Chapter 1 : New York Congregational

Bringing Caring to the Synagogue with Jewish Congregational Nursing B'etzelem elohim, the teaching that each individual is valuable because each of us is made in God's image, instructs us to value the young, the healthy, the aged, and the ill.

The relationship between social work field education, religiously affiliated organizations, and local philanthropic organizations is explored in this case study of a grant-funded project called the Congregational Social Work Education Initiative. Religiously affiliated organizations have traditionally been involved in the provision of social welfare services; yet, social work education has not embraced this tradition in ways that are intentional. Additionally, the impact of religion-based traditions on philanthropy is interesting and, here, this relationship is explored through tracing the history of a prominent family in the community of Greensboro, North Carolina. The unlikely collaboration between social work field education, religiously affiliated organizations, and a local philanthropic community health entity yields some interesting considerations for how communities can come together toward a vision of improved health. At the time, there was no model that demonstrated a partnership between religiously affiliated nursing programs and schools or departments of social work. Certainly, there is a historic link between social work and religiously affiliated organizations RAOs but, as a small group of visionaries searched for exemplary models in an attempt to address the health concerns of the people of Greensboro, North Carolina, the pairing of parish-based nurses and social work students was not something that emerged in the literature. Approximately eight years earlier, the Cone Health Foundation had funded the Congregational Nurse Program, which is based on parish nursing as developed by Dr. Granger Westberg [1]. The central principle of parish nursing is that professional nurses work within and alongside congregations or RAOs addressing health and wellness concerns. The Congregational Nurse Program in Greensboro was very successful and by was working with over 50 congregations and religiously affiliated organizations. Several of the nurses identified feeling overwhelmed by the social and emotional needs of the people they were serving and asked the coordinator about the possibility of having social workers assist. Through a series of discussions both planned and accidental, an idea emerged to have social work students engage with congregational nurses in fulfillment of their field internship requirements, both at the undergraduate and graduate levels. A grant application was written to the Cone Health Foundation and, based on the successes of the Congregational Nurse Program, the Foundation granted a year of funding, renewable for two subsequent years, to the University of North Carolina at Greensboro Department of Social Work. Thus, the Congregational Social Work Education Initiative was launched with its first cohort of twelve students, six undergraduate and six graduate, who completed a 40 h pre-service training program before being placed with nurses in the field [2]. Reflecting on the project, some questions are raised: What historical contexts lead the Cone Health Foundation to take a risk by funding an effort that was not based on any evidenced-based model of care? These are the questions that are addressed here. In order to begin to understand the link between congregations, religiously affiliated organizations and social work a review of the literature is conducted. Lastly, by using the case of the Congregational Social Work Education Initiative as an exemplar, a discussion of how religion, religious tradition, religiously affiliated organizations, and social work education may come together to address local, regional, national, and global needs is presented. Literature Review Religious affiliated organizations RAOs such as The Salvation Army, and religious congregations such as churches and synagogues have long played a foundational role in the delivery of social services. Our beliefs about helping those in need have their roots in ancient spiritual teachings and these beliefs have influenced the development of American social welfare programs. Through history, religious organizations and congregations have provided social services for members while also acting as a voice for the poor and oppressed [4]. Early Christians provided mutual aid and care to the needy. During the middle ages, religious organizations such as monasteries provided food, shelter, and clothing to individuals and families [5]. Organizations such as the Baptist Training School Settlement provided services to the poor in the early 20th century [7]. In addition, religiously affiliated organizations throughout the United States, such as urban

ministry and Salvation Army organizations, have and continue to play a central role in the delivery of social services. The leadership by religiously affiliated organizations in providing care has influenced not only American social welfare but also the development of the social work profession. Faith-based social service delivery has long been an important system of care [10] and the prominence of this delivery approach has received increased attention in the past twenty years as a result of Bush administration faith-based initiatives [11 , 12 , 13]. Despite the importance of religiously affiliated organizations in the history, development, and current delivery of social and health services, professional social work has often missed opportunities to join with these organizations in the delivery of services [14]. While social workers in medical settings have recognized the spiritual needs of patients and the importance of collaborating with clergy, social workers in child and family settings, mental health, and schools have been less active in this collaboration. As Manthey notes, during the modern development of the social work in the 20th century, there has been a drive for professionalization and a separation from volunteerism and religious-based service delivery [15]. This missed opportunity has been historically reinforced in social work education. Only in the past twenty years has the social work national accrediting agency, the Council on Social Work Education, required curricular content in spirituality as part of all Bachelor of Social Work and Master of Social Work programs. Despite the historical and current contributions religiously affiliated organizations have made to social work, recent research shows that building new partnerships can be challenging [16]. Research has shown that individuals and families often seek help from their pastor or church staff when facing unemployment, family dysfunction, and poverty [17]. However, church leaders may not always be skilled in recognizing or meeting the mental health needs of members. In addition, research has shown that church staff members rarely make referrals to mental health professionals [18]. Low levels of collaboration among professional social workers and religiously affiliated organizations and resulting low referral rates have expanded the professional distance between social work mental health professionals and clergy [19]. Social workers have been slow to embrace the importance of spirituality to many clients, while clergy do not always recognize the need for referral. Although there are exceptions opportunities for collaboration are being missed which result in low levels of service provision to people in need [20]. On the other hand, there are opportunities and needs for increased collaboration. Given the number of people who prefer seeking help in their religious organization, there are opportunities for social workers to more effectively meet health and mental health needs by reconnecting professionally with faith organizations [21 , 22]. Prior research has shown that clergy are concerned about the health needs of their members. Clergy support for specific programming such as health screenings, prevention interventions, health education, and health-related classes is strong [23]. This support provides opportunities for effective service delivery, student education, and interdisciplinary practice with congregants. In the current environment of sweeping changes in health and mental health delivery while continuing to face budget retrenchment, opportunities and potential benefits for collaboration are great [25]. Such collaborations require a mutual respect for the contributions of religiously affiliated organizations, the pressures faced in meeting congregant needs by pastors and other religious leaders, and a commitment by social workers to include the importance of spirituality and collaboration with religiously affiliated organizations in everyday social work practice. In addition to the consideration and inclusion of spirituality, social workers and social work students must begin to understand and access the vast resources that may be a part of the ministries of many community congregations. For example, the Congregational Social Work Education Initiative students have become very aware that local churches will often help with the purchase of needed medications or assist with paying utility or grocery bills for the people being served. Social welfare assistance has never really left religiously affiliated organizations but many social workers have historically relied on secular social services agencies in accessing resources. Now, churches are often at the forefront of providing food, fiscal assistance, and shelter in some cases. As exemplified by the history of the Cone family below, religious traditions often emphasize acts of philanthropy and community service. It is very important for social workers and social work students to recognize the potential to access and enhance resources by building relationships with religiously affiliated organizations at the local and regional levels in particular. No longer can social welfare be regulated to departments of social services or secular charitable aid organizations. Congregational Social Work Education

Initiative students are encouraged to work closely with religiously affiliated organizations in order to foster strong relationships so that the people served have access to resources. The fact that CSWEI has become a part of the effort to enhance the health and wellness of the community it serves reflects the principles of the Cone family and the Cone Health Foundation. The time has come to re-imagine possibilities and to explore partnerships between religiously affiliated organizations, social services, and social work education. Both were visionary industrialists, establishing their leadership in textile manufacturing, international trade, finance, and philanthropy. They called upon merchants and small mill operators who often had little cash to purchase goods; they bartered taking cloth as payment, in-turn selling it to other customers in their travels. Moses Cone did not want to go into textile manufacturing but he seized the opportunity to reorganize textile manufacturing by assisting distressed small mill operators, many who had been former clients, by stabilizing textile prices and acting as an agent to sell their goods across the United States and overseas [26 , 27]. When the mills could not provide enough finished textiles, especially denim, Moses Cone saw the opportunity to build their own mill to complete the full process from processing raw cotton to producing a finished product. Greensboro had always been known as a tolerant and welcoming city. Authors attribute this to the early Quakers, Moravians, and Presbyterians, who settled the area prior to the American Revolution, and their experiences with discrimination and hostility toward their religious tenants and practices. These and other faith traditions had a positive respect for the small number of Jewish merchants in Greensboro and other small nearby towns [28 , 29 , 30]. The city leaders envisioned such a large mill could provide needed jobs for small farmers and tenant farmers and their families, many of whom were leaving rural areas seeking better living and work opportunities. In Proximity Manufacturing Mill was opened for the production of denim. Greensboro offered multiple advantagesâ€”lower labor costs, affordable land for mills and housing, water for hydro-power, low freight costs with seven rail lines converging in the city; it was the ideal location where raw cotton could be shipped in and finished products shipped. They would open other mills to meet increasing demand for denim, flannel, and other finished textiles. Unfortunately Moses Cone died in at the age of 51; Cesar Cone carried on the work building Proximity Printworks in and entered into the lucrative long-term contract supplying blue denim to jean maker Levi Strauss in Younger Cone brothers would join and continue managing the family enterprises [31 , 32]. Most laborers in the early mills were illiterate, often tenant farmers, making attempts to escape rural poverty. Historians and researchers have denounced many Southern mill towns, built by mill owners and operated by mill superintendents, as paternalistic and authoritarian models to exploit workers [29 , 31 , 34]. Overall these mill families faced grinding poverty with poor work and living conditions; they suffered from pellagra, poor sanitation, substandard street maintenance, lack of health care for infants, or assistance when sickness or injury occurred [31 , 34 , 35 , 36]. Mill owners hired ministers for church worship with sermons built around the themes of duty to the master, hard work, and acceptance of the social order [35 , 37]. Moses and Cesar Cone did take a paternal role in their villages; however, they believed the welfare of their workers and families was as important as volume and profits. Balliett chronicled the expansion of the Cone business and how they attended to the physical, spiritual, health, education, and well-being of their workers and families [32]. Since building their first mill outside Greensboro in , five self-sufficient villages were built to serve workers in its factories. At their peak, the villages covered acres and housed workers in about houses. For African-American workers a separate mill village was built along with their school, church, and recreational center. Boarding houses for single men and family housing was constructed. Each village company store provided wood and coal at absolute costs; dairy, beef, pork, flour produced on company farms were offered at prices below those charged by local merchants along with other food staples, household goods, and clothing items at prices below town prices [32]. Each house sat on a large lot, with many residents having their own poultry house to supply eggs daily and chicken for the Sunday table. Canneries were provided in each village where residents could preserve fruit and vegetables raised in their home gardens. As the villages were incorporated into the city, by the late s workers could buy their houses and join others in private homeownership [38]. Classes for expectant mothers, well-baby clinics, dental clinics, physician visits were provided for sick or to attend work injuries. Social workers and nursing provided classes on sanitation, the domestic areas of cooking, sewing, canning, and food preparation. Cesar Cone was

especially supportive of the Y. Two separate large facilities were erected for social, recreational, organized sports teams, and academic activities; women and girls could access the gymnasium and in-door pools for their organized games and clubs. Community wide activities were planned by village representatives along with Y. Both brothers believed in the importance of education, finding existing schools in the county to be inadequate in size, ill-equipped, and lacking competent teachers. They built schools in each village, hired and paid university trained teachers, instituted a nine-month school term, and encouraged workers to send their children to the schools and kindergartens. Night classes for adults offered reading, arithmetic, applied textile mechanics to encourage advancement plant and middle management positions. Women were encouraged to take classes in reading, writing, mathematics, and domestic sciences. The brothers provided land to build six churches in the mill villages, constructing one for African American residents, and providing monies to an established congregation close to one village. The company provided major financing to erect these buildings; later provided lots and paid entirely for construction of their parsonages. These churches continue to operate today [32 , 40]. As noted, Moses H. Cone died at the age of 51 in without a will. He and his wife Bertha Landau Cone had no children.

Chapter 2 : Bedford Center for Nursing and Rehabilitation

Congregational Nurse Program. Our Congregational Nurse Program is a unique, specialized nursing practice established as a collaborative relationship between Cone Health and our area's faith communities.

From Dream to Reality: Farrell and Dawn B. Rigney Thinking about a parish nurse ministry? Eleven parish nurses share the ups and downs of getting started, revealing 5 phases of program development. The best thing is to do a lot of reading and get all the information you can on the subject and the role of the nurse in the church and with the congregation. Determine if your church could use this position and these services. Consult with your pastor and other leaders to determine level of interest. Then draw up an action plan based on your readings. This will lead you to present the program as a volunteer service to your church board or leadership team. Select a committee to help, get them elected by the church, lead them in planning the program based on your readings. Or, you may want to write for a grant to pay for the nurse initially, hoping the congregation will assume more responsibility after a couple of years. Certainly after 1 yr. This is pretty much what I did, and the Congregational Health Program is pretty well established in our church now, in our third yr. However it is all volunteer. It is my personal goal to try to get a paid nurse on staff within 5 yrs. I am retired and am not interested in being part or full time any more. A parish nurse is: A health educator; 2 a personal health counselor; 3 a teacher of volunteers; 4 a laison with community health organizations; 5 a clairifier of the close relationship between faith and health; 6 most importantly a client advocate. The basic requirements are: BE a registered professional nurse with a current nursing license; and have a baccalaureate degree and two years working in the health field. Experience in any of the following is beneficial: The most important qualification is a high degree of spiritual maturity. It is crucial tha the nurse have a talent for counseling. This entails considerable teaching and the development of various support groups. It is the responsibillity of the parish to create interest in a variety of health-related programs. There is certification given after completing a training which can be done on the internet or at a local college or university that offers it. University of Indiana gives them over the internet. Its a six week course complete with readings, assignments and written work to be evaluated. The difference in the parish nurse PN as oppose to the faith ministry nurse FMN is that the parish nurse extends her role outside the congregation to the surrounding parish. The FMN contains herself strictly to the congregation. I hope this answers some of your questions. Critical Care RN Joined: I am currently taking a community health class in my B. We were just talking about Parish nursing and I got the impression it was a volunteer position in most areas? Does anyone know for sure? However, some medical centers and hospitals have programs where they arrange with churches to provide Parish Nurses over a period of time, usually years. The medical center pays the salary of the Parish Nurse the 1st year, then in decreasing increments over the years with the plan that the church will take over full salary by the end of that time. So, if one wants to get paid to do this highly satisfying and rewarding type of nursing, you have to search for a large congregation that is committed to promoting the health of its congregation and understands the great value of the professional contributions of the Parish Nurse, or work for the medical center that contracts for the services. Some churches in my area actually pay for a part time Parish Nurse to be on their staff as an employee, with performance evaluations and the whole bit. However, probably 9 out of the 10 I know are volunteer. I am volunteer and probably put in hours a week on a program I developed. It could easily become a full-time job, but I purposefully prevent it from becoming that. I am now taking a Basic Parish Nurse Preparation course that my church is paying for however, so progress is being made.

Chapter 3 : Interfaith Health & Wellness Association

The Impact of New Models of Congregational Jewish Education Page ii The Impact of New Models of Congregational Jewish Education A report submitted to The Jewish Education Project, July

This article needs additional citations for verification. Please help improve this article by adding citations to reliable sources. Unsourced material may be challenged and removed. June Learn how and when to remove this template message Faith Community Nursing, also known as Parish Nursing, Parrish Nursing, Congregational Nursing or Church Nursing, is a movement of over 15, registered nurses , primarily in the United States. Faith community nursing is a practice specialty that focuses on the intentional care of the spirit, promotion of an integrative model of health and prevention and minimization of illness within the context of a community of faith. The intentional integration of the practice of faith with the practice of nursing so that people can achieve wholeness in, with, and through the population which faith community nurses serve. Parish nursing began in the mids in Chicago through the efforts of Rev. Granger Westberg as a reincarnation of the faith community nursing outreach done by religious orders, such as the "Parish Deaconesses" in Europe and America in the s. However, it is not only available to Christian congregations. Scope and Standards of Practice was approved by the American Nurses Association in and updated in and define the specialty as " Each standard is measurable by a set of specific competencies that serve as evidence of minimal compliance with that standard. To become a faith community nurse, the registered nurse must have a minimum of 2 years experience, must have a current license in the state where the faith community is located, and have completed a parish nurse foundations course for the specialty practice as recognized by the American Nurses Association. There are several different curriculum offerings for the faith community nurse which have been developed by a panel of nursing faculty. Faith community nurses serve in several roles, including: They coordinate existing services and supplement them with a holistic dimension of health and caring. A parish nurse program or faith community nurse program can operate in several different ways. In the United States, faith community nurses typically belong to the Health Ministries Association which is the national professional membership organization for faith community nurses. It began with an initial course spanning a three-week period and brought together nurses from various denominations who were commissioned on 27 February It is intended that there will be continued training and that the programme will spread throughout the Commonwealth of The Bahamas and the Caribbean. Resources for faith community nurses[edit] These organizations help to support faith community nursing and serve a wide variety of faith communities:

Chapter 4 : JGS Lifecare | Redefining Aging | Longmeadow, Massachusetts

Our Congregational Nurse Program is a unique, specialized nursing practice established as a collaborative relationship between Cone Health and our area's faith communities. This partnership recognizes that religious organizations have a long history of promoting healing and caregiving.

Chapter 5 : What exactly is parish nursing? | allnurses

congregational model Parish nurse arrangement in an individual community of faith in which the nurse is accountable to the congregation and its governing body. faith communities.

Chapter 6 : Long-Term Care - The New Jewish Home

Faith Community Nursing, also known as Parish Nursing, Parrish Nursing, Congregational Nursing or Church Nursing, is a movement of over 15, registered nurses, primarily in the United States.

Chapter 7 : Faith community nursing - Wikipedia

DOWNLOAD PDF A MODEL FOR JEWISH CONGREGATIONAL NURSING

The Memphis Model The Memphis Model "maps" (aligns and leverages) existing assets â€” integrating congregational and community caregiving with traditional healthcare to.

Chapter 8 : Congregational Nurse | Greensboro Jewish Federation

At the Jewish Home, individuals can receive a range of services, including: Long-Term Care for those who require ongoing health care and assistance with daily activities Transitional Care for individuals who need short-term inpatient care after a hospitalization.