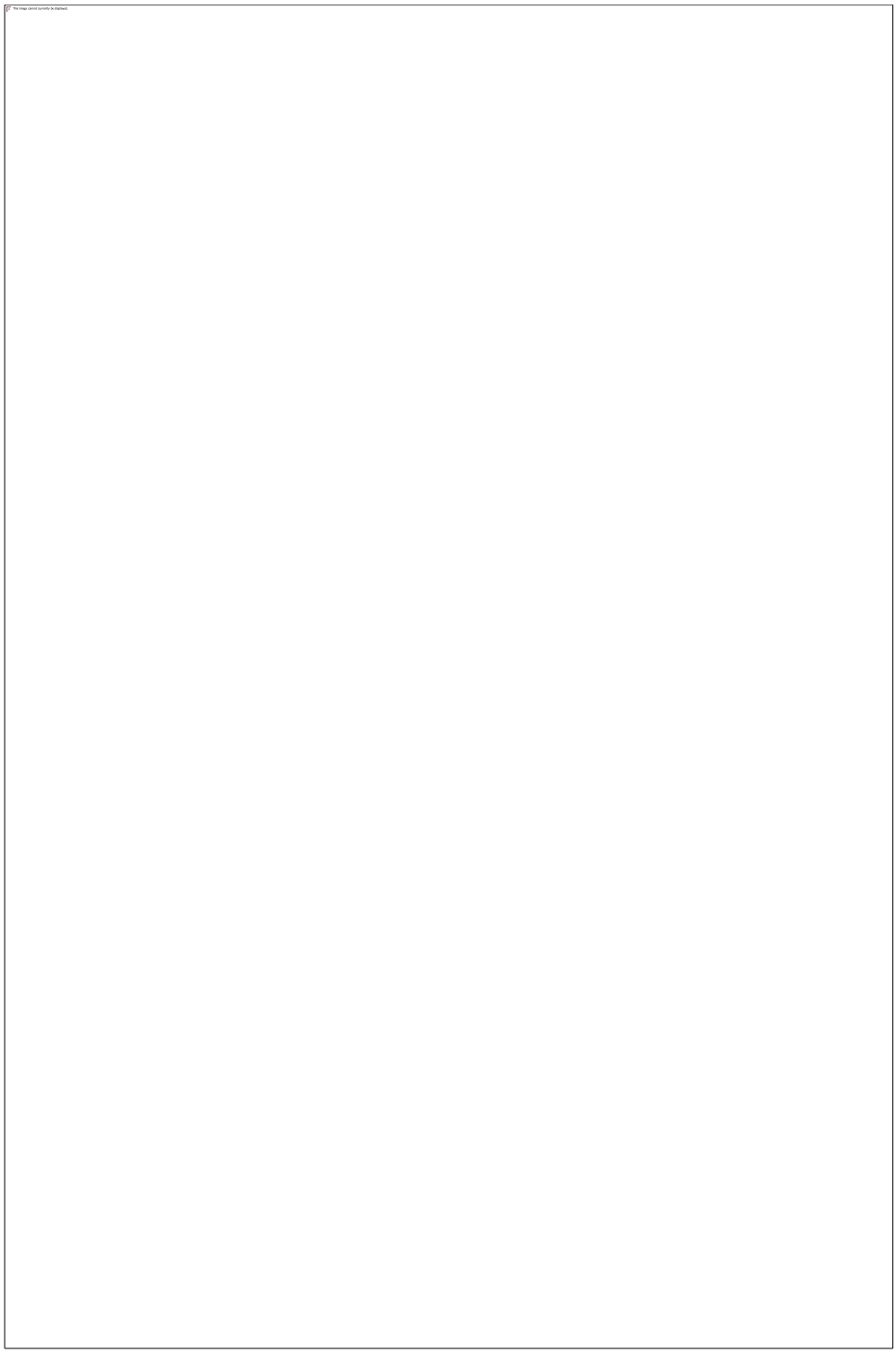
Q2 - Would you say you have more males or females in your congregation?

Answer	%	Count
Males	0.00%	0
Females	100.00%	8
Other	0.00%	0

Q4 - How would you characterize the marital status of most of your members?

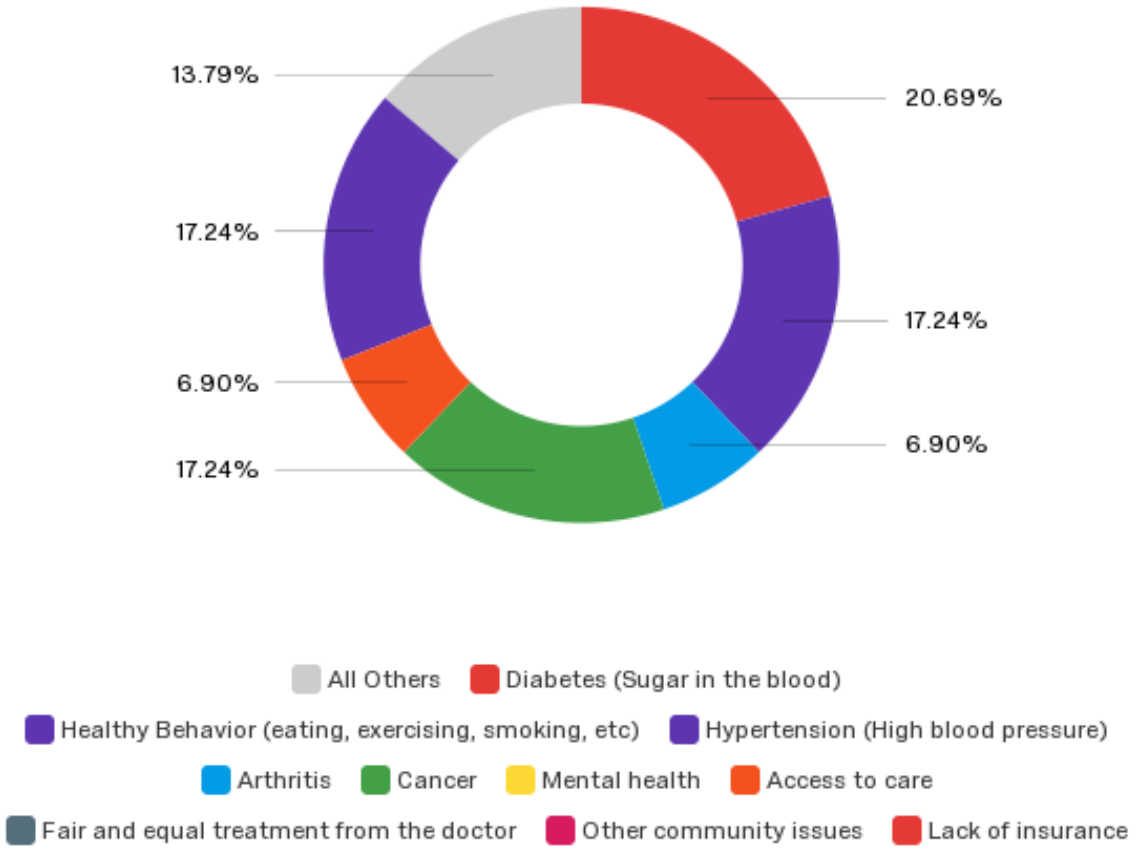
Answer	%	Count
Single, never married	25.00%	2
Married or domestic partnership	62.50%	5
Widowed	25.00%	2
Divorced	0.00%	0
Separated	0.00%	0

Q5 - In each of the following boxes, please rank the employment status of your congregation from 1 to 10 (1 being the highest and 10 being the lowest). The number indicates the most common employment status in the congregation down to the least common status.



Question	1		2		3		4		5		6		7		8		9		10		Total
Employed for wages	57.14%	4	0.00%	0	0.00%	0	0.00%	0	28.57%	2	0.00%	0	0.00%	0	14.29%	1	0.00%	0	0.00%	0	7
Self-employed	16.67%	1	33.33%	2	0.00%	0	16.67%	1	0.00%	0	0.00%	0	0.00%	0	33.33%	2	0.00%	0	0.00%	0	6
Out of work and looking for work	0.00%	0	0.00%	0	0.00%	0	0.00%	0	20.00%	1	20.00%	1	20.00%	1	0.00%	0	20.00%	1	20.00%	1	5
Out of work and not currently looking for work	0.00%	0	0.00%	0	20.00%	1	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	60.00%	3	20.00%	1	5
A homemaker	25.00%	1	0.00%	0	25.00%	1	25.00%	1	0.00%	0	0.00%	0	25.00%	1	0.00%	0	0.00%	0	0.00%	0	4
A student	20.00%	1	0.00%	0	20.00%	1	20.00%	1	40.00%	2	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	5
Military	25.00%	1	25.00%	1	0.00%	0	0.00%	0	0.00%	0	50.00%	2	0.00%	0	0.00%	0	0.00%	0	0.00%	0	4
Retired	57.14%	4	14.29%	1	0.00%	0	14.29%	1	14.29%	1	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	7
Unable to work	20.00%	1	20.00%	1	0.00%	0	0.00%	0	20.00%	1	0.00%	0	20.00%	1	20.00%	1	0.00%	0	0.00%	0	5
Other	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	100.00%	3	3

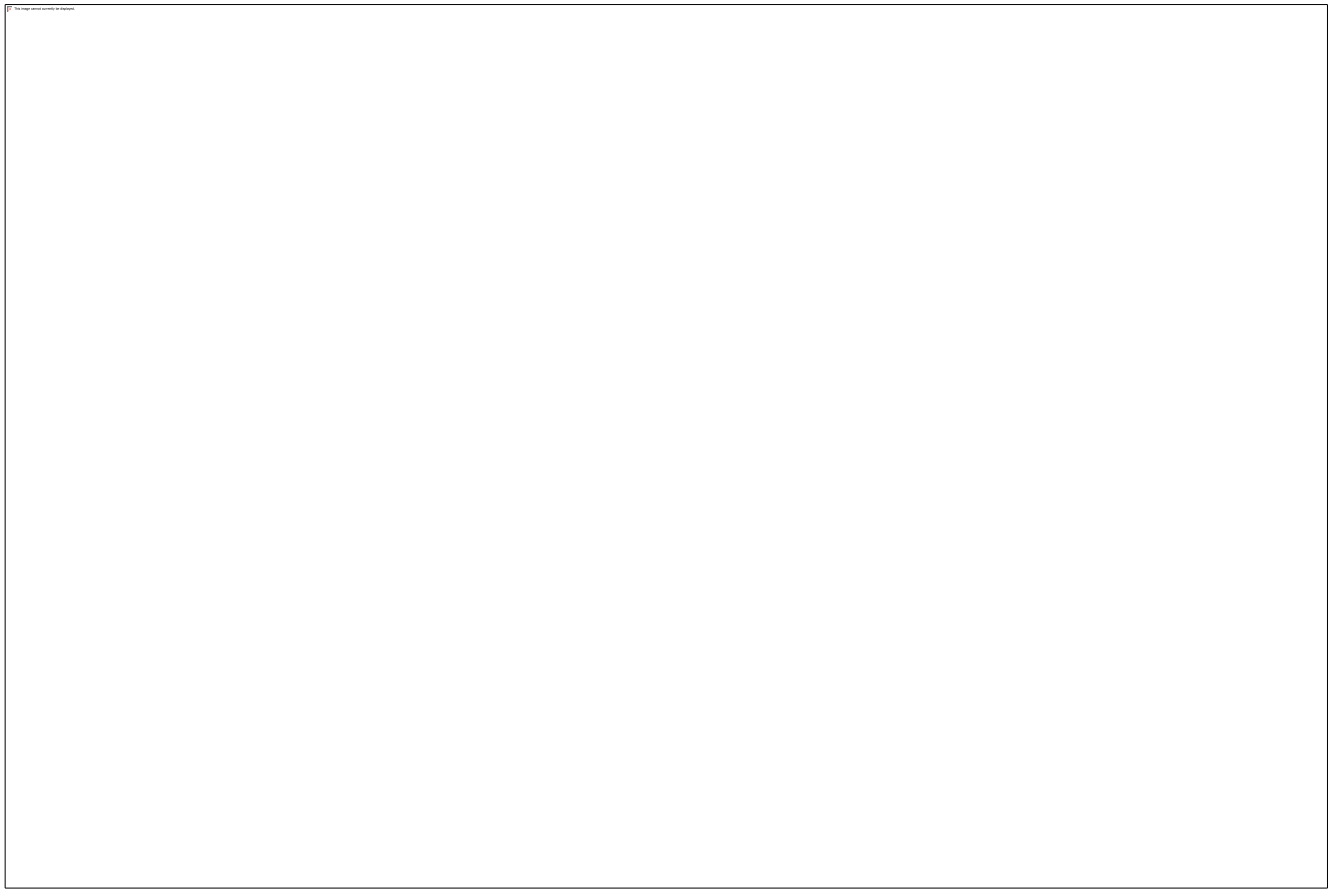
Q6 - Please check any of the health-related issues below that concern at least 20% of your congregation.



Answer	%	Count
Diabetes (Sugar in the blood)	75.00%	6
Hypertension (High blood pressure)	62.50%	5
Arthritis	25.00%	2
Cancer	62.50%	5

Mental health	12.50%	1
Access to care	25.00%	2
Fair and equal treatment from the doctor	12.50%	1
Other community issues	12.50%	1
Lack of insurance	12.50%	1
Healthy Behavior (eating, exercising, smoking, etc)	62.50%	5

Q7 - [MYSELF] How much interest do you and your congregation have in learning more and taking some active steps toward improving health at each of these levels? Please check all that apply by indicating whether you or your members are: (1) Not at all interested (2) Slightly interested (3) Moderately interested (4) Very interested (5) Extremely interested



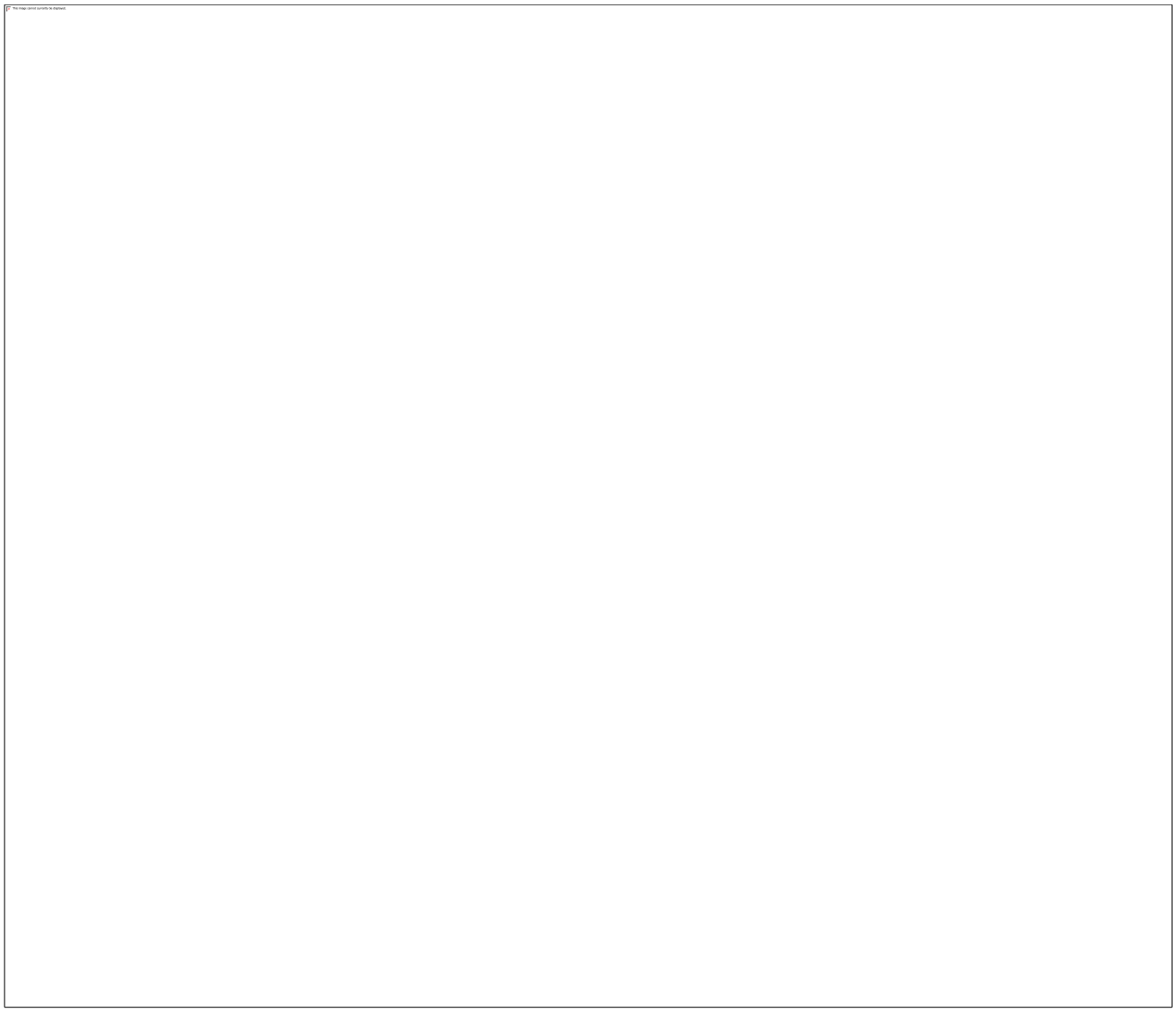
Question	Not at all interested	Slightly interested	Moderately interested	Very interested	Extremely interested	Total
Individual health issues	0.00% 0	0.00% 0	14.29% 1	42.86% 3	42.86% 3	7
Family health issues	0.00% 0	14.29% 1	14.29% 1	42.86% 3	28.57% 2	7
Congregational health	0.00% 0	14.29% 1	0.00% 0	57.14% 4	28.57% 2	7

Health in your community	16.67%	1	0.00%	0	0.00%	0	66.67%	4	16.67%	1	6

Q9 - [CONGREGATION] How much interest do you and your congregation have in learning more and taking some active steps toward improving health at each of these levels? Please check all that apply by indicating whether you or your members are: (1) Not at all interested (2) Slightly interested (3) Moderately interested (4) Very interested (5) Extremely interested

Question	Not at all interested		Slightly interested		Moderately interested		Very interested		Extremely interested		Total
Individual health issues	0.00%	0	0.00%	0	14.29%	1	57.14%	4	28.57%	2	7
Family health issues	0.00%	0	14.29%	1	0.00%	0	57.14%	4	28.57%	2	7
Congregational health	0.00%	0	25.00%	2	12.50%	1	50.00%	4	12.50%	1	8
Health in your community	14.29%	1	0.00%	0	28.57%	2	42.86%	3	14.29%	1	7

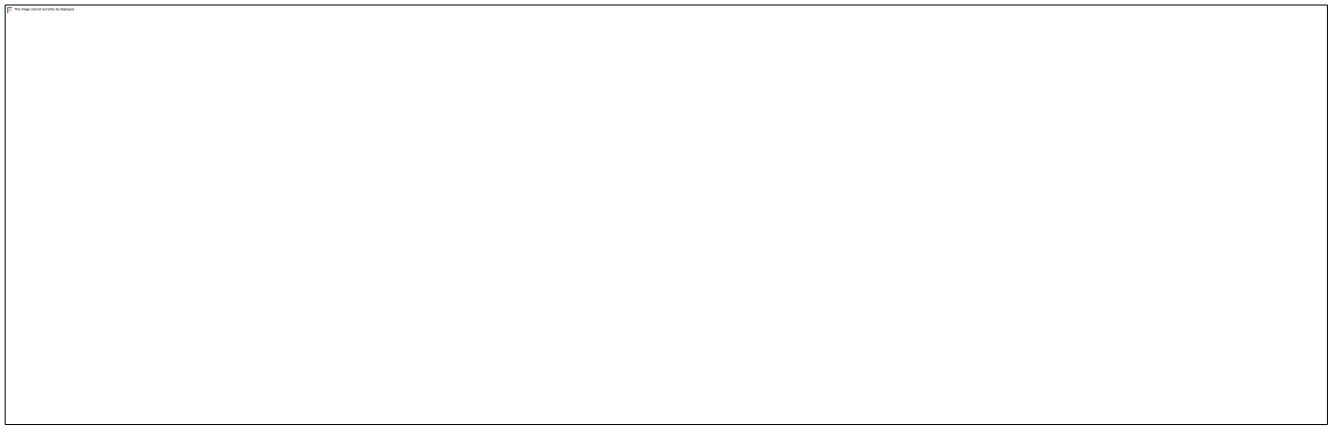
Q10 - Please check all health-related activities conducted at your church:



Answer	%	Count
Inviting health professionals to speak at your church	62.50%	5
Distributing health information to the congregation (pamphlets/resources)	75.00%	6
Community outreach (e.g. feeding the hungry, volunteering at a shelter)	75.00%	6
Hosting Affordable Health Care (ACA) Market Place insurance enrollment events at the	50.00%	4

church		
Visiting the sick and shut-in	100.00%	8
Prayer or support groups	87.50%	7
Participating in testimony services	50.00%	4
Sponsoring national health observance (e.g. American Heart Month, Prostate Cancer Awareness Month)	50.00%	4

Q11 - Please check all underlying community activities related to health conducted at your church:



Answer	%	Count
Working to improve county bus service	50.00%	3
Strategizing to keep the local hospital open	0.00%	0
Volunteering to help provide bottled water to residents of Flint, Michigan	16.67%	1
Other(s):	50.00%	3

Other(s):

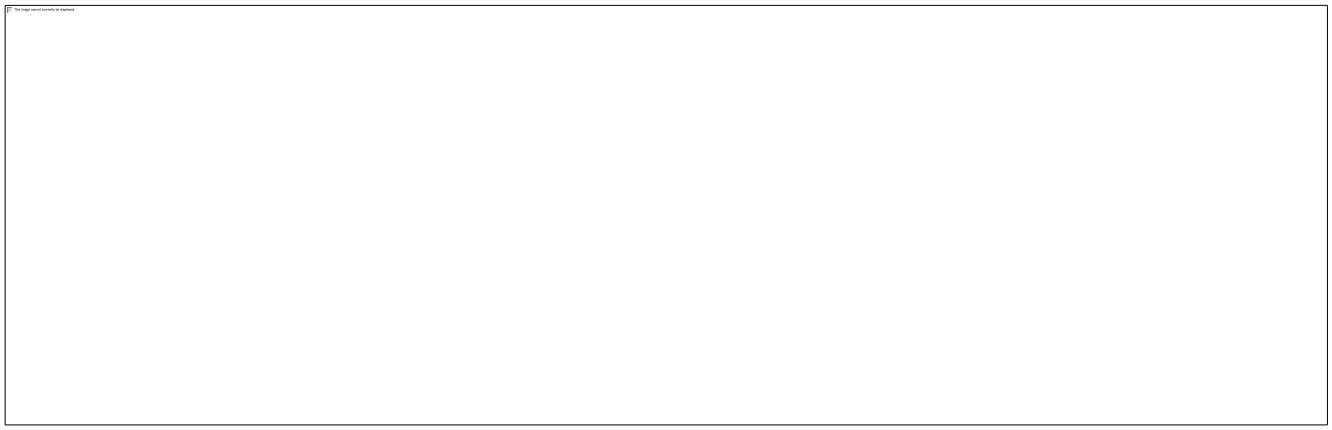
Other(s):

Working with the local department of health.

Pen pal to prisoners

We feed and give bottled water to metro area homeless once a month, give to missions, Feed the Hungry, St. Jude Children's Hospital, and Wounded Warrior Project

Q12 - Does your church currently have a health ministry? If so, please give the mission of the health ministry, who leads it, what it does and how often does it meet. If you do not have a mission statement please describe what you think the mission is.



Answer	%	Count
Yes	42.86%	3
No	57.14%	4

Yes

Does your church currently have a health ministry? If so, please give the mission of the health ministry, who leads it, what it does and how often does it meet. If you do not have a mission statement please describe what you think the mission is.

To inform the congregation on the various health issues. To provide information and resources regarding these issues.

Our church provides holistic care for the entire year. Spirit, soul and body.

Inc. Mission Statement To fulfill the mission of Jesus Christ by making faithful disciples; reaching and teaching the gospel of Jesus Christ and teaching people that they can start where they are and by changing their thinking, they can change their lives. Our purpose is to glorify God and allow His people the opportunity to come in and worship Him. By equipping the saints we aim to take this ministry to a higher level of service, praise and worship and education which will enhance individuals as well our

collective body and communities. Reach out in our communities with ministry.

No

Does your church currently have a health ministry? If so, please give the mission of the health ministry, who leads it, what it does and how often does it meet. If you do not have a mission statement please describe what you think the mission is.

However we are in the process of seeking a grant from Firehouse Subs, Inc restaurants for an AED Defibrillator to be placed in the church, and we will be getting the training from RN.

Q13 - If you do not have a formal health ministry, please list the ministries at your church. Please list others.

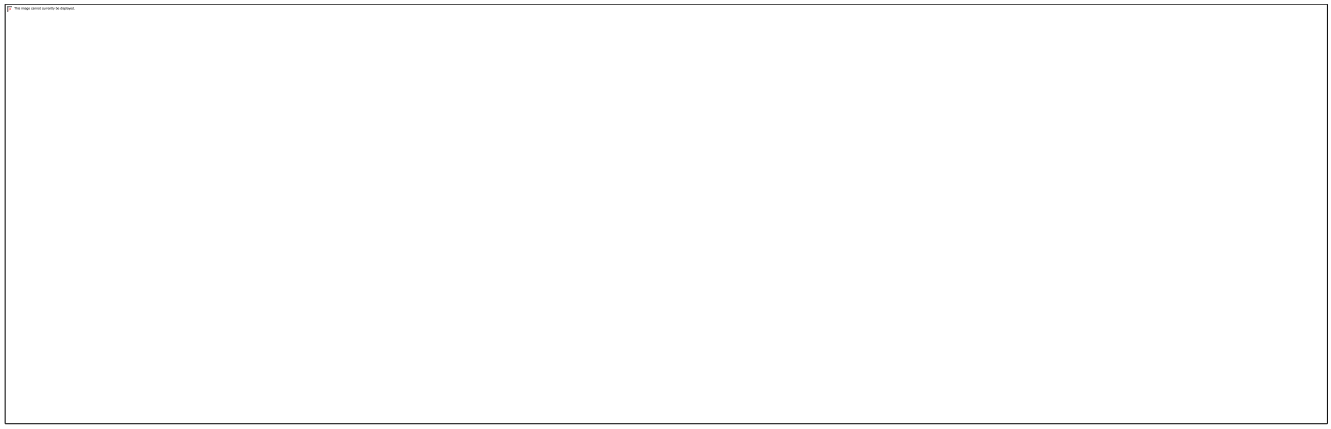
If you do not have a formal health ministry, please list the ministries at your church. Please list others.

Usher Board, Choir/Music Dept., Deacon/Deaconess Board, Food Committee, Hospitality Committee, Adult Sunday School, Children Sunday School

Deacon Board Ministry, Usher Board Ministry, Choir Ministry, Fiscal Ministry Trustee, Pastor Aid Board

Supper saints - 55 and up, support group, prison ministry, prison ministry, young adult ministry, dance ministry, women's ministry.

Q14 - Are women or men more active in the above groups you checked, or do both genders participate equally. Please comment.



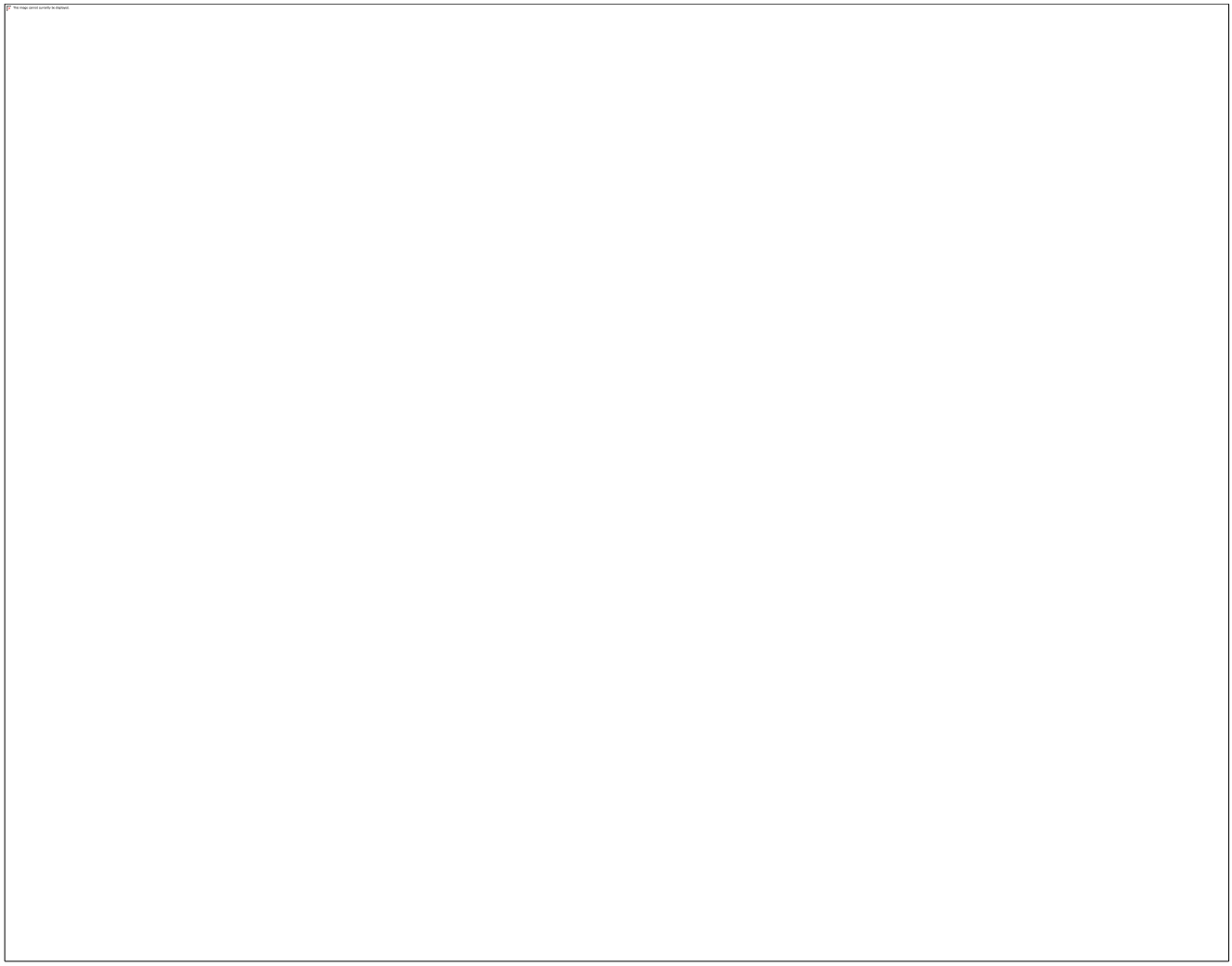
Answer	%	Count
Women	16.67%	1
Men	0.00%	0
Both	83.33%	5
Total	100%	6

Both

Please comment.

Equal participation
Both genders participate in these ministries.
Both participate but mostly women.
Both male and female participate equally with the exception of the women's ministry.

Q15 - What has been your experience in your congregation regarding how members prefer to have health issues addressed?



Answer	%	Count
Sermons, presentations or general discussion with the whole congregation, e,g, during services or testimonial sessions	25.00%	2
One-on-one mentoring or sharing with another congregation member, coordinated by a health ministry or church leadership	75.00%	6
Small group discussions or classes	62.50%	5

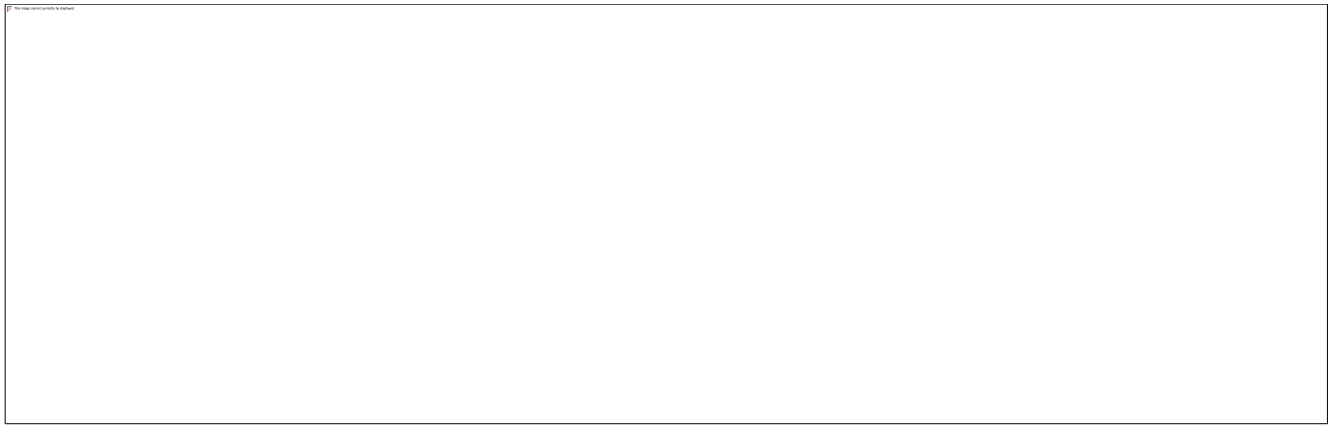
Other (please describe)	12.50%	1

Other (please describe)

Other (please describe)

Workshops/training with health and community liaison

Q16 - Have you observed any differences in format preference between women and men? Please describe.



Answer	%	Count
Yes	42.86%	3
No	57.14%	4
Total	100%	7

Yes

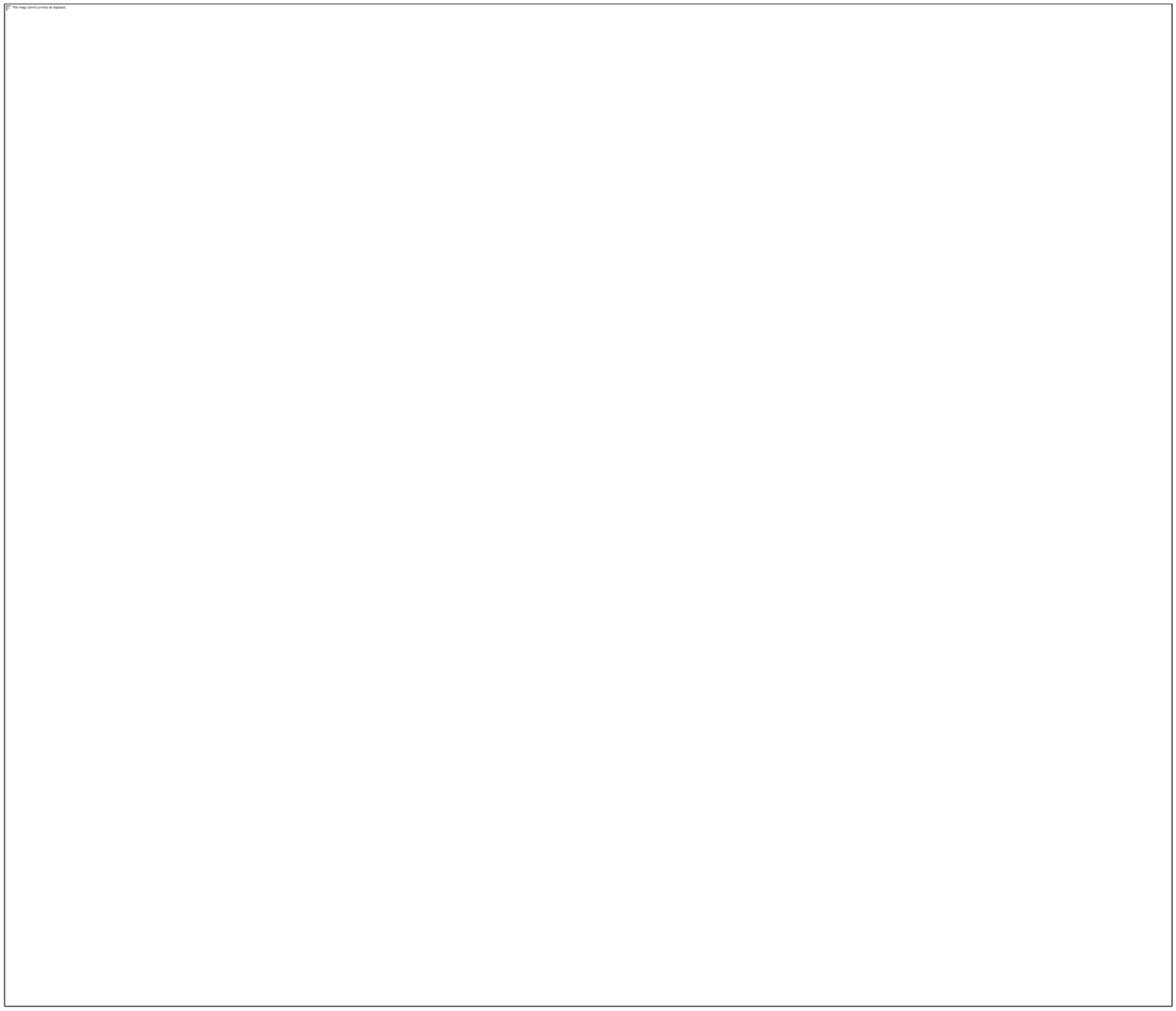
Please describe.

men are certainly more private with issues

Men need more prompting about health issues. Especially, Afro-American men concerning all health issues. Nevertheless, men would prefer talking to another man or male doctor concerning their health issues.

Women are more open, otherwise, preference is same.

Q17 - Please check whether the following church leaders or groups are actively engaged in furthering a health agenda, meaning they spend time on it at least once a month. (Check all that apply)



Answer	%	Count
Pastor	50.00%	4
Pastor's wife or spouse	25.00%	2

Health ministry leader or committee	37.50%	3
Brothers at the church	37.50%	3
Sisters at the church	62.50%	5
Other ministry (or ministries) or recognized group(s) within church. Please specify.	25.00%	2
Informal group-- for example, are there persons or a group of people within the church who are furthering health-related activities but are not an official part of the church organizational structure (e.g. congregants who are doctors or nurses who informally counsel others); Please describe.	12.50%	1
N/A-- doesn't exist in your church	0.00%	0

Other ministry (or ministries) or recognized group(s) within church. Please specify.

Other ministry (or ministries) or recognized group(s) within church. Please specify.

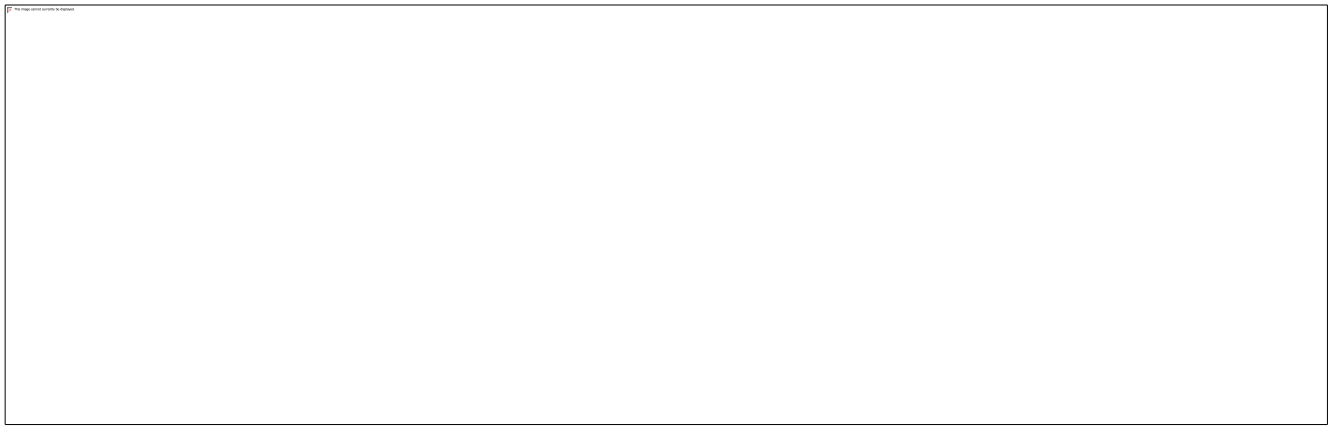
Prime timers (older adults)

Informal group-- for example, are there persons or a group of people within...

Informal group. Please describe.

There are about four members that are CNA’s and health issues are usually discussed during fellowship times (about twice a month)

Q18 - Do your members share stories about their health during testimonial service?



Answer	%	Count
Yes; please give an example:	87.50%	7
No	12.50%	1
Total	100%	8

Yes; please give an example:

Yes; please give an example:
Breast and prostate cancer survivors.
Healing
One deacon discuss an equilibrium problem he had and he was getting test run to see what is the problem Another deacon just recently discuss a prostate cancer diagnosis.
Sharing health issues and how they progressed through it.
Usually if they have been healed or have a report from the doctor.

Q19 - How do these testimonials affect the person and others?

How do these testimonials affect the person and others?

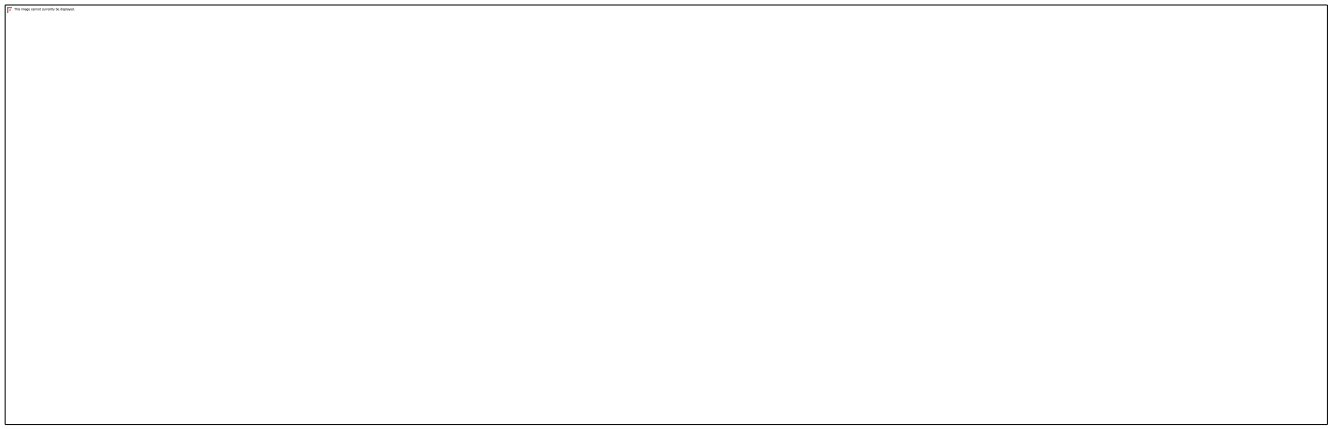
Inspirational

Increased awareness

These testimonials enlighten our congregant about their health and encourage us to pray for one another, and support one another. The bible says "we overcome by our testimony." Revelation 12:11.

It gives hope, peace, love and ability to go on when tragedy strikes.

Q20 - Do you presently have community partnerships with any health-related organizations?



Answer	%	Count
Yes. Please list organizations:	0.00%	0
No.	100.00%	7
Total	100%	7

Yes. Please list organizations:

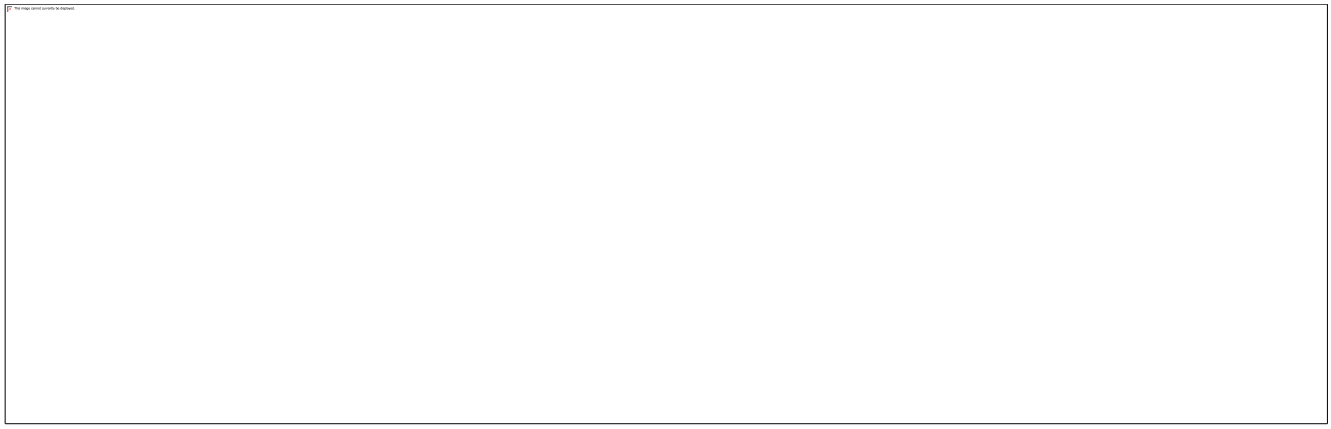
Yes. Please list organizations:

No.

No.

But we will be reaching out to a local health hospital to get assistance on health issues at the church from a physician that works there.

Q21 - If you do not presently have community partnerships with health-related organizations, would you like to?



Answer	%	Count
Yes	75.00%	6
No	25.00%	2

Q22 - Please explain in your opinion, what makes a partnership.

Please explain in your opinion, what makes a partnership.

Common interest and goals

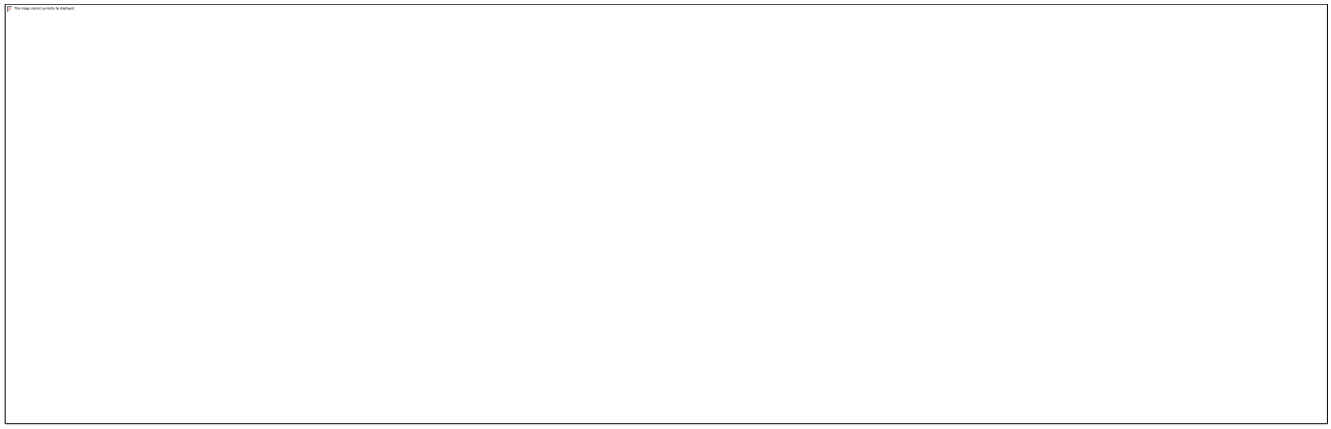
Partnership on community events and resources

A working collaboration with a liaison who gives data to help inform an organization and the organization provides support and cooperates to advice their mutual interests.

When different organizations work together for same cause.

Will need information about this.

Q23 - Have you conducted any Affordable Health Care insurance enrollment activities at your church? If so, please describe briefly.



Answer	%	Count
Yes	75.00%	3
No	25.00%	1
Total	100%	4

Yes

Please describe briefly.

A company by the name of came to inform our congregation about Affordable Health Care insurance, Medicare, Medicaid, retirement and investing. This information was presented by an insurance agent that works for the company.

Information on affordable health care a representative spoke to members who had questions

Q24 - How did you advertise it to participants? (e.g. church website, Facebook, or other forms)

How did you advertise it to participants? (e.g. church website, Facebook, or other forms)

Church bulletin and website

Facebook, Church announcements.

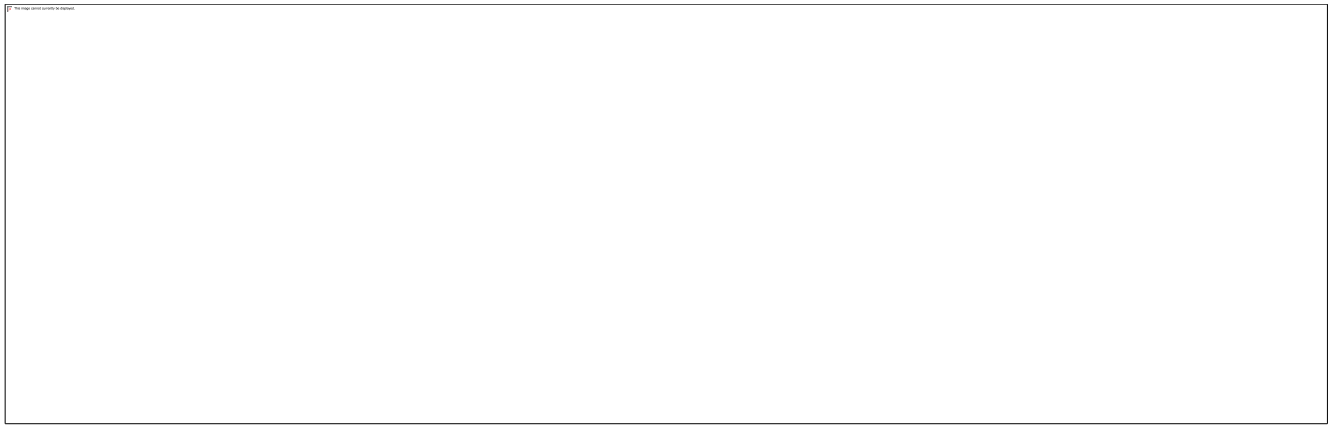
Church bulletin flyers.

They have been conducted on individual levels with a qualified consultant. The agent took care of this. We have not conducted any of these activities in church or during church time. They have been conducted on individual levels with a qualified consultant. We have not conducted any of these activities in church or during church time. They have been conducted on individual levels with a qualified consultant.

Q25 - Did you invite community members from outside of your church to attend?

Answer	%	Count
Yes	66.67%	2
No	33.33%	1
Total	100%	3

Q26 - Did you or your membership learn anything about health or health behavior as a result? If so, please explain.



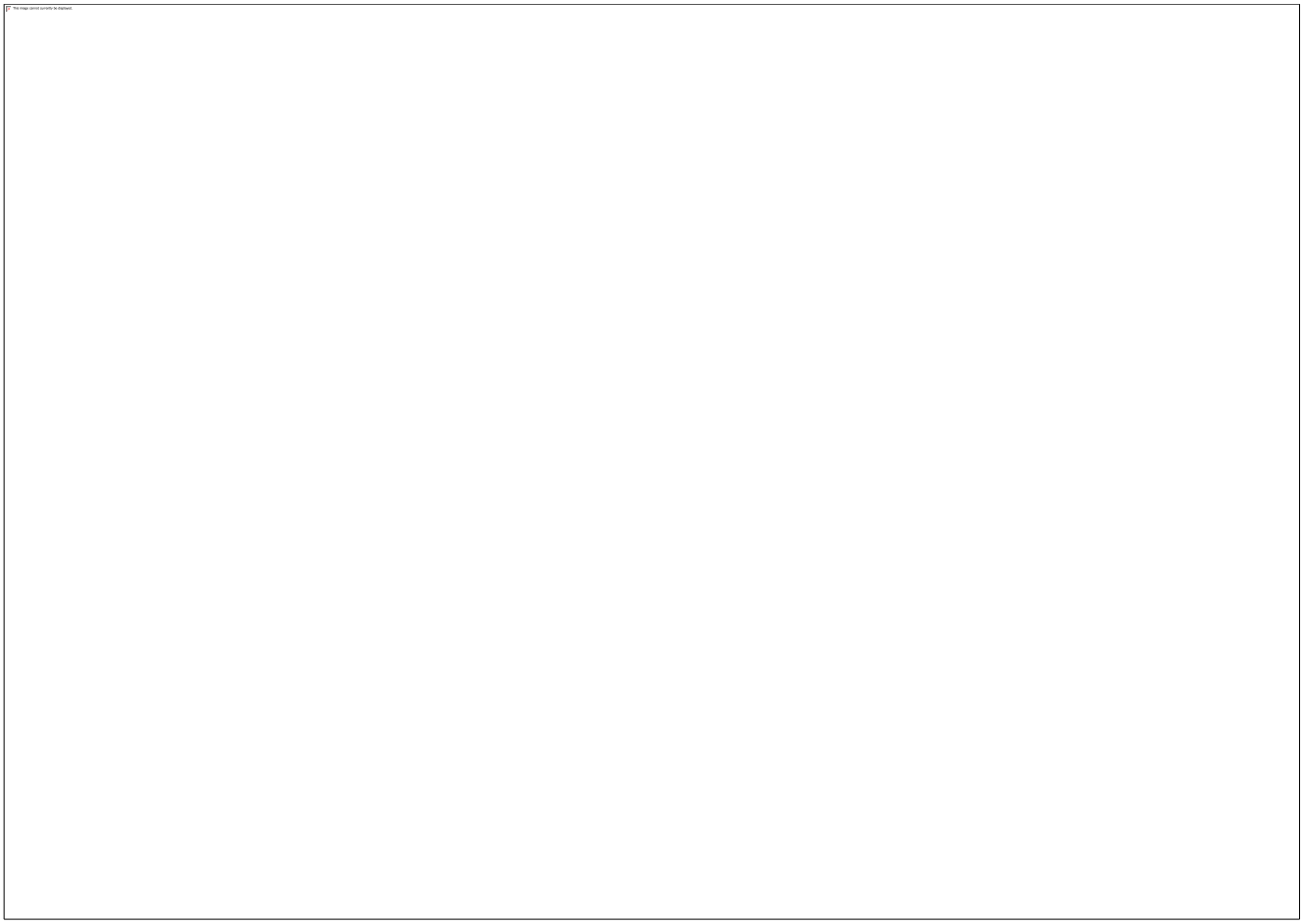
Answer	%	Count
Yes	100.00%	3
No	0.00%	0
Total	100%	3

Yes

Please explain.

Need instructions were provided
There were a lot of senior citizens that got a better understanding of the parts of Medicare, and Affordable Healthcare programs.
Health issues derive from early behaviors. I.e. not paying attention to various symptoms.

Q27 - How do you plan, implement, and evaluate initiatives in your church? (Check all that apply, if other add comment).



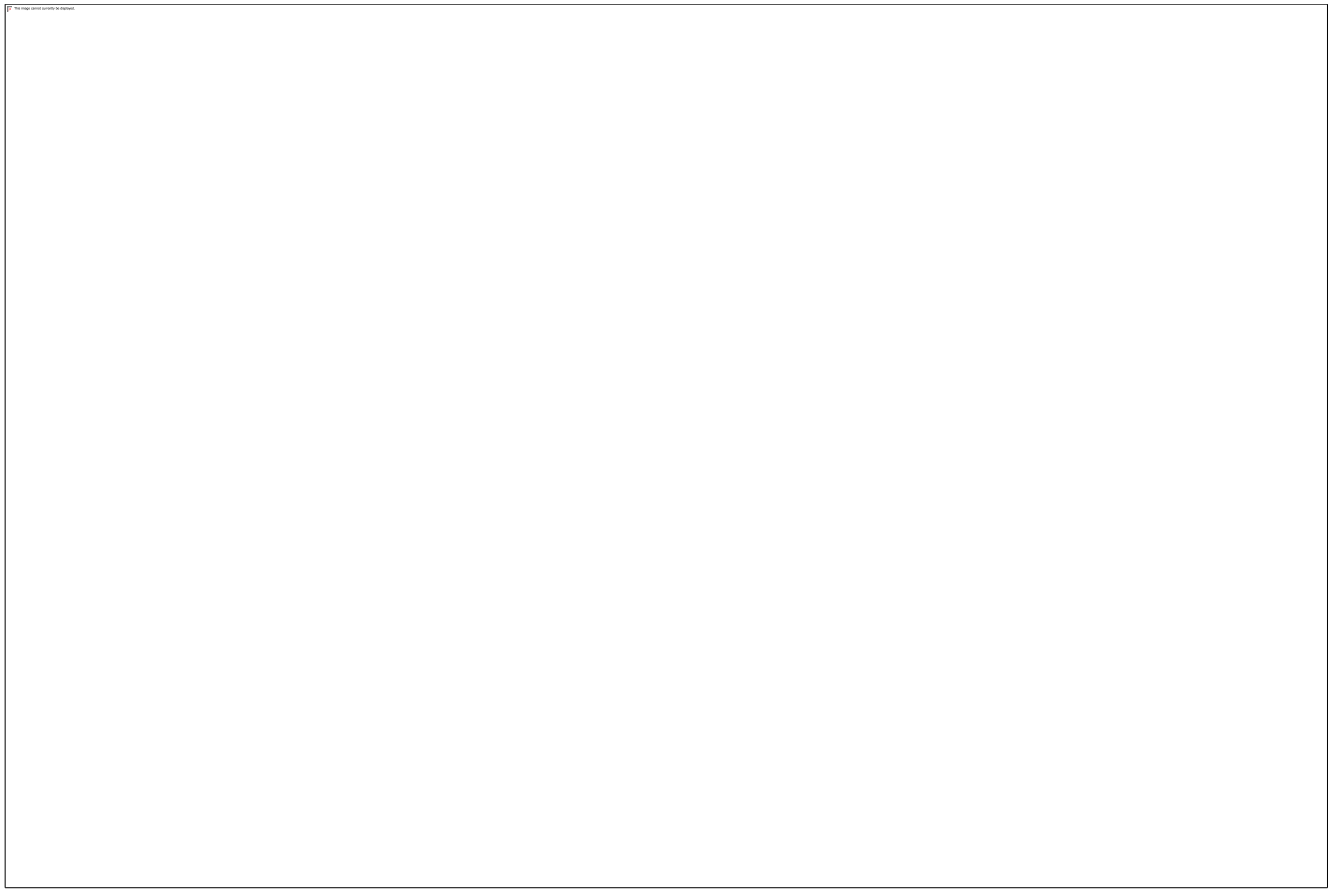
Answer	%	Count
During monthly meetings	50.00%	3
At annual church planning sessions	33.33%	2
By designating a new committee	33.33%	2
In a congregational needs assessment	16.67%	1
In surveys	33.33%	2

At church conferences	16.67%	1
In a congregational workgroup	16.67%	1
Other	0.00%	0

Q28 - How are health issues part of that planning?

How are health issues part of that planning?
Health ministry is usually included.
They are not. Handled by a specific ministry.
We will discuss designating a new committee to start healthcare initiatives for the church.
Not normally.

Q29 - If you are interested in learning more about ways to start a health ministry or how to conduct assessments and evaluations of activities please check what resources would be most helpful.



Answer	%	Count
Fact sheets	50.00%	3
Meetings	33.33%	2
Training sessions	50.00%	3
Web resources	66.67%	4
Phone conferences	16.67%	1
With facilitation of church leaders	33.33%	2

Other	0.00%	0
Comments:	33.33%	2

Comments:

Comments:

This will be great resources for our church because the Bible says in 3 John 1:2 "Beloved, I wish above all things that thou mayest prosper and be in health, even as they soul prosperth."

The church as a whole is really not interested.

APPENDIX H: CURRICULUM VITIATE

OBJECTIVE:

Experienced public health professional, serving in a challenging team leadership position that requires use of creative management techniques which integrate the organization's mission and vision into team strategies, goals, objectives, work plans and work products and services.

EDUCATION:

Master's in Public Administration, (1993)

Troy State University, Troy Alabama

Bachelor of Arts in Political Science, (1984)

Adelphi University, Long Island, New York

EXPERIENCE:

12/2014 – Present

Team Lead, BRFSS Program

National Center for Environmental Health

Centers for Disease Control and Prevention, Atlanta, GA

1. Provides project support to and acts as the primary technical lead on all state support aspects of the Behavioral Risk Factor Surveillance Screening Program (BRFSS).
2. Contributes to the development, implementation, monitoring and evaluation of BRFSS programs and services.

3. Serves as the subject matter expert for budgetary management for BRFSS programs.

4. Provides guidance on policy and programs affecting public health surveys in support of population health prevention and surveillance

5. Contributes to the planning of national programs partnered with the population health surveillance branch, assists in the development and coordination of assessment activities and establishes program's guidelines, procedures and strategies.

6. Leads the State Support Team and is responsible for supervising the project officers in all areas cooperative agreement management.

7/2007 – 12/2014

Public Health Advisor, GS – 685

National Center for Environmental Health

Centers for Disease Control and Prevention, Atlanta, GA

1. Served as a senior level project officer or technical advisor for designated interagency agreements, contracts, cooperative agreements and/ or grants.
2. Developed contracts, task orders and program announcements that support program goals, objectives, and priorities.

3. Expertly reviewed and processes new or continuation applications for cooperative agreement or contract funds.

4. Provided technical assistance to academic partners, state, and local health departments and other government agencies and organizations on the design, development, management, and evaluation of the Environmental Public Health Tracking Programs (EPHT).

5. Effectively monitored program/project activities to optimize outcome, and communicates to senior management any problems or issues beyond ability of incumbent to resolve, along with suggestions for resolution.

6. Regularly analyzed data to examine the effectiveness of the EPHT program's funded partners.

7/2004 – 2002

Public Health Advisor, GS – 685

National Center for Public Health Informatics

Centers for Disease Control and Prevention, Atlanta, GA

1. Served as project officer or technical advisor for designated interagency agreements, contracts, cooperative agreements and/ or grants in support of PHIN related activities and projects.
2. Communicated regularly with grantees via email, and telephone /conference calls to offer consultative services regarding the development, management and maintenance of their area specific public health information technology infrastructure and capacity building projects.
3. Conducted site visits to provide hands on programmatic guidance and technical assistance in the resolution of complex management needs and problem solving as it relates to the development and implementation of information systems, surveillance systems, and communications systems

7/2004 – 2002

Public Health Advisor, GS – 685

Public Health Practice Program Office (PHPPO)

Centers for Disease Control and Prevention, Atlanta, GA

4. Served as project officer or technical advisor for designated interagency agreements, contracts, cooperative agreements and/ or grants in support of the nation-wide implementation of the Health Alert Network (HAN) a nationwide, high-speed, secure Internet based alerting system.
5. Communicated regularly with grantees via email, and telephone /conference calls Conducted site visits to provide hands on programmatic guidance and technical assistance
6. Coordinated conferences, meetings and workshops for newly appointed state and county health directors and students in schools of public health.

6/2001 - 6/2002

Diabetes Prevention and Control Program (DPCP) Manager

Georgia Department of Human Resources, Atlanta, GA

1. Responsible for the design, implementation and management of all DPCP activities that improve the state's capacity to address the needs of Georgia residents living with and affected by diabetes.
2. Collected, analyzed and interpreted statistical data to support the evaluation of both measurable health outcomes for groups of persons with diabetes and the programs which are in place to support them.
3. Developed and maintained relationships with statewide stakeholders and identified mechanisms to increase communication, networking and educational opportunities among these groups.
4. Identified program and community needs and remained current on promising practices, best practices and evidence-based initiatives in diabetes prevention and care.

12/1999 - 6/2001

Tobacco Use Prevention Program (TUPP) Consultant

Georgia Department of Human Resources, Atlanta, GA

1. Provided technical assistance and consultation to local health district TUPP Coordinators regarding the planning, management, preparation of grant applications and execution of the tobacco use prevention and control efforts.
2. Developed and administered training programs to local health districts and other groups on the state's tobacco use prevention goals and mission.
3. Identified and built relationships with institutions and organizations that served racial, ethnic and minority populations; establish partnerships with these organizations, to conduct population based tobacco use prevention activities.
4. Established relationships with rural populations to engage communities in tobacco use prevention efforts.

7/1997 – 10/2008 (Retired)

Intelligence Specialist

US Navy Reserves, **Ft Gillem, GA**

1. Responsible for intelligence analysis on all-source data
2. Provided research and analysis to support US Navy intelligence organization
3. Determined methods and procedures to be used on new assignments and provided guidance to non US military personnel and trained others.

PROFICIENCIES:

1. Statistical Analysis Software SAS/STAT
2. Microsoft Office applications
3. Atlas.ti qualitative data Software

PRESENTATIONS:

1. American Evaluation Association Annual Conference, 2015
2. Region IV States Environmental Justice Coordinators Face-to-Face Meeting, 2013
3. U.S. Environmental Protection Agency Region IV, 2012
4. CDC's National Environmental Public Health Tracking Network: An Introduction for Nurses. Advocacy in Action session at the Alliance of Nurses for Health Environments and the University of Maryland School of Nursing National Conference, 2010
5. CDC's National Environmental Public Health Tracking Program: Opportunities for Unfunded States, Invited presentation, Ohio Environmental Health Association Annual Educational Conference, 2009
6. Keeping Track, Promoting Health: CDC's National Environmental Public Health Tracking Network, Invited presentation **for Region1 meeting of the Agency for Toxic Substances and Disease Registry (ATSDR) and Environmental Protection Agency (EPA), 2009**
7. PHIN Technical Assistance Plan. An Open Conversation session during the National PHIN Conference, 2007

AWARDS/HONORS:

1. NCEH/ATSDR Award for Excellence in Surveillance and Monitoring, 2010
2. Public Health Performance Award, 2000 -2011, 2016
3. Health and Human Services Spotlight Award, 2002, 2007
4. Public Health Informatics Network Award for Excellence in Service, 2005

PROFESSIONAL SOCIETY MEMBERSHIP:

1. American Evaluation Association, 2011 - present
2. Watsonian Society – An organization for public health advisors, 2003 - present
1. Behavioral Social Science Work Group, 2016

CERTIFICATIONS:

1. Contracting Officer Representative (COR), 2014
2. Initiative for Leadership Enhancement and Development (I-LEAD) Training, Nov. 2011
3. Team Lead Certification, November, 2008
4. CDC Public Health Readiness Certificate (PHRCP), December, 2005