Bridging the Gap: The Use of a Faith Based Intervention to Improve the Management of Hypertension among African Americans.

By

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Dedication

This project is dedicated to my father Clarence Bowens and my sister Sherrie who were laid to rest due to complications secondary to chronic diseases. It is my love for them that I continue to do my part in decreasing mortalities and morbidities related to chronic diseases such as hypertension and diabetes.

Acknowledgments

Thanks to God for blessing me with this opportunity and adjoining me with exceptional people who supported me through this academic journey. Thank you to Dr. Winter, Dr. Lewis and Dr. Hoover for your guidance, expertise, and support, which contributed to the development of this project. Thank you Dr. Tracey Murray for your mentorship. A special thanks to my husband Kenneth and our three children, Latoria, Kennice, and Kenneth for their patience and support. My mother, additional family members, and friends are also appreciated for their ongoing encouragement, which helped me reach this point in my career.

Abstract

The high mortality rates among African Americans related to complications of uncontrolled hypertension continue to be an unresolved issue. Successful management of chronic diseases such as hypertension require self-care behaviors which foster healthy outcomes and limit morbidities and mortalities related to uncontrolled hypertension. The purpose of this DNP project was to determine if a faith based self-management education program would improve self-care activities related to the management of hypertension among African American adults. Participants completed the Hypertension Self-Care Activity Level Effects Scale (H-Scale), a self-reported assessment designed to measure the practice of recommended self-care activities to control high blood pressure prior to and at the conclusion of eight faith based hypertension education sessions. The Self Transcendence Scale was administered at the beginning of the study to assess participants' views of life and to what extent they utilize psychosocial resources and introspective means to promote a sense of well-being. Participants were also asked to complete a Spiritual Perspective Scale at the beginning and end of the project to assess to what extent they hold their spiritual views and engage in spiritually-related behaviors. The Wilcoxon Signed Rank Test revealed a statistically significant increase in medication adherence among participants post intervention. This data revealed an increase by 30% in the number of participants who were adherent with medication adherence after the intervention and a decrease of 10% of non-adherent participants. Increase in medication adherence among individuals with hypertension is substantial. Results of this project contributes to the limited body of knowledge regarding spirituality and its potential role in managing chronic disease.

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Project Overview

The prevalence of hypertension among African Americans is the highest in the world with more than 40% of Non-Hispanic African Americans being diagnosed with hypertension (American Heart Association, 2016). The associated chronic diseases such as kidney disease, heart disease, and stroke contributes to the high mortality rates of African Americans with high blood pressure. "Nearly 44% of African American men and 48% of African American women have some form of cardiovascular disease that includes heart disease and stroke" (CDC, 2016). High prevalence of hypertension among African Americans continue to be reported and is one of the main causes for cardiovascular disease (Fuchs, 2011).

"Health disparities related to cardiovascular disease (e.g. heart disease, high blood pressure, diabetes, and stroke) have remained higher in the African-American community than in other populations" (Butler-Ajibade, Booth, & Barnell, 2012, p. 33). Biological differences, environment, and habits have been identified as significant causative factors for the disproportionate rates of hypertension among African Americans (CDC, 2016). African Americans being identified as a vulnerable population due to the susceptibility to disease, such as hypertension. In addition, barriers to health behaviors among African Americans include lack of trust of health care providers and perceived prejudice when receiving health care services (Lukoschek, 2003 & Murray 2015). Consequently, African Americans have poor blood pressure control and suffer from high rates of associated complications and premature mortalities (Grant et al., 2016).

"Most health disparities are rooted in unequal access to resources and opportunities to promote healthy behaviors" (Barbot, 2014, p.2). African Americans develop hypertension at young ages and have higher rates of severe uncontrolled hypertension as compared to all other ethnic groups. "Blacks have nearly 8,000 excess blood pressure related deaths annually compared with whites" (Grant et al., 2016 p.690). The prevalence of health disparities among African Americans persist, contributing to the disproportioned mortality rates related to poor control of hypertension (Lancaster et al., 2013). It is likely that complications will occur among individuals whose hypertension is managed poorly therefore, the management of hypertension in African Americans is crucial (Lancaster et al., 2013). In addition, health care providers are challenged with the need to provide multifaceted care in order to successfully manage chronic disease, such as hypertension, along with the restricted time frame for office visits. The limited time frame of fifteen minutes for clients who come in for follow up appointments presents a challenge to include assessment of knowledge and effective teaching regarding management of chronic diseases (K. Trent-Mims, personal communication, March 2017).

Culturally appropriate models of care contribute to improved health outcomes (Lewis, 2011). Spirituality play a significant role in the beliefs and cultural practices among African Americans. Research suggests that religious practices brought comfort to African Americans during the dark times of slavery (Lewis, 2011). Religious practices and the belief in a spiritual being was a coping mechanism for African Americans when faced with the negative aspects of slavery. Due to the strong correlation between religious beliefs and behavior, a suggested intervention to decrease

hypertension in this group is to use FBOs. The same religious practices can be utilized in the attempt to manage health challenges experienced by African Americans. FBOs offer an environment where African Americans are comfortable and can utilize religious based interventions to cope with health challenges (Lewis, 2011). It is likely that multiple comorbidities and premature deaths associated with uncontrolled hypertension will continue to rise without the implementation of innovative and culturally sensitive interventions, such as this project.

Faith Based Organizations (FBOs) can be successful vehicles for disseminating health information and promoting healthy behaviors. Historically, the African American church play a significant role in the engaging of the community and influencing behaviors (Woods-Jaeger et al., 2014). FBOs offer an environment where African Americans are comfortable and can utilize religious based interventions to cope with health challenges (Lewis, 2011). The utilization of FBOs offer a safe and trusted environment for most individuals, fostering an environment where positive influence and behavioral changes are likely. Spirituality is significant to the African American culture and are beneficial in promoting changed behavior.

Problem Statement: The high mortality rates among African Americans related to complications of uncontrolled hypertension continue to be an unresolved issue. Successful management of chronic diseases such as hypertension require self-care behaviors which foster healthy outcomes and limit morbidities and mortalities related to uncontrolled hypertension. Use of faith based approaches in the African American population is supported in the literature.

The purpose of the project was to determine if a faith based self-management education program would improve self-care activities related to the management of hypertension among African American adults. The clinical question: Among African Americans diagnosed with hypertension, will a faith based self -management education program improve self-care activities related to hypertension management?

Succinct Synthesis/Analysis of Supporting/Related Literature

In the attempt to gain insight into the phenomenon of spirituality and faith based organizations in promoting healthy behaviors among African Americans, a literature review was conducted. Several scholarly databases which included EBSCO, CINAHL, and ProQuest Nursing and Allied Health were utilized. Initial search terms were, faith based organizations AND health care AND African Americans and hypertension. After reviewing articles found using these terms, additional articles were found from reference lists. Reading these articles prompted a search for additional literature utilizing the terms, blacks, heart, heart disease, faith-based, church, spirituality, and hypertension management. Literature acknowledges spirituality as a significant component of African American culture thus, FBOs can be used as a valuable platform for promoting healthy behaviors and improving health outcomes among this population (Newlin 2002, Barnes-Grant et al. 2016, & Boltri et al., 2011).

FBO Support for Improved Health Behaviors

Aaron, Levine, and Burstin (2003), completed a cross sectional analysis of data collected from African American adults living in low income neighborhoods to gain

insight on the influence of church attendance and health care practices. Two thousand one hundred and ninety –six African American adults completed a survey of questions related to church attendance and health practices. Analysis of the collected data revealed a positive correlation between church attendance and health practices. Those who reported regular church attendance also reported having regular mammograms, dental appointments, and blood pressure measurements. The limitations of the study include the lack of follow up of long term effects of the health practices, the homeless were not represented, and spirituality and experiences while attending church were not addressed. This literature suggests that faith based organizations can contribute to the improvement of health care. Giger, Appel, Davidhizar, and Davis (2008), provides insight of the role of the church in African American communities as a form of social support and confirms Aaron, Levine and Burstin, (2003) findings. Giger et al. (2008), support previous literature (Aaron et al. 2003), which found that overall attendance of religious services and church based interventions often increase trust and show a positive correlation with beneficial health practices. Giger, et al. and Davis (2008), presents the need to include FBO as partners with government agencies, and institutions within the community in the attempt to promote health; identifying churches as an "untapped potent resource to decrease health disparities" (Giger, et al. 2008, p.381).

DeHaven, Hunter, Wilder, Walton, and Berry (2004), completed a ten-year qualitative review of FBOs and their effectiveness in promoting wellness and disease prevention. These authors identified that health programs offered in non- secular settings such as churches can increase the knowledge of diseases, and improve

screening behaviors. DeHaven et al., 2004 revealed that faith based health programs focused primarily on prevention (50.9%) and health maintenance (25%). There were signs of improvement in cholesterol and blood pressure levels, preventive care (mammograms), and weight management (DeHaven et al. 2004). Data found supported that faith based organizations can provide a significant contribution in the maintenance and improvement of health. More research is needed that addresses the effectiveness of faith based health maintenance programs. DeHaven et al, 2004, suggested that improved collaboration among FBOs and health professionals could enhance the evaluation of health activities and expand the work being done in African American communities.

Boltri, Davis-Smith, Okosun, Seale, and Foster (2011), conducted a research study to identify the effectiveness of a diabetes prevention program in churches where the predominance of attendees and members are of African descent. In addition, there was comparison of the effectiveness of a six-week program to a 16-week program. A modified version of the National Institute of Health diabetes prevention program was the tool utilized in this study. This study included three African American Baptist churches which were chosen based on size of membership, and interest in participating in the program. Members were screened utilizing The Diabetes Risk Assessment (DRA) tool which was developed by the Centers for Disease Control and Prevention. Individuals whose risk score was 10 or greater were chosen to participate in the program. There was a total of 36 participants, seventeen participated in the six session program and twenty in the sixteen session program. Two churches were provided the modified six session church based diabetes prevention program in comparison to the

one church which was provided the same program over 16 sessions with a six- and 12-month follow up. The program was formatted to be group sessions, providing social support and 60-90 minutes of discussion of topics relevant to diabetes control. These topics were adapted from the National Institutes of Health Diabetes Prevention Program. Both programs resulted in improved glucose levels and weight however, there was a higher number of attendance among the six session participants. In addition, the six session program cost $140.82 less to the implementation than the 16 session program. It was concluded that the Diabetes Prevention Program could be successfully implemented in churches where the majority of attendees and members are of African descent, with no significant differences in the outcomes of a six session in comparison to a 16-session implementation, other than the cost. Although this was a program specific to diabetes, information provided from this study provides insight on the cost and suggest the appropriate time frame for implementation of successful health programs.

Butler-Ajibade et al. (2012), provides a summary of the utilization of the churches to promote healthy behaviors. This study provides a meta-analysis of findings and offers suggestions as it relates to the use of churches as a platform for health promotion. The authors acknowledge the need to include churches to help meet the health needs in communities. Strengths identified include, easy access to participants, the environment in the church is one of learning values and attitudes that contribute to living a “good” life, which is a good foundation for the promotion of healthy behaviors. The challenges expressed included, the hesitancy of church leaders to agree to participation in programs due to the lack of programs’ sustainability. Many

churches are left with no resources or a way to continue with the programs after the grant or project has ended. Parrill and Kennedy (2011), conducted a comprehensive review of research surrounding community resources used to address health disparities which supports previous literature, acknowledging the church as a dominant force in the African American community. Parill and Kenedy identify the church as a valuable resource that can be used to bridge the gap between the health care system and the African American community. The success of several programs in FBO were identified; substance abuse prevention, breast and cervical cancer prevention, childhood safety practices, HIV/AIDS prevention, diabetes mellitus, cardiovascular disease, and stroke prevention (2011). The focus of many of the programs offered through FBO focus on prevention which has proved to be helpful however, Butler-Ajibade et al., acknowledged the need for health management programs that can be sustained (2012).

Lancaster, et al. (2014) implemented a cluster-randomized control study of the effectiveness of faith-based therapy life change (TLC) intervention as compared to health education (HE) to control blood pressures in African Americans which proved to be an effective strategy to assist African Americans in controlling blood pressure. Thirty-two churches where the majority of attendees and members were of African descent were selected and randomly assigned either the TLC intervention or the HE intervention. The TLC intervention included 12 sessions focused on topics such as diet and physical activity, accompanied by motivational interviews. The HE intervention consisted of one session on lifestyle changes to promote controlled blood pressure and 18 sessions on health topics unrelated to hypertension management with

no motivation interviews. The projected outcomes included a decrease in blood pressure measurements and improved healthy lifestyles in the TLC group will be greater than the HE group. No outcomes of this study was reported, because implementation had not occurred at the time the article was written. Information discussed provided in the article provided possible session topics and the interventions that are consistent with previous studies which proved to be successful in improving blood pressure, specifically with the use of FBOs. In addition, the article mentioned challenges in securing participants and the consistent support from church leaders. Knowing of these challenges were beneficial in planning strategies for the implementation of the DNP project. Dodani, Arora, and Kraemer acknowledged having the same challenges with the implementation of a faith based lifestyle intervention for African Americans (2014). In addition, to the previously mentioned challenges, Dodani et al. mentioned the difficulty in recruiting males as well as scheduling difficulties due to holidays and special church events (2014). The program lay out was very similar to previous studies; group sessions addressing topics relevant to blood pressure management and the inclusion of religious practices such as prayer and reading of scriptures. Dodani et al. noted an increase with adherence to a healthy diet when reading of scriptures are integrated in the education sessions (2014). This 12-week program produced significant changes in baseline blood pressure; a mean reduction of 22mmHg in systolic blood pressure and 6.5 mmHg diastolic blood pressure was noted among participants.

FBOs play a significant role in the African American community where individuals are able to gain the support from congregational members, leadership, and

motivation through religious facets. These mechanisms, provided through FBOs, are expressly significant to the African American culture and are beneficial in promoting changed behavior particularly among African Americans.

Spirituality and Health Practices among African Americans

In addition to the utilization of FBO, it was beneficial to explore the role of spirituality in health practices among African Americans. In the attempt to provide clarity to spirituality and how it can be used in health care Newlin, Knafl, and Melkus, (2002) completed a concept analysis of African American spirituality. It was noted that spirituality is a broad term with aspects of religion. Key defining characteristics were identified as transcendence, and faith in God or Supreme Being. Spirituality is a process of discovering meaning, hope and purpose in life, and interconnections with self and others. In addition, cultural influence, life adversities, and faith in God were identified as antecedents of African American spirituality. This concept analysis suggests that spirituality is a significant aspect of African American culture and can influence health care practices among this ethnic group. No definitive definition of African American spirituality was revealed however; it is noted that this analysis contributes to the ongoing development of the definition. The provision of a clear understanding of African American spirituality will provide the foundation for the formation of cultural sensitive, spiritual based health interventions for African Americans.

Lewis (2011), study of African American older women and their perspective of spirituality, adds to the body of literature that suggest spirituality is a constructive resource for African Americans. This qualitative study of older African American

women diagnosed with hypertension, revealed how their beliefs and practices associated with God fostered positive attitudes and behaviors. Prayer, scripture reading, and discussion with members of the same faith who are faced with the same challenges of medication adherence proved to be effective resource which can promote positive health practices Lewis (2011) suggest the utilization of faith based interventions that are consistent with African American cultural beliefs would be beneficial in improving health behaviors and health outcomes.

Literature also reveal the significant influence that the African American church has on the African American community and how it is viewed as a place of refuge and trust. FBOs can play a significant role in improving the health of African Americans, by providing a place where trust is built for health care providers and support is provided for heath maintenance behaviors. There is a significant composition of literature that supports the need to include FBOs to assist with health care management. Innovative interventions that include the enhancement of partnerships among community resources and the health care system, such as the proposed DNP project should be pursued and encouraged. Many of the studies evaluated the health prevention programs provided in FBOs but few evaluated health maintenance programs nor did they address sustainability. A deficiency in this information further validates the need for the proposed DNP project, which aims to evaluate health maintenance as opposed to prevention. Literature further acknowledges the importance of spirituality and its role in health and well-being. It is a critical time to include spirituality as an aspect to health and wellbeing and explore innovative ways to integrate it into both practice and the education of health

professionals. It is vital to address the mortality rates among African Americans due to conditions that can be controlled, such as hypertension. The literature supports the benefit of using spiritual facets such as scriptures, support groups within FBOs, and prayer to encourage a healthy lifestyle and improve self-care behaviors. This collection of literature provides enlightenment as it relates to the appropriate methodology to utilize in the implementation of the proposed DNP project as well as validates the need to address the questioned phenomena.

Theoretical Framework

The Theory of self-transcendence proposes that a significant change in one's health will result in an increased awareness of ones' vulnerability. The awareness of vulnerability will prompt self-exploration and a greater awareness of relationships with others, the environment, and spiritual facets. This heightened awareness fosters the desire to improve circumstances and gain an improved meaning of life (Reed, 2008). Key concepts of the theory include, vulnerability, self-transcendence, and well-being, (Coward, 2010). Vulnerability is identified as the awareness of personal mortality brought on by situations in life to include, disability, chronic illness, childbirth, and parenting (Coward, 2010). Self-Transcendence refers to the ability to extend beyond constricted views or self -boundaries to connect with others, the environment, and beliefs including faith in the spiritual realm, to foster a broader perspective of life (Coward, 2010 & Reed, 2003). It is through self-transcendence that an individual develops a greater appreciation for things seen and unseen and inner knowledge of self (Reed, 2008). Well-being is the sense of feeling whole and healthy, according to an individual's' criteria (Reed, 2008).

This theory proposes that self-transcendence is a part of human development and is linked to positive health promoting experiences. The theory suggests life experiences that increase the feeling of vulnerability will increase self-transcendence, resulting in positive changes in behavior. "Person's participation in self-transcendence is integral to well-being and nursing should have a role in facilitating this process" (Reed, 2008, p.107). This theory originated through the study of older adults and their ability to cope with the aging process and the end of life (Reed, 2008). Upchurch and Mueller (2005) utilized the self –transcendence scale to explore the influence of spiritual factors on elder African Americans' ability to perform activities of daily living (ADL). This study concluded that self-transcendence was positively associated with increased ability to perform ADLs (Upchurch and Mueller, 2005). Garcia-Romeu (2010) identified the self-transcendence theory as a "measurable transpersonal construct with observable features" (p.27). Vitale, Shaffer and Fenton (2014), operationalized the self-transcendence theory to study the role of self-transcendence in caring for patients with Alzheimer's disease and concluded that self-transcendence can be difficult to achieve with individuals who have cognitive challenges but can provide comfort and support. Thomas, Burton, Quinn -Griffin, and Fitzgerald (2010) utilized the self-transcendence theory in a study of women with breast cancer. This study validated the use self-transcendence as a beneficial holistic nursing intervention. Rehnquist and Reed (2007) used the spiritual perspective scale and the self- transcendence scale to examine the relationship of spirituality and well -being among homeless adults. Positive correlations were found among spiritual perspective, self-transcendence, health status, and well-being (Runquist and Reed,

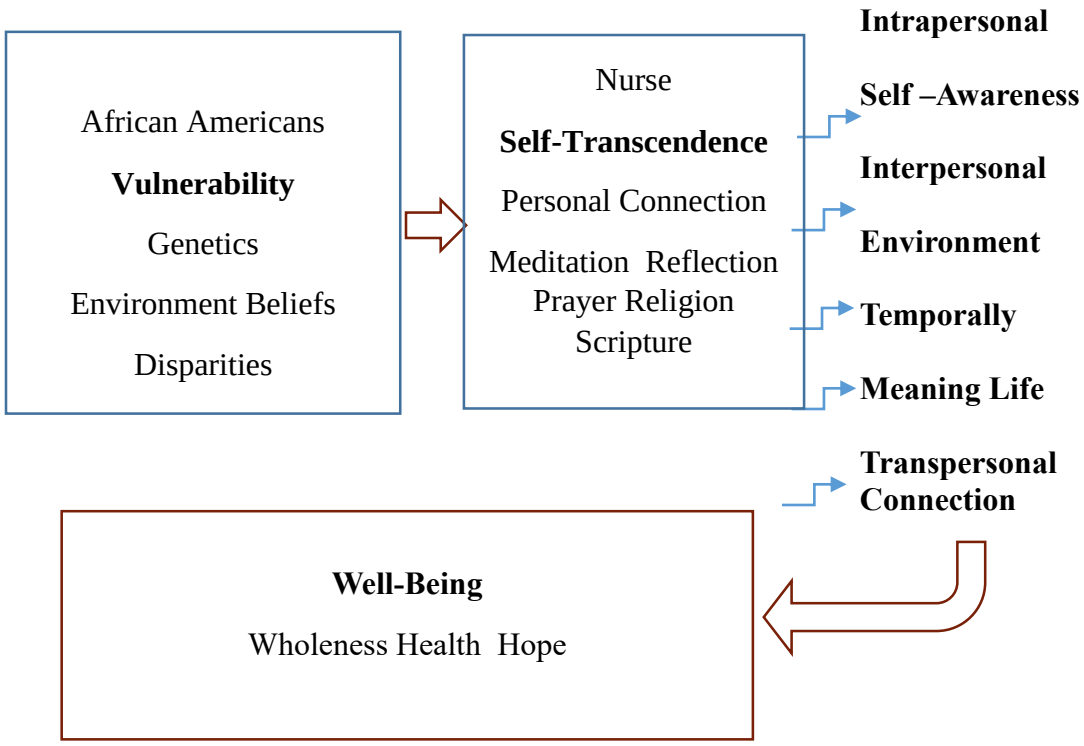
2007). Studies, including the utilization of self-transcendence among individuals suffering from terminal and chronic diseases, supports the role of spirituality and self-transcendence in changed behaviors. Research suggests that vulnerability ultimately transforms into well-being through the process of self –transcendence and ones' spiritual perspective is an integral part of this process (Piedmont, 2010).

Articulation with Clinical Problem

Participants of the project gained an understanding of hypertension and the seriousness of the associated morbidities and mortalities (vulnerability). In addition, as aforementioned African Americans are identified as a vulnerable population due to their susceptibility to chronic diseases such as hypertension. This vulnerability is enhanced by genetics, environmental factors, and cultural habits. Each session emphasized the potential consequences of uncontrolled hypertension and The Eighth Joint National Committee (JNC 8) recommendations for the management of hypertension. The author of the program, a registered nurse, facilitated the participants' ability to experience self- transcendence through reflection and journaling. The use of a small group format provided participants the opportunity to explore and discuss self-care behaviors associated with hypertension management and facilitate relationships with others with the same challenges of hypertension management (self-transcendence). Participants were encouraged to examine their spirituality and gain a deeper understanding of the role it plays in their lives, especially, health behaviors through reflective journaling and discussion of the provided scriptures (self-transcendence). Participants' spiritual beliefs, relationships formed with others, and the acknowledgement of the severity of their current health

empowered them to execute the behaviors needed for improved hypertension management (well-being). Concepts identified in this theory were beneficial in exploring the phenomena associated with health behaviors, spirituality and FBOs. Figure 1. Provides an illustration of the application of this theory.

Figure 1. Application of The Theory of Self-Transcendence



Project Design

This pilot study applied a quasi-experimental design to explore the effectiveness of a faith based program in fostering improved self-care behaviors among African Americans diagnosed with hypertension. Approval was obtained from the institutional review board of Salisbury University and all participants were required to sign the approved consent form. Participants attended an enrollment session, the author provided an overview of the program and participants completed a demographic form, the SPS, STS, and the H-Scale as pre intervention data. In addition, blood pressure measurements were obtained.

African American adults participated in eight group sessions lasting 45 minutes to an hour, focused on strategies for hypertension management. The sessions were offered over five months. Education was provided to enhance knowledge of strategies that are effective in controlling hypertension and to expound the dangers of uncontrolled hypertension. Sessions were facilitated by the author of the program, utilizing a power-point presentation. A sample lesson plan can be found in Appendix A. Assistance was provided by a registered nurse, who was a member of the church's health ministry as needed. The American Heart Association's booklet entitled, *Understanding and Controlling Your High Blood Pressure*, aided in the creation of the curriculum and identifying the topics for each session (Appendix B). Reading passages from the Holy Bible such as, I Corinthians 6:19-20 19 Do you not know that your bodies are temples of the Holy Spirit, who is in you, whom you have received from God? You are not your own; 20 you were bought at a price. Therefore, honor God with your bodies (New International Version) initiated self-reflection.

Participants were asked questions regarding their health and spiritual activity such as; How have you honored God this week in managing your blood pressure? Participants initiated the discussion of the question in the session and were instructed to further perform self-reflection and record the reflections and any challenges and triumphs experienced in the journal provided to them. Participants were engaged in open discussion as well as the sharing of their journaling. At the completion of the sessions, participants completed the SPS and H-Scale to provide post intervention data. In addition, a program evaluation form was completed to gain further insight regarding the effectiveness of the program.

Participants

Risks related to this project were minimal. Participants were advised to continue with all treatment regimens prescribed by their care providers, as this program was not meant to replace any current medical treatment. Participants were recruited through the advertisement offered by Central Church of Christ. The program was advertised in the church's Sunday bulletin, posted around the church building and displayed on the church's website. Convenience sampling was employed in the selection of participants. All participants were African American adults, having a self-reported diagnosis of hypertension for six months or longer. Although the program was offered to members of the church, individuals within the community who met the criteria were invited during the church community health fair. Individuals who were currently enrolled in a chronic disease management program, were not 18 years of age or older, were pregnant, or not an African American were excluded.

Setting

This study was conducted at predominately African American church located in Baltimore City. The church leadership voiced concern regarding the health and well-being of the congregational members and volunteered to host the program. The church building was very spacious with adequate classrooms, of which one was used for all sessions. The church supplied all required technology for PowerPoint presentations.

A SWOT analysis of the church was conducted (Appendix C), which revealed the strengths and weaknesses. Leadership structure, consist of a minister and ministry leaders, who are the decision makers regarding church activities. This structure provided simplicity and decreased the incidence of gaps in communication. Central Church of Christ has a health ministry that has been in place for several years. The ministry is composed of nurses, a social worker, and other members of the congregation who have interest in health care. The members of this ministry are very knowledgeable of the health care needs of the congregation and have coordinated several health events for the church and the community. One of the members of the health ministry, who is a registered nurse agreed to be trained as a facilitator to assist as needed. The church has a face book page and a website that is used to advertise the church and its activities. In addition, all technology such as computers, screens, and projectors were on site for use, as well as, technical support. The leadership mentioned the challenges they are having in reaching the community and the participation of congregation members during events. This did seem to be a challenge for the

participation in the program as well. There were limitations as it relates to days and times that the program can be offered. Session could not be offered during a time that would interfere with members' ability to attend weekly Bible classes or Sunday services and three sessions had to be rescheduled due to schedule conflicts that could not be planned in advance such as funerals. In addition, Central Church of Christ is located in a high crime area, but this factor did not deter participants from attending sessions. The leadership expressed the need and desire to improve their community engagement and increase partnerships with other organizations within the community. This program provided the opportunity for such discussion and strategies for sustainability of this program.

Tools

The Spiritual Perspective Scale

The Spiritual Perspective Scale (SPS) is a 10-item questionnaire that measured participants' spiritual views and the extent to which they hold those views and engage in spiritually-related behaviors (Reed, 1986, 1987) (Appendix D). Examples of questions that inquire about frequency of spiritually related behaviors include "How often do you engage in private prayer or meditation?" and "I seek spiritual guidance in making decisions in my everyday life. Responses can range from 1 to 6 on a Likert-type scale, 1= Not Likely to 6 = Always (Runquist & Reed, 2007, p. 9). Respondents scores were averaged to arrive at a spiritual perspective score, which can range from 1.0 - 6.0. Positive correlations between the scale and spiritual backgrounds has been noted with all item-scale correlation's above .60 and the Cronbach's alpha above .90 (Gray, 2006). Additional studies of the SPS has demonstrated criterion-related validity and

discriminate validity. Gray's (2002) study of HIV patients and spirituality produced a Cronbach's alpha .91, Conner (2004), study of African American Christians and spirituality provided a Cronbach's alpha .81, and Jesse, Graham, & Swanson (2006), study of pregnant women resulted in a Cronbach's alpha .91.

The Self -Transcendence Scale

The Self-Transcendence Scale (STS) is a 15-item instrument measuring an individuals' view of life and to what extent a person utilizes psychosocial resources and introspective means to promote a sense of well-being (Appendix E). Each item of the scale requires self- exploration of respondents. Examples of this process include finding meaning in one's present or past experiences, having an interest in learning new things or sharing one's wisdom with others, and being able to accept help from others. Participants rated themselves on each of the 15 items using a four-point, Likert type scale. STS responses were averaged to arrive at self-transcendence scores ranging from 1.0 – 4.0, with the highest number indicating greater self –transcendence (Runquist & Reed, 2007). Cronbach's alpha for the STS .83 (Runquist & Reed, 2007), .77 to .85 (Coward, 1991, 1996; Reed, 1991). Permission to use both the SPS and STS has been granted by Dr. Pamela Reed. (Appendix F).

The Hypertension Self-Care Activity Level Effects Scale

The Hypertension Self-Care Activity Level Effects Scale **(**H-SCALE), is a self-report assessment designed to measure the practice of the recommended self-care activities that has proven to control high blood pressure (Appendix G). The H-SCALE is composed of six sections with their own subscales all relating to hypertension self-

care activities. The sections include, medication adherence, diet, physical activity, smoking, weight management, and alcohol.

Medication Adherence

The medication adherence section is composed of three questions regarding medication usage. Participants rated themselves using a seven-point Likert scale on how often they take their prescribed blood pressure medications. The possible range for the responses to the three questions are 0-21. Participants who score a 21 are considered to be adherent to their medication regimen.

Diet

The diet section of the tool prompted participants to rate themselves on how often they consume healthy food items as indicated by the DASH diet. The 11 questions in this section are rated using a seven-point Likert scale. Scores can range from 0-77; scores below 33 are considered low diet quality, scores between 33 and 51 are medium diet quality, and scores 52-77 are considered adherent to DASH diet. The author of the tool does not provide definitions for medium and low diet quality.

Activity

Participants were also rated on how often they engage in physical activity by answering two questions in the activity section. Responses are summed and can range from 0-14, scores of 8 or better are considered adherent to the physical activity recommendations and all other scores are considered non-adherent. There are two additional pilot questions in this section related to strength training. No scoring information was provided for these additional questions.

Smoking

Participants also provided information related to the frequency of smoking and exposure to second hand smoke, by responding to two questions, providing the number of days exposed or engaged in smoking. Responses range form 0-14, the score of zero indicates adherence and any score above 0 is considered non-adherent.

Weight Management

Ten questions are used to assess how often over the past month are weight management activities such as portion control and food substitutions practiced. Responses to the items range from strongly disagree (1) to strongly agree (5), with possible summative scores ranging from 10-50. Scores >40 are considered adherent to good weight maintenance practices. The author of the tool does not provide scoring guidelines for scores below 40.

Alcohol

Three questions are posed to explore the frequency of the consumption of alcoholic beverages, utilizing the National Institute on Alcohol Abuse and Alcoholism Quality and Frequency Questionnaire. Respondents indicate how often per week, per day, and within the last month they consumed an alcoholic beverage. The author of the tool recommends multiplying the number of drinks consumed in a week by the number of drinks in day to provide the total number of alcoholic drinks consumed. Adherence was determined by using the JNC 8 guidelines which acknowledges that adherence to moderate alcohol consumption among men is considered <2 drinks/day (scores of 14 or less) and <1 drink/day for women (scores of 7 or less).

The H-Scale tool was also designed to be a counseling tool to aid hypertensive patients who are seeking to achieve blood pressure control (Warren-Findlow, Basalik, Dulin, Tapp, & Kuhn, 2013). Warren-Findlow et al., 2013 study of African Americans with hypertension found the H-Scale to be an easy instrument to use in assessing an individual's health practices directly related to blood pressure control. This study established preliminary validation of a measure that assesses hypertension self-care activities with clinical blood pressure (BP). The Hypertension Self-Care Activity Level Effects (H-SCALE) was administered to patients with hypertension to assess levels of self-care. Patients (n=154) were predominantly female (68.6%) and black (79.2%). Greater adherence to self-care was associated with lower systolic and diastolic BP for 5 of the 6 self-care behaviors. Medication adherence was correlated with systolic BP (r=-0.19, P<.05) and weight management adherence was correlated with diastolic BP (r=-0.22, P<.05) after controlling for other covariates. Increased adherence to recommended dietary practices was strongly correlated with higher systolic (r=0.29, P<.05) and diastolic BP (r=0.32, P<.05). The H-SCALE was acceptable for use in clinical settings, and adherence to self-care was generally aligned with lower BP with good internal consistency, alpha .88 (Warren-Findlow, et al., 2013). Permission to use this tool was granted by the developer of the scale, Dr. Jan Warren-Findlow (Appendix H). Each tool was completed by participants at the beginning of the project as baseline data and the H-scale and the SPS were completed at the end of the project to identify if change had occurred after the blood pressure management sessions.

In addition, a demographic intake form was completed to collect personal data such as age, education, gender, and history of hypertension. A program evaluation

form was also completed, which provided valuable input that was used to evaluate the effectiveness of the program (Appendices I&J). A mercury sphygmomanometer was used to obtain blood pressure readings, during the enrollment screening. Research supports the use of a mercury sphygmomanometer as the preferred device for accurate blood pressure measurement (Pickering et al., 2005).

Implementation

The faith based self -care management sessions were implemented to foster improved health behaviors of adults with hypertension. In addition, insight was gained regarding the effects of spirituality on health behaviors and the possible role of FBOs in health care management. Members of Central Church of Christ, Inner City Church of Christ, and the surrounding community were invited to participate. A letter and an email was provided to each church's leadership explaining the program. Due to unforeseen circumstances and time constraints, Inner City Church of Christ was not able to participate in the program during the given timeframe but did voice the desire to host the program at a later date. A meeting with the leadership of Central Church of Christ was conducted. At the meeting, an overview of the program was provided, the timeline for completion (Appendix K), days and times for implementation was identified, and a date for the training of the health ministry member, who served as a facilitator was identified. It was also determined that the church would be responsible for advertisement, considering that the author of the program does not have access to the church website and other means of communication. A flyer with all pertinent information and contact number was provided to the church leadership and the administrative assistant.

The author of the program provided an orientation of the program to the member of the church's health ministry, who volunteered to assist the author of the program as needed. The author of the program provided a facilitator guide, which consisted of a learning module for each session, a summary of the program, and all required data measuring tools.

A total of 10 individuals attended the enrollment screening session and all met the criteria to participate in the program. During the enrollment process, the facilitator and the author of program obtained participants' blood pressures. An overview of the program and the schedule of sessions was provided. Each participant completed the H-SCALE, to assess JNC 8 self -care activities and the SPS as pre-tests, and the STS was given as a pretest only.

There were eight sessions held at the church that lasted from 45 minutes to an hour. Although the sessions were schedule to be biweekly for four months, a few sessions were rescheduled due to unexpected church activities that conflicted with the session times and dates. The content of the program was guided by, *The Understanding and Controlling Your High Blood Pressure* booklet (American Heart Association, 2015). The educational component at each session was provided by power-point presentations and followed by open discussion. Open discussion of challenges and triumphs, related scriptures, and prayer enhanced each session, fostering self and spiritual exploration. Participants were provided journals and digital blood pressure monitors. All participants were encouraged to record their daily blood pressure readings and journal daily challenges and triumphs related to the management of their hypertension. During open discussion participants shared successful strategies

utilized and any progression made to reach personal goals related to controlling their blood pressure. Participants were very open to sharing and rich discussion was appreciated. A significant portion of each session was the reading of scriptures related to care of the body. Scriptures were read at each session and discussion was initiated. Further exploration of the scriptures was included in the participants' journaling. Participants discussed how reading the scriptures fostered noteworthy thinking and consideration of their health behaviors and how their choices connect to their spiritual commitment. Each session concluded with prayer.

A certified dietician from St. Agnes hospital was a guest speaker at one of the sessions and provided valuable information regarding healthy food choices. In addition, a Family Nurse Practitioner attended a session for a question and answer session regarding medications. The guest speakers were implemented in response to the concerns and questions that many of the participants had regarding medication and nutrition. At the conclusion of the program, participants completed the H-Scale and SPS, as post tests for statistical comparison and a survey to appraise the program.

Barriers and Facilitators

There were various factors that affected the implementation of this project. Initially three congregations expressed interest in the program and provided letters of support. Unfortunately, two congregations were not able to start the program and finish within the designated timeframe due to previously scheduled activities. At Central Church of Christ, the hosting congregation, there were unforeseen church activities, such as funerals which resulted in revisions of the program schedule several times. This made finding alternate dates and times challenging for the author and participants. Thankfully,

this did not deter the participants and they were able to adjust their schedules accordingly. The sessions extended beyond the allotted time frame due to the often rich discussions. Although, this did not cause a problem for the participants, it could be problematic for others. For those who may choose to replicate the program, it is recommended that at least one hour be allocated for discussion. There were various times that the scheduled day for the sessions had to be changed due to unplanned events being held at the church building. In addition, times were adjusted to accommodate one of the participants' who had to depend on public transportation. Limited participants also limited the rigor of project outcomes. It is likely that there would have been more participants if the author of the project would have been provided an opportunity to speak directly to the members of congregation about the program

The author of the project facilitated the implementation of the project. A member of the congregation's health ministry was oriented to the program and agreed to work with the facilitator and provided coverage for one sessions due to illness of the author of the project. A facilitators' manual was provided that included all of the power point presentations, scriptures, and questions to be used to guide discussion.

Summative Evaluation of Implementation Process

Implementing the project was not problematic. Having the booklet from the American Red Cross made topic selection very easy. Once the topics were identified, creation of the power point presentations was stress-free. Having someone to cover for the author of the program provided for a seamless program. Once the participants were provided journals they were instructed to record their daily challenges and reflect on the scriptures. Many of them brought and shared their journaling to each session. They were

very appreciative for the blood pressure machine that was provided to them also. The machine had the capability to connect to their cell phones thus, providing easy access to blood pressure measurements that could be shared with their health care providers and made it easy for them to monitor themselves. Many of the participants also wrote their blood pressure measurements in their journal and shared with others in the program. Participants valued the information being provided and was genuinely concerned about their health. The participants' desire to learn made the facilitation of discussion simplistic. The most challenging part of implementing the project was the recruitment of participants. It is perceived that many individuals do not find it necessary or beneficial to participate in health care initiatives or there need to be additional means of advertisement. Participants also requested an extension of the sessions, offering them beyond the designated time frame. Considering that this was a project for school, the timeline for completion of the project would not allow for an extended offering of sessions. Grant funding assisted in the ability to offer blood pressure monitoring devices to each participant, the provision of snacks at every session, and the purchase of the education booklets.

Economic Considerations

An ongoing analysis of cost associated with the program was conducted, noting that the cost to implement the program was minimal. Central Church of Christ provided a place inside of the church building where each session took place, eliminating cost to rent space to meet. Required technology, such as internet access, projector, computer, and technical assistance was provided by the church at no cost as well. Cost for duplication of education and training material, journals, guest speakers'

tokens of thanks, light refreshments, and blood pressure monitors were the associated cost, covered by the author of the project, through grant funding. Appendix L contains the itemized project budget.

Analysis

The data collected represents ten participants and was analyzed using Statistical Package for Social Sciences (SPSS) version 23. The participant sample included two males representing 20% and eight female participants, 80%. Participant ages ranged from 48-81 years of age, with 50 % of the participants being between 48-50 years of age. Most reported being high school graduates (50%), with 40% of participants being college graduates, and 10% less than high school. Family history was striking, as 100% reported having a family history of hypertension. All participants with the exception of one reported being under the care of a health provider. One participant was in the process of searching for a new provider. All participants did not provide information regarding frequency of visits to a health care provider. Of the five participants who did respond, one reported visiting every three months, three reported every month, and one reported every six months. All participants admitted to experiencing challenges in managing their hypertension. Stress, exercise, diet, and medication compliance were reported as areas of difficulty, with the most reported being diet (30%) and a combination of diet & exercise (30%). Table1. presents descriptive data of the participants.

Table 1

Characteristics of the participants (N=10)

	n	%
Gender		
Male	2	20
Female	8	80
Age		
48-58 years	5	50
60-68 years	2	20
68-80 years	2	20
81+ years	1	10
Education		
GED	1	10
High School	4	40
College	5	50
Family History of HTN		
Yes	10	100
No	0	0
Years Diagnosed with HTN		
2 Years	2	20
10 Years	4	40
14 Years	1	1
20 Years	2	2
35 Years	1	1
Challenges with HTN		
Diet	3	30
Stress	1	1
Stress Diet Exercise Medication	1	1
Stress Diet Exercise	1	1
Diet and Exercise	3	3
Medication and Stress	1	1

The clinical question proposed: Among African Americans diagnosed with hypertension, will a faith based self -management education program improve self-care activities related to hypertension management? In the attempt to answer this question, data was collected utilizing the H-SCALE, STS, and SPS. Responses to the SPS Scale provided insight of the participants' spirituality and the role it plays in their lives. Responses to the STS provided valuable information as it relates to the participants' ability to acknowledge the need to take responsibility for their health. Responses to the H-SCALE provided insight regarding participants' health practices and behaviors related to hypertension management prior to and after the program.

In consideration of the small sample size, a Wilcoxon Signed Rank Test was conducted as a non-parametric alternative to the t-test. This test is an option when testing small sample sizes. The Wilcoxon converts scores to ranks and was used to compare the differences from pre intervention to post intervention. The Wilcoxon test revealed a statistically significant increase in medication adherence scores of the participants following the hypertension management sessions, $z = -2.117$, $p = .034$, $< .05$. The scores of the remaining categories, diet, weight management, activity, smoking, and alcohol were not statistically significant. Table 2. displays the Wilcoxon Signed Rank Test results.

H-Scale categories of medication adherence, diet, activity, smoking, weight management, and frequency of the consumption of alcoholic drinks were assessed and computed for each participant, pre and post intervention. Ten percent of participants pre intervention were considered adherent to medication regimen, 60% were non-adherent and 30% reported not being prescribed medication. Post intervention 40% were adherent

to medication regimen, 50% non-adherent, and 10% reported not being prescribed medication. This data reveals an increase by 30% in the number of participants who were adherent with medication adherence after the intervention and a decreases of 10% of non-adherent participants. In addition, there was a 20% decrease in the number of participants who reported not being prescribed medications. As it relates to adherence to the DASH diet, 30% of the participants were classified as having low diet quality, 40% medium diet quality, and 30% adherent. The results of the diet responses were the same for both per and post intervention. Scores related to the adherence to the recommended engagement in activity, 50% were non-adherent and 50% was considered adherent pre intervention. Surprisingly, post-intervention scores revealed a 20% decrease in those who were adherent to activity recommendations with 70% being classified as non-adherent. In addition, there was a decrease in the number of participants who were adherent to weight management practices, 50% pre and 30% post. One hundred percent of the participants were considered adherent to smoking and alcohol consumption recommendations. Table 3. displays this pre and post data percentage data.

Table 2
Wilcoxon Signed Rank Test Results SPS & H-Scale (N=10)

	z	Asymp. Sig. (2 tailed)
SPS Pre SPS Post	-1.414	.157
H-Scale Meds Pre H-Scale Meds Post	-2.117	.034
H-Scale Diet Pre H-Scale Diet Post	-.421	.674
H-Scale Activity Pre H-Scale Activity Post	-.281	.779
H-Scale Weight Pre H-Scale Weight Post	-.280	.779
H-Scale Alcohol Pre H-Scale Alcohol Post	-1.00	.317
H-Scale Smoking Pre H- Scale Post	.000	1.000

Table 3

Analysis of Pre- and Post H-Scale & SPS scores (N=10)

	Pre	Post
SPS (score of 6)	90%	70%
SPS (score of 5)	10%	30%
Medication Non-Adherence	60%	50%
Medication Adherence	10%	40%
No Medications	30%	10%
Diet Adherence	30%	30%
Diet Low Quality	30%	30%
Diet Medium Quality	40%	40%
Weight Mgt. Adherence	50%	30%
Weight Mgt. Non-Adherence	50%	70%
Activity Adherence	50%	30%
Activity Non-Adherence	50%	70%
Smoking Adherence	100%	100%
Smoking Non-Adherence	100%	100%
Alcohol Adherence	100%	100%
Alcohol Non-Adherence	100%	100%

Significance

Mortalities and morbidities related to uncontrolled hypertension continue to be problematic. The primary cause of death for more than 410,000 American adults is uncontrolled hypertension (CDC, 2016). The current health care environment does not allot health care providers with sufficient time to thoroughly provide health education that will assist individual with blood pressure management. This DNP project was designed as a pilot study to explore a strategy that can be utilized to fill the health care gap and provide education. This faith based hypertension management program focus was to enhance the knowledge of individuals as it relates to hypertension management and improve health care practices among African American adults. The clinical question proposed: Among African Americans diagnosed with hypertension, will a faith based self -management education program improve self-care activities related to hypertension management?

H-Scale Scores

Medication adherence, one of the six subsets composed of the H-Scale, revealed pre and post score that were statistically significant. Participants reported an increase in taking medications as prescribed and those who reported not being on medications pre intervention, reported being on medications and adherent post intervention. It is presumed that there were participants who found it necessary to obtain care and were prescribed medications during the implementation of the program, contributing to the increase in medication adherence and the decrease in the number of participants who reported not taking medications. This information would be consistent with the

various inquiries and discussion from the participants regarding medication regimens. Antihypertensive therapy reduces the risk of stroke by 30%, coronary artery disease 10%-20%, congestive heart failure 40%-50%, and total mortality by 10% (Wang & Vascan, 2005). Considering the significant role that medication adherence plays in controlling high blood pressure, this increase in adherence post intervention is substantial. Additional subsets, diet, weight management, and activity did not reveal scores that were statistically significant. Interestingly, a significant percentage of the participants identified diet (30%) and exercise (30%) as most challenging for them in the attempt to manage their blood pressure. Weight management and activity are directly related to these components, which could contribute to the lack of significant change in these scores. One must be mindful that the sessions were offered over a short period of time thus, this may not have allotted time for the participants to implement exercise, weight management strategies, and diet changes to report post intervention. However, participants' inquiries, journaling, and discussion validated the need to provide information about these topics. One may suggest that the lack of statistical significance for smoking and alcohol may be due to the fact that all of the participants were "religious" as they identified themselves as members of the church and majority of religions do not encourage drunkenness or smoking. In addition, the small sample size contributed to the statistical test analysis.

Faith Based

In addition to providing relevant education supported by the American Heart Association, special attention was given to the incorporation of faith based components. Prayer and scriptures related to hypertension management topics was

shared at each session. This enhancement to the sessions assisted with the exploration of spirituality and health. Spiritual components, such as the reading of scriptures and relating them to current health challenges and personal behaviors proved to be a significant component of the experience, as shared by the participants. Participants shared that this was the first time they connected their spiritual way of life with their health behaviors. Per participants, the thought of displeasing "God" through the lack of caring for their physical bodies is a new way of thinking. This provided insight regarding the impact of the spiritual components of the program. All participant's spiritual perspective was evaluated by completing the SPS pre and post intervention. There are various events that the participants could have experienced which may have contributed to the slight decreases in post SPS scores. Although a slight decrease was determined it should be noted that the lowest SPS score was 5. Considering that all of the participants were members of the hosting church, it was not surprise that all of the participants' scores ranged 5-6, which is consistent with high spiritual perspectives. This provided foundational information that will require further research.

STS Scores

The STS scores achieved prior to exposure to the hypertension management sessions offered valuable information as it relates to the participants' ability to look beyond barriers or challenges associated with hypertension management and find meaning in the information that was provided during the sessions. All of the participants were engaged and contributed to the open discussions. The sharing of personal challenges and triumphs related to managing hypertension proved to be beneficial, as participants' journals mentioned how hearing that others are facing the

same challenges was a strong source of encouragement. The participants freely discussed their deficits and asked for help from peers. A conscious effort to improve health behaviors was evident in the discussions and journaling.

This DNP project contributes to the limited body of knowledge regarding the utilization of faith based organizations as valid partners assisting in addressing the gaps in health care delivery. The project raises dialogue to gain further insight into the utilization of faith based organizations as valuable platforms for promoting healthy behaviors. Health initiatives should continue, fostering the practicing of self- care behaviors required to manage hypertension. The identification of the need for and value of FBOs in the improvement of health care among African Americans should result in greater opportunities being offered by grant sponsoring organizations. In addition, this project revealed the possible role of spirituality in health care practices, prompting research to gain a better understanding of this phenomenon.

To nurture sustainability of the program, several ideas were discussed with the minister of the church. One being to have the health ministry member who was trained and assisted with facilitation of the sessions to continue offering the sessions. Hosting guest speakers once a month to provide updated information on high blood pressure management, and the implementation of a high blood pressure support group may contribute to sustainability of the program as well. Building upon current relationships with Coppin State University and other community partners was encouraged, as this would provide assistance with health initiatives for the community and church members. In an effort to be self-sufficient and employ additional health programs, the development of infrastructure within Central Church of Christ that includes grant writing was

discussed. Despite the limitations identified, participants gained substantial information and encouragement to them to make lifestyle changes and have reported improvements in the management of their blood pressures.

Implications

This project stimulated discussion of future work. Additional projects, and studies to expand knowledge utilizing larger sample sizes are warranted, as the body of knowledge concerning spirituality and FBOs continue to evolve. Discussion of future research to build the validity of the tools used and test the statistical significance of the program with different ethnic groups and in secular venues has commenced. There has also been discussion of using the data from the participant's journals to collect and analyze qualitative data, which may prove to add richness to the project outcomes. In addition, the STS scale will be used with a larger sample size to gain further understanding of spirituality and the role it plays in health behaviors. Results of this project contributes to the limited body of knowledge regarding spirituality and its potential role in managing chronic diseases, especially among African Americans.

The Joint Commission has acknowledged the importance of spirituality and its role in health promotion, suggesting that improvements be made in the assessment and care of ones' spirituality (Joint Commission, 2011). This project should serve as a pilot study for health care providers, as they consider the integration of spiritual components in healthcare delivery, which could be essential in fostering improved health outcomes. Government agencies should acknowledge the value of FBOs in improving health care, by filling the gaps that exist between visits to primary care providers. This realization

may prompt more funding for FBOs and the development of partnerships among FBOs and state and government agencies.

Utilizing the advanced knowledge and skills of evaluating care delivery models, theories, and strategies, this DNP scholarly project focused on the development and implementation of a faith based self-care management program to help African Americans overcome the challenges associated with hypertension management. This project employed the DNP essentials in identifying a quality improvement strategy that reflects a cost effective holistic approach to well-being. This project has laid the foundation for continued research and scholarly contributions that will positively impact health care delivery and the nursing profession.

Dissemination

The project and its results will be disseminated utilizing Salisbury University's designated platform devoted to DNP projects such as, The Virginia Henderson Global Nursing e-Repository, ProQuest Dissertations and Theses Global, which is the largest collection of dissertations and theses in the world, and SOAR, which is Salisbury University repository for research, creative works, and data. Additional dissemination will occur through presentations at local, regional, and national conferences and programs hosted by local faith based organizations. The project's abstract was accepted for a podium presentation at the Innovations in Faith Based Nursing Conference occurring June 19, 2018 in Indiana and a poster will be presented June 21-22, 2018 at The Central Church of Christ Mid Atlantic Lectureship in Maryland. Manuscript submission to The Journal of Christian Nursing is also scheduled.

DNP Essentials and the Nurse Executive Competencies

Expanding access to health care and containing health care related costs, while ensuring quality care without health care inequality continues to be a challenge and contributes to the complexity of the health care system in the United States (Shi & Singh, 2013). In response to these challenges the American Association of Colleges of Nurses (AACN) identified the Doctorate of Nursing Practice, which provides nurses with enhanced knowledge, preparing them to be significant contributors to the country's health care needs. The Health Professions Education Committee acknowledges the need for nurses to be experts at using technology, synthesizing and integrating evidence based practices, and collaborating across the health care disciplines (Moran, Burson, Conrad, 2017). The AACN incorporated these competencies in the Essentials of Doctoral Education, which are required outcomes for the DNP prepared nurse. The final DNP project provides the opportunity for the assimilation of all of the Essentials of Doctoral Education, translating research into practice and applying new knowledge. My role as a DNP leader has evolved significantly through the development and implementation of the DNP project. The remainder of this paper will discuss how the project contributed to meeting the DNP Essentials and Nurse Executive Competencies.

Essential I: Scientific Underpinnings for Practice is the essential that describes foundations of nursing practice based on the natural and social sciences (Chism, 2013).

The DNP project is to be supported by a theory. Although theories tend to be abstract, the empirically tested theoretical models provide concepts and definitions that can offer explanation of health behaviors. Research and identification of theories to support the DNP project expanded my knowledge of theorist and how to integrate

theories to improve health care practices. The utilization of science based concepts, nursing practices, and theories to identify strategies that can improve health care delivery and outcomes is significant in the development of the DNP project and my ability to use this knowledge has been enhanced. New knowledge of the Self-Transcendence Theory proved to be beneficial. This model was used as the foundation for the DNP project. The Self Transcendence Theory was originally used to understand the mental wellbeing of individuals during the end of life. The theory is related to assessing the ongoing developmental relationships that one may have with others and their environment. Self-Transcendence is achieved when one has the ability to look beyond barriers and find perspective and meaning through the relationships with others and the environment. It is believed that through self-transcendence one will be able to look beyond limitations and obtain wellbeing in the time of vulnerability. In the case of the project, individuals with hypertension are facing barriers and limitations as it relates to the ability to manage blood pressures. It is believed that through self -transcendence one will find meaning and the ability to overcome these challenges through the information and resources provided by the management program.

Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking.

To be an effective nurse leader, one must be able to identify organizational and systems that influence health care outcomes. The DNP project required the assessment of organizations and systems particularly, faith based organizations and how they can be used to enhance health care delivery. Innovative strategies utilizing faith based organizations in addressing health care issues experienced among African Americans was

identified. The knowledge obtained regarding faith based organizations will be used to build partnerships and strategies that will improve the health in all communities, especially the underserved.

Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice

"The DNP graduate is expected to be an expert in the evaluation, integration, translation, and application of evidence based practices" (Chism, 2103, p. 15). In preparation of the DNP project a literature review was completed. The interpretation of the review assisted in the identification of relevant best practices. Knowledge gained from the literature review abetted the practices and methodologies implemented to gain the desired outcomes. Knowledge gained has equipped me to be an expert in the utilization of spirituality and health outcomes.

Essential IV: Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care

Computer systems and software such as SPS was utilized to organize and evaluate collected data. In addition, web sites were used to gain knowledge of concepts and this required the ability to evaluate the accuracy and credibility of websites.

Essential V: Health Care Policy for Advocacy in Health Care

Although knowledge existed regarding inequality of health care delivery that exist for African Americans, the DNP project enhanced my knowledge and ignited my desire to be an advocate for change as it relates to the health care of the African American

population. I have gained a desire to be actively involved in health policies that effect the health care practices and outcomes for the underserved populations.

Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes

The health care system can be complex, requiring collaboration across health disciplines to yield cost effective, quality care that will improve health outcomes. Throughout the development of the DNP project there was collaboration with health care providers and stake holders. Dr. Trent, who provided medical care for African Americans with hypertension provided insight into the challenges that exist in the management of hypertension among the targeted population. Communication with the leadership of various faith based organizations was completed in the effort to share the need for the project and be granted permission to implement at the organization.

Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health

The DNP project focus is to promote health promotion among African Americans. The project functioned to identify strategies that will promote healthy behaviors that will decrease illness and complications associated with uncontrolled hypertension.

Essential VIII: Advanced Nursing Practice

Through the DNP project, the assessment of health and illness among African Americans was completed. The information obtained through this assessment assisted in the identification of appropriate strategies for African Americans. Therapeutic relationships with patients and health care professionals aided in the choice of strategies

used in the DNP project with the hope of ensuring health care behaviors that will improve the management of hypertension and health outcomes. These activities provided a foundation for the building of my expertise in the use of spirituality in health care. The work invested in the DNP project has enhanced current knowledge and uncovered new knowledge as a result of the exploration of the role of faith based organizations in addressing challenges in health care delivery.

Along with the DNP Essentials, Nurse Executive Competencies are identified as desired outcomes for the DNP graduate. The DNP project requires the utilization of all of the identified Nurse Executive Competencies; communication and relationship building, knowledge of the health care environment, leadership, professionalism, and business skills.

Effective communication is essential to successful leadership. This communication can be performed by various means. Oral presentations were provided to the DNP project committee**,** the stakeholders, and participants of the project. Several meetings were conducted with church leadership for project approval and to discuss project outcomes. Communication with facilitator assistant, church leadership, and participants was ongoing throughout the implementation of the project. Collaborative relationships were made with clients, stakeholders, participants, and health care providers in the pursuit of identifying and implementing strategies that will improve health outcomes. As mentioned beforehand, credible relationships were built with Dr. Trent, faith based leaders, and other health care professionals in the development of the DNP project. The facilitation of rich discussion among participants as part of the DNP project inspired improved health behaviors and enhanced my leadership skills of engagement.

Cultural beliefs of the African American population were incorporated in the DNP project to ensure culturally sensitive health care delivery. The involvement of non-health care constituents within the community such as faith based organizations provided representation of community perspectives while serving as a resource for the implementation of the DNP project. The DN project increased my network of professionals. I have also been inspired to explore a business venture, establishing a faith based community health center.

Although there will continue to be a pursuit of leadership development as a new DNP prepared nurse, the identification, development, implementation, and evaluation of the DNP project has contributed significantly to my knowledge of health care delivery and research. This knowledge has laid the foundation for continued research and scholarly contributions that will positively impact the nursing profession.

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Appendix A. Review of the Literature

Table 4. Table of Evidence

Year	Author, Title, Journal	Purpose	Design	Sample	Result
2003	Aaron, K. F., Levine, D., & Burstin, H. African American church participation and health care practices. *Journal of General Internal Medicine*.	Study the prevalence of church participation and whether church participation has an effect on healthy practices.	Cross Sectional Analysis	African Americans 18 years or older living in the lower socioeconomic neighborhoods	Positive correlation between church attendance and the pursuit of preventive health services.
2015	Barnes-Grant, A., Seixas, A., Frederickson, K., Butler, M., Tobin, J., Jena-Louis, G., & Ogedegbe G. Effect of expectation of care on adherence to antihypertensive medications among hypertensive blacks: Analysis of the counseling African Americans to control hypertension (CAATCH) trial. *The Journal of Clinical Hypertension* 18(7): 690-696.	The purpose of the CAATCH trial was to compare the effectiveness of a multilevel BP control intervention vs usual care among blacks.	Cross sectional study	440 African American adults who have been diagnosed with HTN.	Greater expectation of care was associated with greater medication adherence (P=.007), and greater social support was also associated with greater medication adherence (P=.046).
2011	Boltri, J. M., Davis-Smith, M., Okosun, I. S., Seale, J. P., & Foster, B. Translation of the national institutes of health diabetes prevention program in African American churches. *Journal of National Medical Association* 103(3): 194-202.	To test the success and feasibility to translate a national diabetes prevention intervention as a health program in an African American church	Randomized Control Pilot Study	37 Adult African Americans with diabetes.	Post intervention there was a significant decrease in fasting glucose levels among all participants. Cost was Further studies are warranted to test feasibility.

Year	Author, Title, Journal	Purpose	Design	Sample	Result
2012	Butler-Ajibade, P., Booth, W., & Barnell, C. Partnering with the black church: Recipe for promoting heart health in the stroke belt. *Association of Black Nursing Faculty Journal* 23(2): 33-37.	The purpose of the article was to identify factors that will be helpful in planning interventions to implement in churches to address the high mortality rates of African Americans with hypertension.	Analysis of previous research	African Americans with HTN.	Positive correlations between faith - based organization and health behaviors of African Americans diagnosed with hypertension consistent among previous research.
2004	DeHaven, M., Hunter, I., Wilder, L., Walton, J. & Berry, J. Health programs in faith based organizations: Are they effective? *American Journal of Public Health* 94(6): 1030-1036.	Examination of literature to determine the effectiveness of faith based organizations	A Systematic review of articles that address faith based health programs	N/A	Concluded there is significant literature that supports that faith based programs can help improve health outcomes but more effort need to be placed on the evaluation of health programs provided and the dissemination of the outcomes.
2014	Dodani, S., Arora, S. and Kraemer, D. HEALS: A Faith-Based hypertension control program for African-Americans: A Feasibility Study. *Open Journal of Internal Medicine,* 4, 95-100.	To examine the feasibility and effectiveness of a faith based social-cultural lifestyle intervention to reduce blood pressures among African Americans over 12 weeks.	Longitudinal study	22 adult church members	Minimal cost to implementation with the use of community resources. There was a reduction in blood pressure measurements of participants but a study for a longer period of time would be beneficial.

Year	Author, Title, Journal	Purpose	Design	Sample	Result
2016	DeKoninck, B., Hawkins, L. A., Fyke, J. P. Neal, T., & Currier, K. Spiritual care practices of advanced practice nurses: A multinational study. *The Journal of Nurse Practitioners*12 (8): 536-544.	To gain insight on the APN perspective regarding spirituality and how it is used in clinical practice.	Prospective - Descriptive study	136 NP 18 or older practicing in outpatient setting in the United States, England, Switzerland, Australia, and Germany.	Lack of training in spiritual care reported by majority of NP. There is a significant variation in spiritual care provided by NPs. NPs with training in providing spiritual care feel comfortable in providing care and are reports being "spiritual."
2008	Giger, J.N., Appel, S.J., Davidhizar, R., & Davis, C. Church and spirituality in the lives of the African American community. *Journal of Transcultural Nursing*, 19, 375- 383.	To provide information regarding health and health care concerns among African Americans and the role that the church can play in addressing the health care needs of this population.	Not a study Informational	N/A	Churches have played a role in improving healthcare in the past and should continue to be considered to assist with decreasing health disparities.
2016	Jeon, S. M. & Behavente, V. Health coaching in nurse practitioner–led group visits for chronic care. *The Journal of Nurse Practitioners* 12(4): 258-264.	To describe an intervention that integrates health coaching and group visits that can be used to improve the management of chronic diseases.	Randomized experimental study	Not provided	Health coaching and group visits led by trained NP both proved to effective methods.

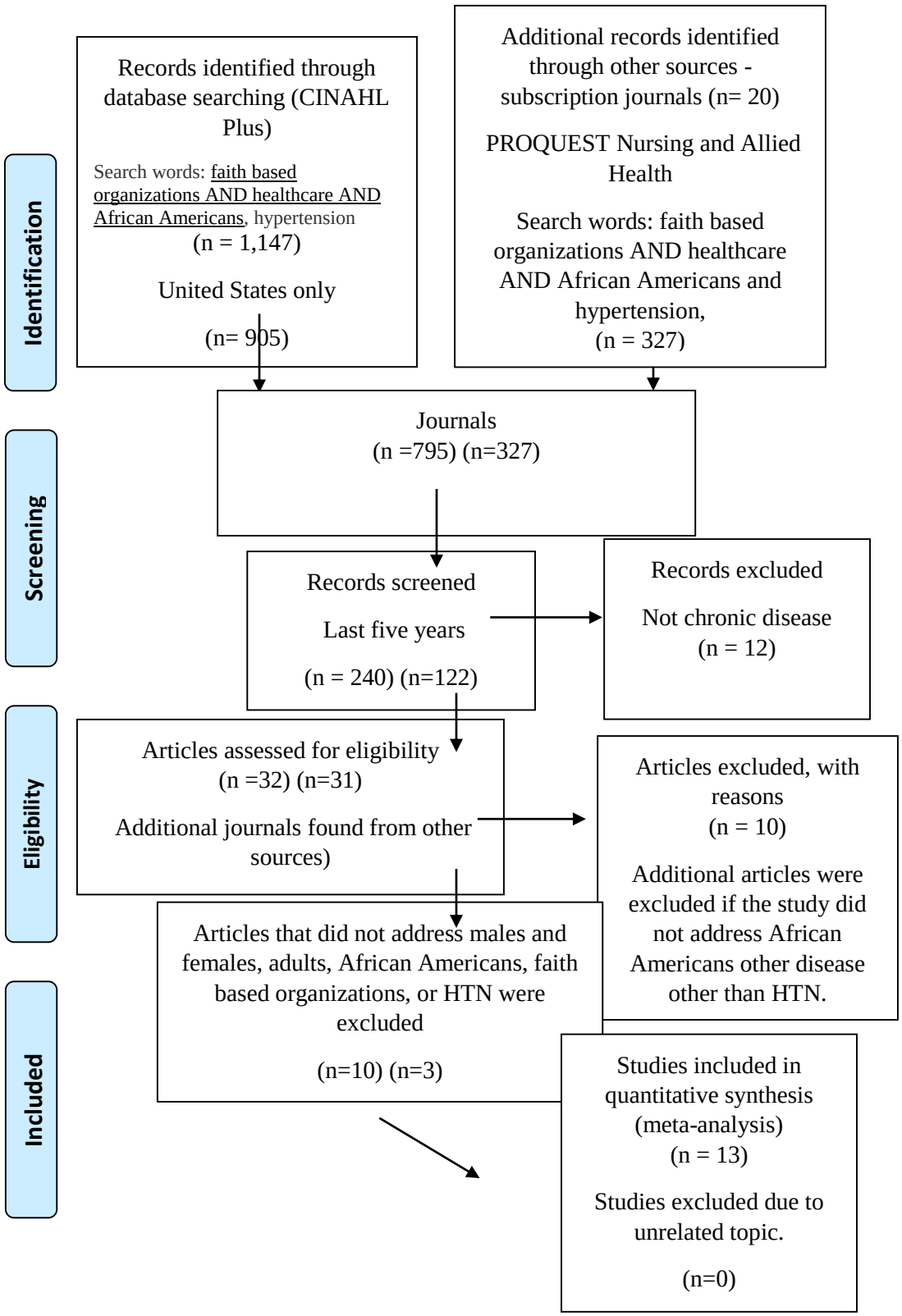
Year	Author, Title, Journal	Purpose	Design	Sample	Result
2013	Kennedy, B. R. Health inequalities: Promoting policy changes in utilizing transformation development by empowering African American communities in reducing health disparities. *Journal of Cultural Diversity.* 20(4): 155-162.	A review of literature related to social and health inequalities experienced by African Americans in order to identify possible resolutions.	N/A	N/A	Collected literature supports the need for a collaborative effort (community, government) is needed to end social and health inequalities.
2014	Lancaster, K. J., Schoenthaler, A. M., Midberry, S. A., Watts, S. O., Nulty, M. R., Cole, H. V., Ige, E., Chaplin, W., & Ogedegbe, G. Rationale and design of faith-based approaches in the treatment of hypertension (FAITH), a lifestyle intervention targeting blood pressure control among black church members. *The American Heart Journal* 167(3): 301-307.	To study the compare, the effectiveness of a group counseling faith based intervention to general health education.	Cluster Randomized study	32 churches	No information provided. Hypothesis: There will be a greater reduction of blood pressure and improvement in health behaviors among the participants among participants of the group counseling intervention.
2011	Lewis, L. Medication adherence and spiritual perspectives among African American older women with hypertension. *Journal of Gernotological Nursing* 37(6): 35-41.	To explore how older African Americans use spirituality to adhere to medication regimen for hypertension.	Qualitative study	21 African American women with a mean age of 73.7	Spirituality is important to older African Americans and contribute to their adherence to medication regimen.

Year	Author, Title, Journal	Purpose	Design	Sample	Result
2003	Lukoschek, P. African Americans' beliefs and attitudes regarding hypertension and its treatment: A qualitative study. *Journal of Health Care for the Poor & Underserved*, 14, 566-587.	To identify barriers to adherence to medication for hypertension among African Americans	Qualitative Case Study	42 African Americans diagnosed with HTN	Lack of trust in healthcare providers and the perception of racial prejudice were the most reported reason for nonadherence.
2002	Newlin, K., Knafl, K., & Melkus, G.D. African-American spirituality: A concept analysis. *Advances in Nursing Science*, 25, 57-70.	Gain an understanding of African American spirituality	Analysis of qualitative and quantitative research studies	Convenient sample of 20 studies	African American spirituality has global attributes and is culturally prominent among African Americans.
2011	Parrill, R., & Kennedy, B. R. Partnerships for healthcare in the African American community: Moving toward community based participatory research. *Journal of Cultural Diversity* 18(4): 150-154.	To identify effective interventions that include partnerships which will facilitate improved health outcomes among African Americans.	N/A (not mentioned)	N/A	Literature was consistent in acknowledging that interventions that include the church, community, healthcare system, and the African American home can be successful in improving health outcomes.

Year	Author, Title, Journal	Purpose	Design	Sample	Result
2003	Lukoschek, P. African Americans' beliefs and attitudes regarding hypertension and its treatment: A qualitative study. *Journal of Health Care for the Poor & Underserved*, 14, 566-587.	To identify barriers to adherence to medication for hypertension among African Americans	Qualitative Case Study	42 African Americans diagnosed with HTN	Lack of trust in healthcare providers and the perception of racial prejudice were the most reported reason for nonadherence .
2002	Newlin, K., Knafl, K., & Melkus, G.D. African-American spirituality: A concept analysis. *Advances in Nursing Science*, 25, 57-70.	Gain an understanding of African American spirituality	Analysis of qualitative and quantitative research studies	Convenient sample of 20 studies	African American spirituality has global attributes and is culturally prominent among African Americans.

Appendix B. Review of the Literature PRISMA

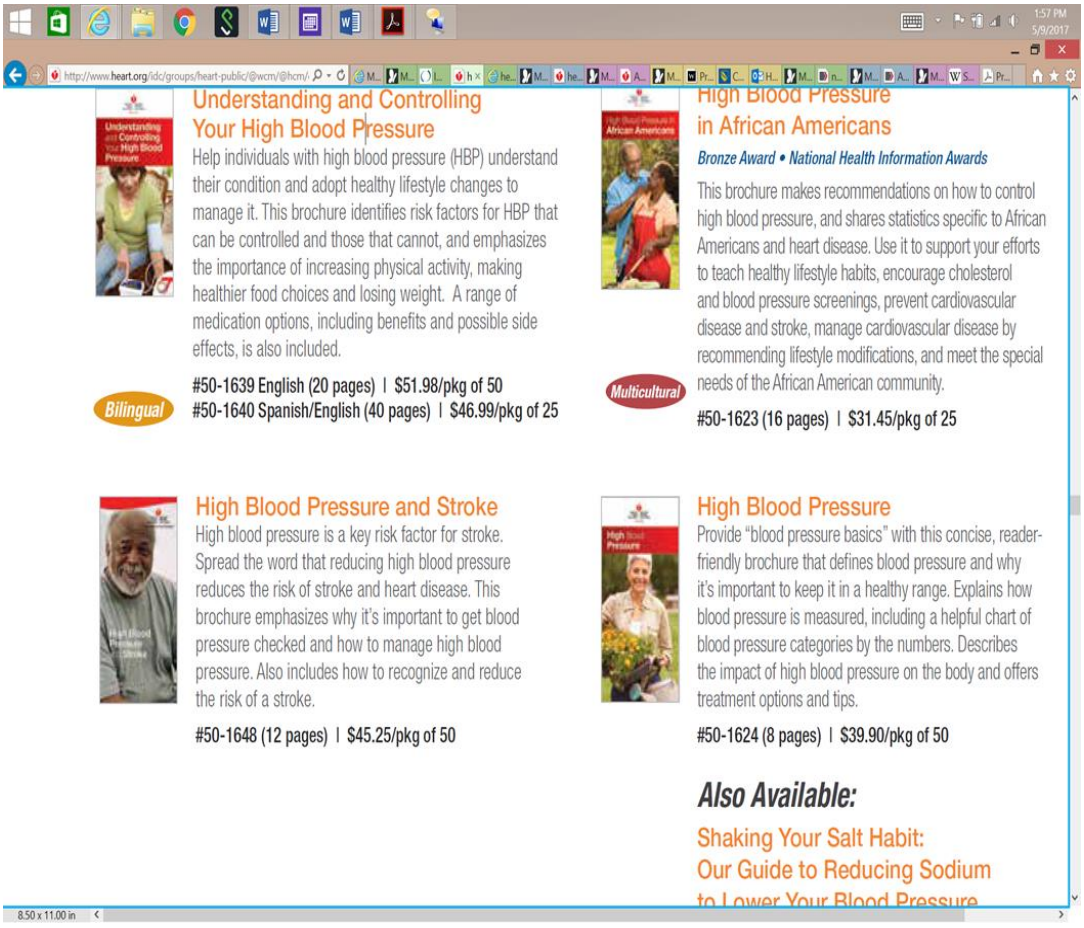
Figure 2. PRSIMA Diagram



Appendix C. SWOT Analysis

Figure 3. SWOT Analysis of Central Church of Christ

Appendix D. American Heart Association: Understanding and Controlling Your High Blood Pressure Booklet



Understanding and Controlling Your High Blood Pressure

Help individuals with high blood pressure (HBP) understand their condition and adopt healthy lifestyle changes to manage it. This brochure identifies risk factors for HBP that can be controlled and those that cannot, and emphasizes the importance of increasing physical activity, making healthier food choices and losing weight. A range of medication options, including benefits and possible side effects, is also included.

Bilingual

#50-1639 English (20 pages) | $51.98/pkg of 50
#50-1640 Spanish/English (40 pages) | $46.99/pkg of 25

High Blood Pressure in African Americans

Bronze Award • National Health Information Awards

This brochure makes recommendations on how to control high blood pressure, and shares statistics specific to African Americans and heart disease. Use it to support your efforts to teach healthy lifestyle habits, encourage cholesterol and blood pressure screenings, prevent cardiovascular disease and stroke, manage cardiovascular disease by recommending lifestyle modifications, and meet the special needs of the African American community.

Multicultural

#50-1623 (16 pages) | $31.45/pkg of 25

High Blood Pressure and Stroke

High blood pressure is a key risk factor for stroke. Spread the word that reducing high blood pressure reduces the risk of stroke and heart disease. This brochure emphasizes why it's important to get blood pressure checked and how to manage high blood pressure. Also includes how to recognize and reduce the risk of a stroke.

#50-1648 (12 pages) | $45.25/pkg of 50

High Blood Pressure

Provide "blood pressure basics" with this concise, reader-friendly brochure that defines blood pressure and why it's important to keep it in a healthy range. Explains how blood pressure is measured, including a helpful chart of blood pressure categories by the numbers. Describes the impact of high blood pressure on the body and offers treatment options and tips.

#50-1624 (8 pages) | $39.90/pkg of 50

Also Available:

Shaking Your Salt Habit:
Our Guide to Reducing Sodium
to Lower Your Blood Pressure

Appendix E. Outline of Sessions

Enrollment Session

Orientation to the program, blood pressure measurements, and completion of forms.

Session 1 Understanding High Blood Pressure

Scripture: I Corinthians 6:19-20- 19 Do you not know that your bodies are temples of the Holy Spirit, who is in you, whom you have received from God? You are not your own; 20 you were bought at a price. Therefore, honor God with your bodies.

Through scripture we know that God values our bodies. Our bodies are said to be a temple of the Holy Spirit, and we are called to take care of and honor God's temple. God's words lead use to use our bodies and the gifts He has given us to achieve the will of God. How did you treat your body this week?

Challenges and Triumphs open discussion

Session 2 Measuring Your Blood Pressure

Scripture: 1 Corinthians 3:16-17- 16 - Don't you know that you yourselves are God's temple and that God's Spirit dwells in your midst? 17 If anyone destroys God's temple, God will destroy that person; for God's temple is sacred, and you together are that temple.

Challenges and Triumphs open discussion

Session 3 Risk Factors

Scripture: Romans 12:1-2 Therefore, I urge you, brothers and sisters, in view of God's mercy, to offer your bodies as a living sacrifice, holy and pleasing to God—this is your true and proper worship. 2 Do not conform to the pattern of this world, but be transformed by the renewing of your mind. Then you will be able to test and approve what God's will be—his good, pleasing and perfect will.

Challenges and Triumphs open discussion

Session 4 Consequences

Scripture: 1 Corinthians 10:31 - 31 - So whether you eat or drink or whatever you do, do it all for the glory of God.

Challenges and Triumphs open discussion

Session 5 Treatment/Nutrition

Scripture- Hebrews 10:22 - 22 let us draw near with a sincere heart in full assurance of faith, having our hearts sprinkled clean from an evil conscience and our bodies washed with pure water.

Challenges and Triumphs open discussion

Session 6 Treatment/Exercise

Scripture: Philippians 4:19- 19 - And my God will meet all your needs according to the riches of his glory in Christ Jesus.

Challenges and Triumphs open discussion

Session 7 Treatment/Medications

Scripture: Psalm 103:2-4 2 Praise the LORD, my soul, and forget not all his benefits— 3 who forgives all your sins and heals all your diseases, 4 who redeems your life from the pit and crowns you with love and compassion.

Challenges and Triumphs open discussion

Session 8 Treatment/Medications Part II

Scripture: 20 My son, pay attention to what I say; turn your ear to my words. 21 Do not let them out of your sight, keep them within your heart; 22 for they are life to those who find them and health to one's whole body.

Wrap Up Session

Complete scales, blood pressure measurement, and healthy alternatives pot luck

Appendix F. Advertisement Flyer

FAITH

Fostering positive ***A***ttitudes ***I***n ***T***he management of ***H***ypertension

A faith based program aimed to improve self-care activities to improve the management of high blood pressure.

8 Biweekly sessions

American Heart Association Curriculum

Scripture Reading

Sharing/Support

Contact

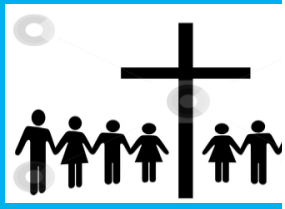
Dr. Dorothea Winter 410-548-5562

BLOOD PRESSURE MANAGEMEN T STRATGIES

UNDERSTAND ING HIGH BLOOD PRESSURE

EMPOWERED

GROUP SESSIONS



CENTRAL CHURCH OF CHRIST

4301 Woodridge Road
Baltimore, MD 21216

www.ccocmd.org

Appendix G. Demographic Data and Enrollment Form

1. Name _____
2. Age_____
3. Gender_____
4. Race/Ethnicity _____
5. Highest level of education completed_____
6. Is there any chance that you are pregnant? _____
7. How long have you been diagnosed with high blood pressure? _____
8. Do you experience challenges with managing your blood pressure, if so what are they?
9. Are you under the care of a health provider? Yes ____ No _____
10. How often do you visit your care provider? _____ Date of last visit_____
11. Family history of high blood pressure? Yes_____ No _____

Appendix H. Hypertension Self-Care Activity Level Effects Scale

Scoring: "The H-SCALE contains items related to six, hypertension self-care activities recommended by the JNC 8: taking medication, following a low-salt diet, engaging in physical activity, avoiding tobacco smoke, using strategies to maintain or lose weight, and reducing alcohol consumption. Each of these subscales is scored and then cut points are applied to determine the individual's adherence to the activity.

Medication (three items) – To calculate medication adherence, add the responses for items 1-3 (range 0-21). Participants who score a 21 are considered adherent. Other measures of medication adherence use 80% adherence as the cut point as opposed to 100%. Note: some respondents may not have been prescribed anti-hypertensive medications.

DASH-Q (11 items; items 4-14) – These items assess intake of healthy foods associated with the nutritional composition of the DASH diet. Responses are summed. The range should be 0 to 77. Scores of 32 and below are considered low diet quality; scores between 33 and 51 are medium diet quality; and scores of 52 or greater should be considered adherent. Physical Activity (two items; 15 and 16) – Responses are summed (range 0-14). Participants who score an 8 or better are considered adherent to physical activity recommendations; all others are non-adherent. This designation was chosen to ensure that participants have to report some combination of both physical activity and exercise in order to be considered adherent. There are two additional items related to isometric or strength training; these are currently being piloted. No scoring instructions are currently available but these items should reflect the US Surgeon General's recommendations to do strength training at least two days a week.

Smoking (2 items; 19 and 20) – Responses are summed (range 0 to 14). Respondents who score zero would be considered adherent.

Weight Management (10 items; 21-30) – These 10 items assess activities undertaken to manage weight through dietary practices such as reducing portion size and making food substitutions as well as exercising to lose weight. Items assessed agreement with weight management activities during the past 30 days. Response categories range from strongly disagree (1) to strongly agree (5). Sum the responses to calculate the score with a range from 10-50. Participants who reported that they agreed or strongly agreed with all 10 items (score $\geq$ 40) are considered to be adherent to good weight management practices.

Alcohol (3 items; 31-33) - Alcohol intake is assessed using an existing measure, the 3-item, National Institute on Alcohol Abuse and Alcoholism (NIAAA) Quantity and Frequency Questionnaire. Originally, adherence was deemed to be alcohol abstinent. The scale was validated using Southern African Americans who were very religious and had a correspondingly high prevalence of alcohol abstinence. Participants who reported not drinking any alcohol in the last seven days (item #31), or who indicated that they usually did not drink at all, were considered adherent. Currently, we recommend multiplying item #31 by item #32 which would indicate the total number of alcoholic drinks consumed per week" (Warren-Findlow, 2016).

The following questions ask about your hypertension (high blood pressure) self-care activities during the past 7 days. For each question, circle the number of days that you performed that activity.	
Medication Usage ***How many of the past 7 days did you:***	**Number of Days**
1. Take your blood pressure pills?	0 1 2 3 4 5 6 7 ☐ I have not been prescribed blood pressure pills.
2. Take your blood pressure pills at the same time every day?	0 1 2 3 4 5 6 7 ☐ I have not been prescribed blood pressure pills.
3. Take the recommended number of blood pressure pills?	0 1 2 3 4 5 6 7 ☐ I have not been prescribed blood pressure pills.
Diet ***How many of the past 7 days did you:***	**Number of Days**
4. Eat nuts or peanut butter?	0 1 2 3 4 5 6 7 ☐ I am allergic to nuts.
5. Eat beans, peas, or lentils?	0 1 2 3 4 5 6 7
6. Eat eggs?	0 1 2 3 4 5 6 7
7. Eat pickles, olives, or other vegetables in brine?	0 1 2 3 4 5 6 7
8. Eat five or more servings of fruits and vegetables?	0 1 2 3 4 5 6 7
9. Eat more than one serving of fruit (fresh, frozen, canned or fruit juice)?	0 1 2 3 4 5 6 7
10. Eat more than one serving of vegetables?	0 1 2 3 4 5 6 7
Diet How many of the past 7 days did you:	Number of Days

11. Drink milk (in a glass, with cereal, or in coffee, tea or cocoa)?	0	1	2	3	4	5	6	7
12. Eat broccoli, collard greens, spinach, potatoes, squash or sweet potatoes?	0	1	2	3	4	5	6	7
13. Eat apples, bananas, oranges, melon or raisins?	0	1	2	3	4	5	6	7
14. Eat whole grain breads, cereals, grits, oatmeal or brown rice?	0	1	2	3	4	5	6	7
Physical Activity How many of the past 7 days did you:	Number of Days							
15. Do at least 30 minutes total of physical activity?	0	1	2	3	4	5	6	7
16. Do a specific exercise activity (such as swimming, walking, or biking) other than what you do around the house or as part of your work?	0	1	2	3	4	5	6	7
17. Engage in weight lifting or strength training (other than what you do around the house or as part of your work)?	0	1	2	3	4	5	6	7
18. Do any repeated heavy lifting or pushing/pulling of heavy items either for your job or around the house or garden?	0	1	2	3	4	5	6	7
Smoking How many of the past 7 days did you:	Number of Days							
19. Smoke a cigarette or cigar, even just one puff?	0	1	2	3	4	5	6	7
20. Stay in a room or ride in an enclosed vehicle while someone was smoking?	0	1	2	3	4	5	6	7
The following questions ask about your efforts to manage your weight <u>during the last 30 days</u>. If you were sick during the past month, please think back to the previous month that you were not sick. <u>Circle the one answer</u> that best describes what you do to lose weight or maintain your weight.								
<u>Weight management</u>	**Strongly**			**Not**				**Strongly**

In order to lose weight or maintain my weight…	**Disagree**	**Disagree**	**Sure**	**Agree**	**Agree**
21. I am careful about what I eat.	1	2	3	4	5
22. I read food labels when I grocery shop.	1	2	3	4	5
23. I exercise in order to lose or maintain weight.	1	2	3	4	5
24. I have cut out drinking sugary sodas and sweet tea.	1	2	3	4	5
25. I eat smaller portions or eat fewer portions.	1	2	3	4	5
26. I have stopped buying or bringing unhealthy foods into my home.	1	2	3	4	5
27. I have cut out or limit some foods that I like but that are not good for me.	1	2	3	4	5
28. I eat at restaurants or fast food places less often.	1	2	3	4	5
29. I substitute healthier foods for things that I used to eat.	1	2	3	4	5
30. I have modified my recipes when I cook.	1	2	3	4	5

The next three questions are about alcohol consumption. A drink of alcohol is defined as:

One, 12 oz. can or bottle of beer;

One, 4-ounce glass of wine;

One, 12 oz. can or bottle of wine cooler;

One mixed drink or cocktail;

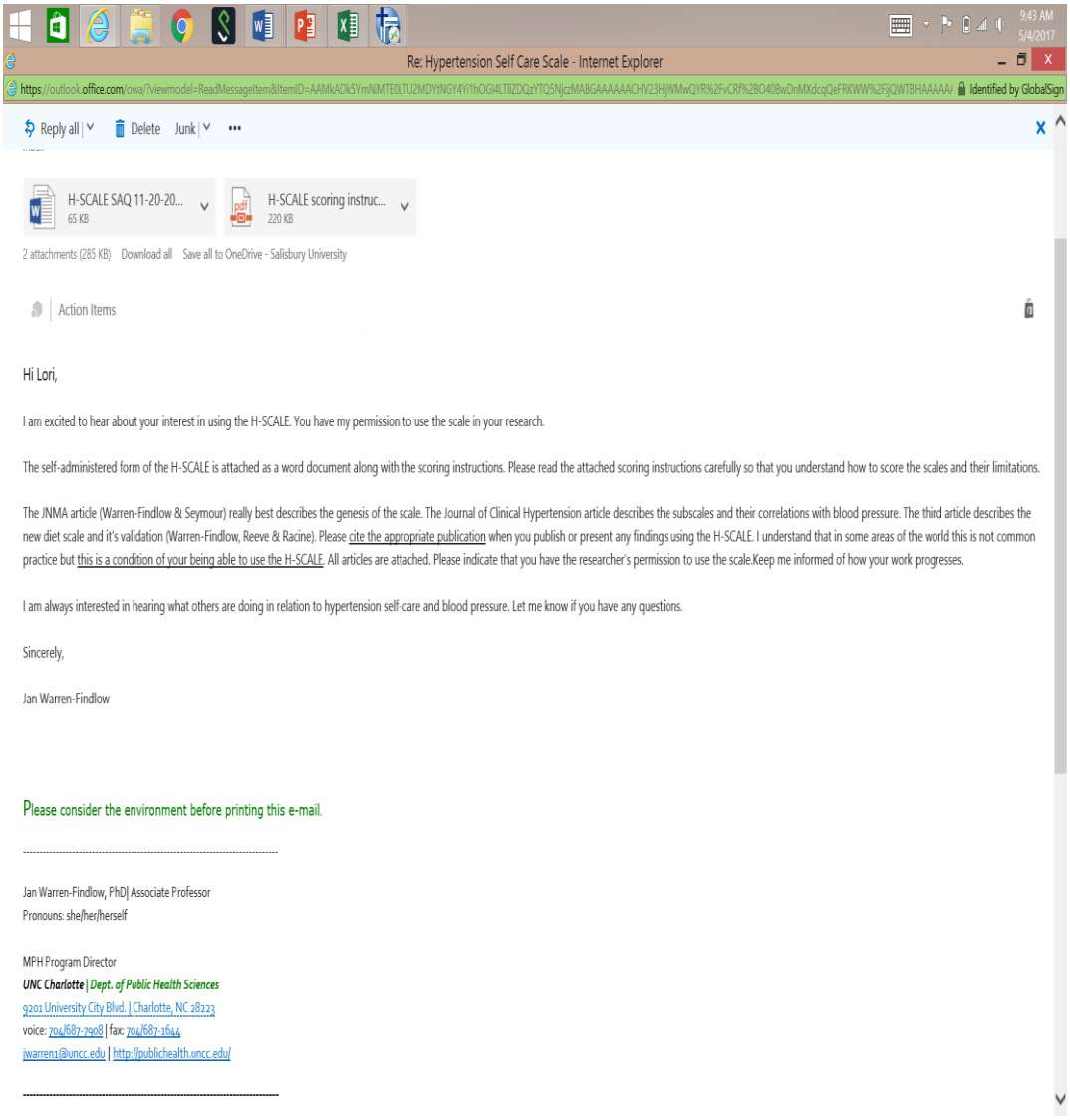
Or 1 shot of hard liquor.

31. On average, how many days per week do you drink alcohol?	0 1 2 3 4 5 6 7

32. On a typical day that you drink alcohol, how many drinks do you have?	0 write in # _____
33. What is the largest number of drinks that you've had on any given day within the last month?	0 write in # _____

Permission granted to use H-Scale by Dr. Jan Warren-Findlow 2017

Appendix I. Permission to Use H-Scale



Re: Hypertension Self Care Scale - Internet Explorer

https://outlook.office.com/owa/?viewmodel=ReadMessageItem&ItemID=AAMkADk5YmNiMTE0LTU2MDYtNGY4Yi1hOGI4LTliZDQzYTQ5NjczMABGAAAAAACHV23HJWIMwQYR%2FvCRf%2BO40BwDnMXdcqQeFRKWW%2FijQWTBHAAAAA/ Identified by GlobalSign

Reply all | Delete Junk |

H-SCALE SAQ 11-20-20... 65 KB

H-SCALE scoring instruc... 220 KB

2 attachments (285 KB) Download all Save all to OneDrive - Salisbury University

Action Items

Hi Lori,

I am excited to hear about your interest in using the H-SCALE. You have my permission to use the scale in your research.

The self-administered form of the H-SCALE is attached as a word document along with the scoring instructions. Please read the attached scoring instructions carefully so that you understand how to score the scales and their limitations.

The JNMA article (Warren-Findlow & Seymour) really best describes the genesis of the scale. The Journal of Clinical Hypertension article describes the subscales and their correlations with blood pressure. The third article describes the new diet scale and it's validation (Warren-Findlow, Reeve & Racine). Please cite the appropriate publication when you publish or present any findings using the H-SCALE. I understand that in some areas of the world this is not common practice but this is a condition of your being able to use the H-SCALE. All articles are attached. Please indicate that you have the researcher's permission to use the scale.Keep me informed of how your work progresses.

I am always interested in hearing what others are doing in relation to hypertension self-care and blood pressure. Let me know if you have any questions.

Sincerely,

Jan Warren-Findlow

Please consider the environment before printing this e-mail.

Jan Warren-Findlow, PhD| Associate Professor
Pronouns: she/her/herself

MPH Program Director
UNC Charlotte* | *Dept. of Public Health Sciences
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voice: 704/687-7908 | fax: 704/687-1644
jwarren1@uncc.edu | http://publichealth.uncc.edu/

Appendix J. Spiritual Perspective Scale

Introduction and Directions: In general, spirituality refers to an awareness of one's inner self and a sense of connection to a higher being, nature, others, or to some purpose greater than oneself. I am interested in your responses to the questions below about spirituality as it may relate to your life. There are no right or wrong answers. Answer each question to the best of your ability by marking an "X" in the space above that group of words that best describes you.

Scoring Instructions: The SPS is scored by calculating the arithmetic mean across all items, for a total score that ranges from 1.0 to 6.0. Responses to each item are selected using a 6-point Likert-type scale that is anchored with descriptive words. Response range from:

1 = *Not at all*/ *strongly disagree* to **6** = *about once a day*/ *Strongly Agree*

1. In talking with your family or friends, how often do you mention spiritual matters?

_____/_____/ _____/ _____/ _____/ _____

Not at all Less than once About once a year About once a month About once a week About once a day

2. How often do you share with others the problems and joys of living according to your spiritual beliefs?

_____/_____/ _____/ _____/ _____/ _____

Not at all Less than once About once a year About once a month About once a week About once a day

3. How often do you read spiritually related material?

_____/_____/ _____/ _____/ _____/ _____

Not at all Less than once About once a year About once a month About once a week About once a day

4. How often do you engage in private prayer or meditation?

_____/_____/ _____/ _____/ _____/ _____

Not at all Less than once About once a year About once a month About once a week About once a day

5. Forgiveness is an important part of my spirituality.

_____/_____/ _____/ _____/ _____/ _____

Not at all Less than once About once a year About once a month About once a week About once a day

Appendix I. Spiritual Perspective Scale

6. I seek spiritual guidance in making decisions in my everyday life.

_____/_____/ _____/ _____/ _____/ _____

Not at all Less than once About once a year About once a month About once a week About once a day

7. My spirituality is a significant part of my life.

_____/_____/ _____/ _____/ _____/ _____

Not at all Less than once About once a year About once a month About once a week About once a day

8. I frequently feel very close to God or a "higher power" in prayer, during public worship, or at important moments in my daily life.

_____/_____/ _____/ _____/ _____/ _____

Not at all Less than once About once a year About once a month About once a week About once a day

9. My spiritual views have had an influence upon my life.

_____/_____/ _____/ _____/ _____/ _____

Not at all Less than once About once a year About once a month About once a week About once a day

10. My spirituality is especially important to me because it answers many questions about the meaning of life.

_____/_____/ _____/ _____/ _____/ _____

Not at all Less than once About once a year About once a month About once a week About once a day

Appendix K. Self-Transcendence Scale

DIRECTIONS: Please indicate the extent to which each item below describes you. There are no right or wrong answers. I am interested in your frank opinion.
As you respond to each item, think of how you see yourself at this time of your life.

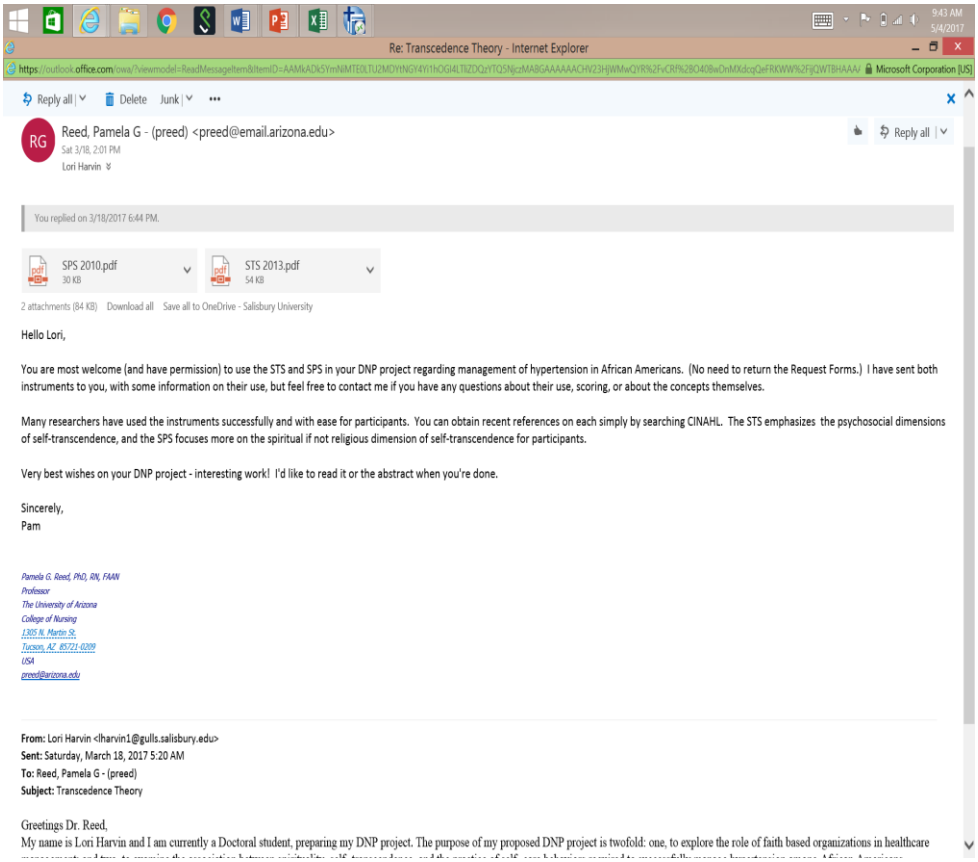
Check the number that is the best response for you. Numbers indicate how often you experience the questioned experiences-**1 Not At All, 2 Rarely, 3 Often, 4 Very Often**

At this time of my life, I see myself as:

Item	1	2	3	4
Having hobbies or interests I can enjoy.				
Accepting myself as I grow older				
Being involved with other people or my community when possible				
Adjusting well to my present life situation				
Adjusting to changes in my physical abilities				
Adjusting well to my present life situation				
Adjusting to changes in my physical abilities				
Sharing my wisdom or experience with others				
Finding meaning in my past experiences				
Helping others in some way				
Having an ongoing interest in learning				
Able to move beyond some things that once seemed so important				
Accepting death as a part of life				
Finding meaning in my spiritual beliefs				
Letting others help me when I may need it				
Enjoying my pace of life				
Letting go of my past regrets				

Permission granted to use SPS & STS by Pam Reed 2017

Appendix L. Permission to Use STS and SPS



Re: Transcedence Theory - Internet Explorer

Reply all | Delete Junk | •••

Reed, Pamela G - (preed) <preed@email.arizona.edu>
Sat 3/18, 2:01 PM
Lori Harvin

Reply all

You replied on 3/18/2017 6:44 PM.

SPS 2010.pdf 30 KB
STS 2013.pdf 54 KB

2 attachments (84 KB) Download all Save all to OneDrive - Salisbury University

Hello Lori,

You are most welcome (and have permission) to use the STS and SPS in your DNP project regarding management of hypertension in African Americans. (No need to return the Request Forms.) I have sent both instruments to you, with some information on their use, but feel free to contact me if you have any questions about their use, scoring, or about the concepts themselves.

Many researchers have used the instruments successfully and with ease for participants. You can obtain recent references on each simply by searching CINAHL. The STS emphasizes the psychosocial dimensions of self-transcendence, and the SPS focuses more on the spiritual if not religious dimension of self-transcendence for participants.

Very best wishes on your DNP project - interesting work! I'd like to read it or the abstract when you're done.

Sincerely,
Pam

Pamela G. Reed, PhD, RN, FAAN
Professor
The University of Arizona
College of Nursing
1305 N. Martin St.
Tucson, AZ 85721-0209
USA
preed@arizona.edu

From: Lori Harvin <lharvin1@gulls.salisbury.edu>
Sent: Saturday, March 18, 2017 5:20 AM
To: Reed, Pamela G - (preed)
Subject: Transcedence Theory

Greetings Dr. Reed,
My name is Lori Harvin and I am currently a Doctoral student, preparing my DNP project. The purpose of my proposed DNP project is twofold: one, to explore the role of faith based organizations in healthcare

Permission granted to use SPS & STS by Pam Reed 2017

Appendix M. Program Evaluation

According to the scale, choose the best response to each statement. **-1- 5 (1 Strongly; Disagree; 2 Disagree; 3 Neutral; 4 Agree; 5 Strongly Agree)**

Item	1	2	3	4	5
I would recommend the program to a friend or colleague					
The program met my expectations.					
The dates and times were convenient for me.					
How often did you attend the sessions? (write in response)					
What did you like about program? (write in response)					
What did you like least about the program? (write in response)					
What did you learn that was most helpful? (write in response)					
What additional topics or information would you find helpful?					
Do you have any other comments, questions, or concerns?					

Appendix N. Consent Form

I am Lori Harvin, currently a Salisbury University DNP student. In conjunction with my faculty advisor, Dr. Dorothea Winter, I am currently doing a study to determine if a faith based education program will improve managing high blood pressure among African American adults.

I am seeking the assistance of African American adults who have high blood pressure to participate in eight week sessions focusing on strategies that can be used to manage high blood pressure. The sessions will last 45 minutes and will be offered every other week for four months at your church. In addition, there will be three short surveys to be done at the beginning and the end of the program.

Every effort will be made to keep all information collected and shared in group sessions private but cannot be guaranteed. Your name will not appear on the surveys.

Please note that this program does not replace the treatment plan from your health care provider. You are encouraged to continue with that treatment plan for the management of your blood pressure.

Your cooperation and participation are strictly voluntary. You may leave any questions unanswered if you choose. Your attendance to all of the sessions is encouraged but not required. Please know that you are free to drop out at any time.

Your participation will help me identify helpful strategies that can be used to improve the health practices and health outcomes of African Americans who are diagnosed with high blood pressure.

A copy of this consent form will be provided to you for you to maintain for your records.

If you have any adverse effects or concerns about the research, please contact the primary investigator, Dr. Dorothea Winter at dmwinter@salisbury.edu or the Office of Graduate Studies and Research at Salisbury University at 410-548-3549 or toll free 1-888-543-0148.

Thank you for your cooperation.

Signature _____ Date _____

Readability Grade Level: 10 Reader's Age: 14-15 yrs. old (Nine to Tenth graders)

Appendix O. Letter of Support from Central Church of Christ

4301 Woodridge Road
Baltimore, Maryland 21229

410-945-2080

Willie L. Rupert, Jr. - Minister

November 28, 2016

Mrs. Lori Harvin

Salisbury University

Dear Mrs. Harvin,

I am delighted to support your project. We acknowledge the importance of addressing health and wellness, especially among African Americans. We are excited about your exploration of the role of Faith Based organizations in health care maintenance. We are willing to assist you with this project, with the understanding that all information provided from our members will be used for the project and confidentiality of our members will be maintained according to HIPPA regulations and guidelines. We are able to provide a place for the conduction of education sessions and blood pressure screening.

Please be mindful that sessions cannot be offered during our scheduled time for worship services or Bible classes. It is my prayer that assisting you with this project will shed light on the health care needs of the African American population and help us to better understand how we can help our members achieve health and wellness. I look forward to discussing further details with you soon.

In His Name,

Willie L. Rupert, Jr.

Appendix P. Projected Budget

Project Title: FAITH	
Budget Category	**Expenses**
A. Marketing/Advertisement	
Flyer	$0.00
Duplication (30 copies)	$30.00
B. Materials and Supplies	
Booklets	$117.34
Digital Blood Pressure Machines for each participant	$50/each $500.00
D. Equipment	
Projector	$0.00
Computer	$0.00
A mercury sphygmomanometer	$40.00 each 2 at each church $80.00
C. Travel	
Program Manager Travel	$1200.00 (In Kind)
D. Other (Specify)	
Thank you gift for team members service (facilitator assistance)	$150.00
Thank you gift for any special guest (dietician)	$50.00
Thank you gift for any special guest (Nurse Practitioner)	$50.00
Light Refreshments at each session	$200.00 (In Kind)
H. Total	$2,377.34 (In Kind $1400.00

Appendix Q. Project Timeline for Implementation of Project Elements

Activity	Project Months April – December 2017									
	4	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	
Obtain IRB approval	X									
Send letters to church letters. Meet with church leaders and selected team members who will serve as program facilitator (one at each church)		X								
Make flyer to be used for advertisement		X								
Purchase education booklets			X							
Meet with team members for training			X							
Explore partnerships (American Heart Association, Dietician, Fitness Instructor) that may be used as special activities	X	X	X	X	X					
Advertise program			X	X	X					
Duplicate tools, participant letter, and survey			X							
Develop program schedule for each church		X								
Enrollment and screening				X						
Implement program				X	X	X	X	X	X	
Monthly meetings with team members to conduct ongoing evaluation of program					X	X	X	X		
Conduct debriefing sessions with church leaders and team members. Identify components of the program that can be ongoing.									X	
Identify a statistician						X				
Meet with statistician to organize and input data						X	X	X	X	
Analyze data						X	X	X	X	
Begin to formulate a formal summary of data analysis findings									X	
Disseminate thank you letters to churches and participants									X	
Conduct debriefing session with church leaders and team members. Identify ongoing components of program.									X	