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Development of tailored feedback reports on organizational capacity for health promotion in African American churches

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Abstract

Standard community-engaged research methods involve reporting research findings back to study participants. Project HEAL is an implementation trial conducted in 14 African American churches. This paper reports on a strengths-based approach to reporting Project HEAL organizational capacity data back to church leadership, through use of individualized church reports. Pastors in each church completed a church organizational capacity assessment. The study team, including community partners representing church leadership, co-created a channel and content to disseminate the capacity data back to Project HEAL church leaders. This consisted of a 4-page lay report that included the church's capacity scores, and recommendations for future evidence-based health promotion programming matched to their capacity. The study team was able to meet with nine of the 14 churches to review the report, which took an average of six and a half weeks to schedule. The individualized church reports were well-received by pastors, who expressed an intention to share the information with others in the church and to sustain health promotion activities in their organizations. Though the individualized reports were embraced by the pastors, it is unknown whether this process will result in sustainable health promotion in these organizations without further follow-up.

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1. Introduction

Community-based participatory research (CBPR) posits that action and community stakeholder participation are critical parts of the research process (Minkler & Salvatore, 2012). Community engagement is one approach to facilitate the translation or uptake of evidence-based interventions into practice in community settings (Minkler & Salvatore, 2012). CBPR can increase the relevance and effectiveness of research, support community trust and participation, and facilitate the processes of data collection, analysis, and dissemination of findings (Cargo & Mercer, 2008). It is also recommended that community partners share in ownership of the data and are involved in co-creating data-derived meaning from the results. One of the key CBPR principles is the dissemination of research findings to community partners and stakeholders in order to facilitate sustainable change in promoting health (Israel, 2005; Minkler & Wallerstein, 2008). Community partners are critical in the identification of effective strategies for reaching key decision-makers/leaders/stakeholders in the community and in the selection of appropriate dissemination channels (Minkler & Salvatore, 2012). Disseminating findings to key community stakeholders requires ongoing communication, collaboration, and trust between academic and community partners (Eng, Strazza, Rhodes, & Mebane, 2005; Parker et al., 2005).

While a best practice in community-engaged research, there is little practical guidance on how best to disseminate data back to individual research participants. Discussing research findings through meetings and the importance of dialogue have been previously discussed (Garnett et al., 2015; Piggot-Irvine, 2010). Recommended formats have included briefs, interim reports at project milestones, presentations, and final reports (Shulha, Whitmore, Cousins, Gilbert, & al Hudib, 2016). Alternative approaches have been considered for presenting evaluation findings, such as a values-engaged framework and use of poetry. Johnson and colleagues (2013) found that use of poetry helped to engage stakeholders around evaluation findings, add richness to the data, and ease potential tensions that can accompany the communication of evaluation data. Furthermore, dissemination of research findings can contribute to the capacity of organizations once a program/intervention is no longer funded, and might help work towards the long-term institutionalization or sustainability of a program and the health benefits it delivers (Scheirer & Dearing, 2011; Stirman et al., 2012). The step of providing data back to participants also aligns with sustainability planning processes and strategies in the literature (Johnson, Collins, & Wandersman, 2013).

Whereas reporting research data is important at the participant level, for some types of projects it is also appropriate to report back to the participating organizations. The aforementioned strategies might be useful for reporting data back to organizations; however, there are fewer examples of specifically how to do this at an organizational level. As one example, the Chinatown Restaurant Worker Study used CBPR approaches to study the

health and working conditions of restaurant workers in San Francisco's Chinatown (Minkler & Salvatore, 2012). Survey data from 433 restaurant workers were collected, as well as observational data using a Restaurant Worker Safety Checklist. Preliminary results were shared with all partners through email and in-person communication at steering committee and project meetings and the restaurant workers were involved in the data interpretation. Study findings were shared through lay/ethnic media, targeted meetings with restaurant workers and owners, and policymakers. As part of the dissemination plan, approaches were targeted to each stakeholder group.

Another community organization that has been heralded as a successful setting through which to reach medically underserved audiences are churches or faith-based organizations (FBOs). FBOs play a pivotal role in the African American community, providing access to large interpersonal networks, sources of social support, and an infrastructure that can facilitate the establishment and maintenance of health interventions. FBOs have access to volunteers who can support health intervention efforts, often guided by the strong influence of the pastor (Baruth, Wilcox, & Saunders, 2013; Bopp, Baruth, Peterson, & Webb, 2013).

While a promising setting to implement evidence-based interventions, FBOs vary extensively in their governance structure, staffing, physical plant, connections with other community organizations, and in the size and characteristics of congregations. Similarly, a great degree of variability can also be observed in the success that churches have in implementing health promotion interventions. Success in implementing and sustaining such programs is likely associated with the church's organizational capacity (Author et al., (2017)). There is considerable recent emphasis on "capacity building" in public health research and practice (National Institutes of Health, 2011). Rabin and Brownson (2012) define capacity building as "Any activity...that builds durable resources and enables the recipient setting or community to continue the delivery of an evidence-based intervention..." (p. 27).

The purpose of this paper is to describe a strategy for disseminating organizational capacity data back to African American church leaders whose congregations had participated in an implementation trial, Project HEAL (Health through Early Awareness and Learning). Project HEAL was a cluster randomized implementation trial that included 14 African American churches in Prince George's County, MD. Half of the churches were randomly assigned to receive an in-person ("traditional") training of community health advisors (CHAs) with the other half receiving web-based training ("technology") for CHAs [see Author et al. (2014) for a detailed description of the intervention]. Interventions administered by CHAs promoted guideline-consistent screening for breast, prostate, and colorectal cancers. This manuscript documents the development and dissemination of a report on organizational capacity to the Project HEAL churches, individualized for each church based on their organizational capacity scores. Based on previous research (Chen, Diaz, Lucas, & Rosenthal, 2010; Whitt-Glover, Porter, Yore, Demons, & Goldmon, 2014) and the experiences of the project team, we felt that these data could be helpful for fostering sustainability of health promotion in the churches. This work has implications for those working with organizations, and churches in particular due to their unique organizational characteristics, to encourage the implementation and sustainability of evidence-based interventions and health promotion activities.

2. Methods

2.1 Project HEAL Intervention

Project HEAL churches self-identified as predominately African American mid-size (i.e., 150–500 members) Christian churches, that had not hosted a previous similar cancer educational intervention during the previous year. After training and certification, CHAs accessed Project HEAL intervention materials (e.g., recruitment materials, presentation materials) that they used to implement a series of three monthly educational workshops for members of their churches on cancer early detection (cancer overview, breast/prostate, colorectal). Follow-up data on workshop participants were collected at 12- and 24-months. A detailed description of the CHA training process, including feasibility, is described elsewhere (Author et al., 2014). Institutional review board approval was obtained prior to data collection.

2.2 Church Organizational Capacity Assessment

After enrollment, each pastor completed a church capacity assessment, which consisted of a one-hour in-person interview with study staff that served to obtain descriptive and organizational capacity data about the churches [described in detail in (Author et al., (2017))]. The capacity assessment tool is rooted in previous theory (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004) as well as literature on organizational readiness and capacity (Rabin & Brownson, 2012; Weiner, Amick, & Shouu-Yih, 2008). The capacity assessment contained largely closed-ended questions in three areas including *staffing and space* (e.g., number of paid and volunteer staff, pastor outside employment and education, estimated number of church members, building ownership vs. rental); *health promotion experience* (e.g., church's previous involvement in health promotion activities, presence of a health ministry); and *external collaborations* (e.g., previous collaborations and partnerships with outside organizations, involvement in research, technical assistance). Each church received a score on each of the three subscales as well as a total sum capacity score (Author et al., (2017)). Initial instrument performance is previously reported (Author et al., 2017) and data collection for a larger validation study is ongoing (Author et al., (2018)).

2.3 Development of Tailored Feedback Reports

The research team, including our community partners, discussed how best to disseminate the church-level data to the churches in a sensitive and useful manner. It was critical to include the community partners in these discussions—each of whom had held leadership positions in African American churches—to hear their perspectives on a number of issues that came up during this process. For example, questions arose regarding the most useful way to report the church data for each church's planning purposes. The research team also discussed whether the churches would be provided with their own data exclusively or aggregate data from all of the Project HEAL churches for comparative purposes. We decided to provide each church only with their own data in light of the variability in church capacity and to be sensitive to the lower capacity churches.

Overall, we decided to take a strengths-based approach in reporting back these data. The team held exhaustive discussions about how to present the capacity data, in particular the

“anchors” used to characterize churches that had limited capacity. For example, we wanted to avoid terms such as “low” or “weak” on the low end of the capacity continuum, so as not to alienate the church leaders. The goal was to give churches an authentic report of the data that they provided, while not making the pastors or other church representatives feel negatively about their answers. Potential scale anchors were considered (e.g., modest/moderate vs. high), but the team settled on “room for growth” to reflect the lower end of the capacity scores and “strength” to reflect the higher end. Capacity subscale scores were reported continuously using a visual analogue display (see Figures 2–3). Another difficult process was determining a suitable format for the report. The team had iterative discussions across several months about how to contextualize the data, while also providing something that would hopefully be of value to the church leadership.

2.4 Content of Tailored Feedback Reports

The tailored print-based church reports were customized for each church with their name and scores on the capacity assessment. Each report was four pages and printed in color, beginning with an introduction to the purpose of the report and a less technical definition of each of the three subscales (i.e., staffing and space, health promotion experience, and external collaborations). The team was careful to avoid jargon and be mindful of principles of health literacy throughout. Figure 2 shows “Church A” with moderate staffing/space and health promotion experience, and more limited external collaborations. Figure 3 shows “Church B” with strengths in staffing/space and external collaboration and moderate scores on health promotion experience. These two examples illustrate the variability in capacity scores both within and between churches.

The reports then characterized the church’s scores on the three capacity subscales, each with a description of the subscale, an explanation of how it was assessed linking back to the questions from the pastor interview, and a visual analogue indication of where the church’s score fell. The reports included recommendations for church health policy matched to the church’s overall high/low capacity score. For example, a church with high capacity received the Congregational Wellness Project (Winters, 2017) as a recommendation for an example church health policy. The reports also included recommendations for evidence-based health promotion interventions based on the church’s expressed interests in areas of chronic disease collected at the 12-month workshop. For example, a church that expressed interest in the area of nutrition received the Body and Soul program (National Cancer Institute, 2004) as a recommendation. Finally, all churches received a standard health resource page that provided information and screening guidelines for chronic disease, including but not limited to diabetes, heart disease, and vaccines, as well as a list of other health-related resources and websites.

3. Results

We first describe the 14 Project HEAL churches and present demographic data analyzed by church from enrolled project participants. The 14 Project HEAL churches each enrolled 13 to 47 participants, with an average of 27 participants per church. Demographic characteristics of the Project HEAL church congregations, analyzed by church, indicate the

mean Project HEAL workshop participant age ranged from 50.47 ($SD=5.29$) to 64.42 ($SD=6.60$). The percent of participants with health insurance varied from 75% to 100%, participants' median income ranged from \$40,000-\$50,000 to \$90,000-\$100,000, and while 11 churches reported a median participant educational level of some college or technical school, three reported a median education level of a high school diploma.

Capacity scores were standardized and converted to t-scores for each subscale, each with a mean of 50. Scores ranged from 35.89 to 59.48 ($SD=6.66$) on the staffing/space subscale, 34.73 to 61.19 ($SD=8.33$) on the health promotion experience subscale, and 44.26 to 64.11 ($SD=7.30$) on the external collaboration subscale. This suggests that Project HEAL churches varied in capacity on several different dimensions, thus the use of a tailored report was appropriate.

3.1 Dissemination of Tailored Reports

Following the development of the tailored reports, study staff scheduled individual in-person meetings with the pastors and any other church leaders the pastor invited (e.g., CHAs) to present the report, debrief, and discuss possible sustainability strategies for health promotion activities. These meetings occurred roughly two years after the implementation of the Project HEAL workshops, during which initial sustainability was evaluated [reported in (Author et al., (2017))]. In general, it took six and a half weeks to schedule meetings with the pastors, and five of the 14 meetings were unable to be scheduled after multiple attempts. We emailed the tailored report to the pastors who were unable to be reached for the in-person meeting.

3.2 Summary of Meetings with Pastors

We applied a standard series of open- and closed-ended questions for use in the pastor meetings. Pastors were first asked if they had any questions about the report. Although most did not have questions, two pastors remarked on the importance of sustainability, though they did not use that specific term. Rather, one pastor suggested that the report was actionable and indicated the need for a coalition of community leaders, churches, and schools for sustainable church health promotion. Another pastor suggested that health promotion activities might be seasonal in nature, but recommended consistent follow-up for sustained activities year-round. When asked how the tailored report could be improved, no ideas were put forward.

In response to the question of how the information in the report could be helpful to the pastor and congregation, pastors made reflective statements and expressed thoughts about health promotion activities moving forward. For example, one pastor indicated that a written health policy would be useful for their church. Another indicated that the report could help to identify strengths and weaknesses, make improvements, and identify areas to focus on. In one church there had been a pastor transition, and the new pastor had a more critical view of the church's strengths/limitations when he reacted to the data provided by the previous pastor.

Regarding the question about plans to share the report with others, the pastors unanimously expressed intention to do so, ranging from other pastors, church leaders, congregation

members who are nurses, or the entire congregation. One pastor indicated an intention to recruit other pastors/churches in their assembly in order to create a health policy and hold additional Project HEAL workshops.

When asked to rate on a scale of 1 (not at all likely) to 5 (very likely) how likely the church was to conduct cancer-focused health activities during the next six months, responses ranged from 3 to 5 with a median of 4 and modes of 3 and 5. In response to the question of how likely the church was to conduct other health-related activities during the next six months, responses also ranged from 3 to 5 with a median and a mode of 4.5. We asked what would be helpful to the churches as they move forward into future plans for health promotion activities, and responses included materials and resources, print materials/PDFs, partnership grants for churches, and proper preparation and planning.

Considering the team's interest in the potential scale-up of Project HEAL, we asked the pastors what would be the best way to share Project HEAL with other pastors. Responses largely centered around working through the church's networks. Pastors suggested approaches such as meeting with sister or affiliate churches, hosting a forum or luncheon for church leaders, working through congregational conventions, and word of mouth. A number of these approaches involved getting an audience with a large group of pastors.

4. Discussion

This paper reports on a strategy for disseminating organizational capacity data back to African American church leaders using a tailored report with capacity-matched features. Sharing data collected in partnership with communities is a central tenet of CBPR. Nonetheless, little is known about effective and appropriate strategies for disseminating research data at the organizational level. We provide new insights into the design and delivery of organizational-level data to community partners using tailored reports. The unique contribution of this report is the focus on a tailored strategy to disseminate organizational capacity data back to community organizational leaders. We believe that this approach to organizational data dissemination could encourage the sustainability of health promotion interventions through the reinforcement of an ongoing relationship between the university and the churches, continued engagement of leadership, and a source for church leadership to obtain recommendations for planning future health promotion activities based on the members' expressed interests.

Dissemination of evidence-based programs and interventions require a plan or set of targeted strategies that should commence early in the intervention development process (Gaglio & Glasgow, 2012). The targeted distribution of findings and information to intended beneficiaries and other audiences are important to behavior change, to sustained health outcomes, and to continued adoption and promotion of new interventions (Gaglio & Glasgow, 2012). Given the heterogeneity among churches in terms of organizational structure, protocol, and doctrine, planning for dissemination in the context of churches should include community representatives that have knowledge of what is culturally appropriate and compatible for faith-based settings. Including community representation on

our research team allowed us to develop an appropriate way to disseminate the organizational capacity data back to the churches.

Though relatively little work has been done in this area, our findings are consistent with the research that has highlighted the important yet challenging work of appropriately disseminating information back to community partners (Chen et al., 2010), particularly in ensuring that the communication of the results are not perceived as judgmental by the community. As one example, Garnett and colleagues (2015) disseminated information from a community coalition and study called the Healthy Eating and Living Project (HELP) to six community forums (parents, students, pastors, men's health group, community leaders, and a health coalition), as well as through email lists and websites. PowerPoint presentations were tailored to each community group and age level, and lasted 30 minutes followed by 30 minutes for feedback and learning with community members. Several studies have focused on potential or actual dissemination of findings to community partners in the context of church-based settings (Berkley-Patton et al., 2010; Whitt-Glover et al., 2014). For example, Berkley-Patton and colleagues (2010) assessed church partners' input on the capacity and culture of 58 African American churches to deliver HIV interventions, and developed and delivered the TIPS HIV Tool Kit in collaboration with church leaders using multilevel church dissemination outlets (e.g., church service, ministry group, peer-to-peer dissemination). Whitt-Glover and colleagues (2014) collaborated with 24 churches that participated in a one-year Health Ministry Institute to help them develop sustainable health promotion ministries. Congregational Health Assessments were conducted with churches and results were discussed with the Health Ministry Institute to prioritize health issues to be addressed at individual churches. Similar to our study, each church received a report of their congregants' summarized responses; however, data were also provided on how each church compared with the larger population of participating churches. Health Ministry Institute participants used these reports to determine health-related needs within their churches and plan health-related activities, with technical assistance for planning provided by study staff.

5. Lessons Learned

In conducting this work, we encountered considerable challenges in reporting church-level data back to these organizations and we hope that our experiences can provide some guidance to others doing similar work. The first challenge was that pastors were very busy and sometimes had unpredictable schedules (e.g., funerals, member visitations). This challenge is evidenced by the time it took to schedule meetings and that five of the pastors were not able to schedule meetings after multiple attempts. We also found that pastors did not always attend Project HEAL workshops during the intervention period. Although support from the pastor is critical for health initiatives to move forward, as previously discussed, they often have to delegate to church volunteers, in this case, the CHAs.

With regard to sustainability, we found that it was difficult to determine the optimal timing to deliver the report in order to encourage sustained health promotion activities relative to Project HEAL. Providing the report appeared to remind some pastors of the intervention and generated discussions about continuing health promotion activities in the church. In other cases, the pastors expressed that they did not recall some details about the intervention based

on the time lag between the last Project HEAL workshop and the tailored reportback meeting. This raises questions about the best time to report data, particularly when data entry, analysis, and interpretation commonly takes quite some time. Overall, the pastors expressed appreciation that the team came back as promised to provide and discuss the report.

Critical in research collaboration between community-based organizations and academic institutions is a shared commitment to building capacity—in the present case within the church's structure—to sustain programming that is suitable for them. Churches can benefit from additional resources and technical support while also recognizing that each church's culture is different and that some activities might be universally accepted, such as practicing healthy behaviors, while others might not, such as a topic on end-of-life. Finally, context matters and the diversity in churches and the heterogeneity in congregations in terms of capacity and other factors must be appreciated.

6. Limitations

Before discussing implications, it is important to note study limitations. We included a convenience sample of African American churches across various different denominations. Data collection included only pastors of each church, which means that data on organizational characteristics is from the perspective of just one individual. Therefore, the generalizability of results is limited. Our experience reflects our perspective, which may or may not be consistent with the experience of different denominations or racial and ethnic groups. Our approach contrasts with previous research that asked the entire congregation to report on church health activities (Whitt-Glover et al., 2014). In the future, it might be found that other 'champions' of health programming within churches (e.g., health ministries) have unique perspectives that could add additional insights into the capacity of churches. Nonetheless, many church-based studies have noted the critical role of pastor involvement and opinions in successful program implementation (Baruth et al., 2013; Bopp et al., 2013; Williams et al., 2017). Another limitation is that we used survey items that had not been validated on a large scale other than preliminary evidence from 30 churches in our research program, including those from Project HEAL (Author et al., (2017)). However, to our knowledge, no such organizational capacity instruments/assessments exist specifically for use in a church setting. Finally, without further follow-up, it is unknown whether the churches actually acted upon the information provided in the tailored reports, in particular for those pastors who received the report by email.

7. Conclusion

From this process the authors conclude that it is important to disseminate research data not only to individual participants, but also to organizations to the extent that they are involved with the research. Final intervention research outcomes might progress over a number of years to conclude and report findings; as such it is important to consider a dissemination framework that incorporates sharing intermediate or preliminary results to increase awareness and interest and to further show commitment of the academic partners to the churches.

Though challenging to translate research data into actionable lay terms, we believe the current report can serve as a useful model for others doing research in partnership with community-based organizations. We encourage future research with community-based organizations to purposively consider organizational capacity in several ways. For example, organizational capacity should be considered when identifying and recruiting partner organizations for research participation, and knowledge of the capacity of the organizations can help interpret findings along the implementation continuum, including moving towards the longer-term sustainability and institutionalization of programs.

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Highlights

- It is important to report study data back to community stakeholders.
- Study data should be reported back in lay terms and be useful to stakeholders.
- There are challenges to reporting data back to community organizations.
- Community organizations vary greatly in their capacity for health promotion.
- Data reporting should be tailored to organizational strengths.

Figure 1.
Project HEAL intervention activities

PROJECT HEAL

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through Early Awareness and Learning) is based in churches, led by trained Community Health Advisors (CHAs), and is spiritually-based. The information we learn from projects like this helps to inform the work that many churches will do in their local communities. We are giving you this report to share what we learned from the Project HEAL church leader interviews and give you resources to help better your congregation's health. Because of your help, we can make a difference in the community!

We encourage you to keep working with your CHAs to promote health activities in CHURCH NAME.

We hope that your CHAs will keep offering the HEAL workshops for more members of your church who were not able to attend the first set of workshops. If you have any questions about this project, please feel free to contact Dr. Cheryl L. Holt at (301) 405-6659 or by email at cholt14@umd.edu.

We pray that you may enjoy good health!

What's inside?

- Capacity for Wellness Programs.....1
- Church Wellness Policies.....1
- CHURCH NAME.....2
- Health Programs for your Congregation.....3
- Sources of Support/Links/Resources.....4

Capacity for Wellness Programs

How can this information from the church leader interview help my church and congregation?

Organizational capacity can be defined as "different aspects of organizations, assessed at the organizational level." By knowing what your church's strengths are and where there is room for growth, we hope that this information can help increase and maintain your church's capacity for hosting health and wellness programs.

Church Wellness Policies

Does your church have a wellness policy in place? Would you like to start one? Would you like ideas on other church wellness policies? Below are some resources to help you get started with your church wellness policy:

- Gateway Community Church
(<http://bit.ly/GatewayWellness>)
- Bayview Baptist Church
(<http://bit.ly/BayviewWellness>)

"Beloved, I pray that you may prosper in all things and be in health, just as your soul prospers." -III John 1:2 [NKJV]

Church Interview Report: Church A**2016****CHURCH NAME**

The church leader interview looked at church capacity in 3 categories: *staffing and space*, *health promotion experience*, and *external collaboration*. The bar graphs below show your church's data from the church leader interview:

Staffing and Space

Staffing and space are aspects of organizations such as: church membership, building ownership, leadership, and staffing. Church membership size can be important as churches with more members may have more resources to hold new programs. Also, church leaders who support the mission of a health promotion activity are more successful with new wellness programs.

Health Promotion Experience

Health promotion experience is how much a church has been involved in previous health and wellness activities at the church. Churches with a background in promoting health behavior and wellness programs or experience in health-related activities have strong capacity for health and wellness activities.

External Collaboration

External collaboration includes: partnerships, involvement in research, or technical assistance from outside organizations or people. Churches with strong networks and collaborations may have more support to carry out health and wellness programs.

Church Interview Report: Church A**2016****Health Programs for your Congregation**

We have put together some examples of health programs that your congregation could use in the future. We chose examples given your expressed needs in the church survey as well as what we heard from church members who went to Project HEAL workshops. All of these programs are evidence-based meaning that they have been found to be effective for promoting good health. Many are readily available and free for you to use.

Physical Activity for Older/Sedentary Adults

This is an exercise program for older adults to enhance spinal flexibility and improve physical functioning. New exercises are added each week to increase range of motion.

For more information:

<http://bit.ly/SpinalExerciseInfo>

For program materials:

<http://bit.ly/AdultExerciseMaterials>

Healthy Body/Healthy Spirit

The Healthy Body/Healthy Spirit program aims to increase eating fruits and vegetables and physical activity among African Americans. Biblical themes are woven throughout. The program includes an exercise video and guidebook; a nutrition video; and a cookbook of recipes.

For more information:

<http://bit.ly/BodySpiritInfo>

For access to program materials:

<http://bit.ly/BodySpiritMaterials>

Eat for Life

Eat for Life is a church-based program to increase eating fruits and vegetables among African Americans. Tailored materials include an Eat for Life cookbook and a videotape featuring biblical and spiritual themes related to fruits and vegetables.

For more information:

<http://bit.ly/EatforLifeInfo>

For access to program materials:

<http://bit.ly/EatforLifeMaterials>

Body & Soul

Body and Soul is a church-based nutrition program that includes church-wide nutrition activities such as: holding nutrition events, an event led by the pastor, and church health policy changes (e.g., guidelines for the types of foods served at church functions).

For more information:

<http://bit.ly/BodySoulInfo>

For program materials:

<http://bit.ly/BodySoulMaterials>

Church Interview Report: Church A

2016

Health Resources

Health Topic	More Info At:	Screening Guidelines
Diabetes	American Diabetes Association http://www.diabetes.org	Screening for type 2 diabetes in adults with high blood pressure
Heart Disease	American Heart Association http://www.heart.org	Hypertension (high blood pressure) and cholesterol check during annual physical
Nutrition	Nutrition.gov http://www.nutrition.gov	Visit www.choosemyplate.gov for individual guidelines
Vaccines	Centers for Disease Control and Prevention – Immunization Schedules http://www.cdc.gov/vaccines/schedules/easy-to-read	<u>Flu</u> – Yearly starting at age 19 <u>Tdap</u> – 1 dose starting at age 19 with one Td booster every 10 years <u>Shingles</u> – 1 dose age 60 and above Talk to your doctor to make sure you get all your needed vaccines
Physical Exam	Centers for Disease Control and Prevention http://www.cdc.gov/family/checkup	Physical exam every 1-2 years

Sources of Support

Learning that you, a family member, or a friend has cancer can change your life and the lives of those around you. Many places offer special support programs for men and women with cancer or for loved ones. Places where you can go for support:

- Doctors, nurses, and other members of your health care team
- Social workers, counselors, or members of the clergy
- Support groups – groups may offer support in person, over the telephone, or on the Internet
- National Cancer Institute information specialists at 1-800-4-CANCER (1-800-422-6237) and at LiveHelp (<http://www.cancer.gov/help>)

Links/Resources

- American Cancer Society
 - Telephone Number: (800) 227-2345
 - Website: <http://www.cancer.org>
- National Cancer Institute
 - Telephone Number: (800) 422-6237
 - Website: <http://www.cancer.gov>
- Centers for Disease Control and Prevention
 - Telephone Number: (800) 232-4636
 - Website: <http://www.cdc.gov>
- National Institutes of Health
 - Website: <http://www.nih.gov>
- U.S. Preventive Services Task Force
 - Website: <http://www.uspreventiveservicestaskforce.org>
- CHAMP Lab
 - Website: <http://bit.ly/CHAMPLab>

This report is made possible by funding from the National Cancer Institute at the National Institutes of Health.
Our community partner: Community Ministry of Prince George's County

Figure 2.
Tailored Church Report Example—Church A (de-identified)

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Church Interview Report: Church B**2016****CHURCH NAME**

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Staffing and space are aspects of organizations such as: church membership, building ownership, leadership, and staffing. Church membership size can be important as churches with more members may have more resources to hold new programs. Also, church leaders who support the mission of a health promotion activity are more successful with new wellness programs.

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Health promotion experience is how much a church has been involved in previous health and wellness activities at the church. Churches with a background in promoting health behavior and wellness programs or experience in health-related activities have strong capacity for health and wellness activities.

External Collaboration

External collaboration includes: partnerships, involvement in research, or technical assistance from outside organizations or people. Churches with strong networks and collaborations may have more support to carry out health and wellness programs.

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Church Interview Report: Church B

2016

Health Resources

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Nutrition	Nutrition.gov http://www.nutrition.gov	Visit www.choosemyplate.gov for individual guidelines
Vaccines	Centers for Disease Control and Prevention – Immunization Schedules http://www.cdc.gov/vaccines/schedules/easy-to-read	<u>Flu</u> – Yearly starting at age 19 <u>Tdap</u> – 1 dose starting at age 19 with one Td booster every 10 years <u>Shingles</u> – 1 dose age 60 and above Talk to your doctor to make sure you get all your needed vaccines
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- National Institutes of Health
 - Website: <http://www.nih.gov>
- U.S. Preventive Services Task Force
 - Website: <http://www.uspreventiveservicestaskforce.org>
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Figure 3.

Tailored Church Report Example—Church B (de-identified)