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ORIGINAL PAPER

Promoting Health and Wellness in Congregations Through Lay Health Educators: A Case Study of Two Churches

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Abstract Religious institutions are in regular contact with people who need education about and support with health issues. Creating lay health educators to serve in these communities can promote health initiatives centered on education and accessing resources. This paper is a prospective observational report of the impact of trained lay health community congregation members in two faith communities based on an urban setting. We describe health efforts made in an African-American Methodist church and in a Latino Spanish-speaking Catholic church. We review the intricacies in establishing trust with the community, the training of lay health educators, and the implementation strategies and outcomes of health initiatives for these communities.

Keywords Medical–religious partnerships · Patient engagement · Community health · Health promotion

Background

The prevalence of chronic diseases, such as diabetes and hypertension, is increasing dramatically. In 1987, 90 million Americans were living with at least one chronic disease; by 2030, it has been estimated that the number will be close to 150 million (Hoffman et al.

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1996). The economic impact is profound and growing rapidly. For example, in 2007, diabetes was estimated to cost $174 billion, with the majority of the costs going toward diabetic complications and excess general medical costs (American Diabetes Association 2008). By 2012, the annual burden of diabetes had increased by 41 % to $245 billion, with 43 % of the total medical costs going toward inpatient hospital care (American Diabetes Association 2013). Hypertension (estimated to cost $73.4 billion) and chronic obstructive pulmonary disease (estimated to cost $50 billion dollars) are also substantial economic burdens (Cohen 2009; Guarascio et al. 2013). Further, these healthcare issues and healthcare burdens are more prevalent in certain racial and ethnic populations (Gibbons and Tyrus 2007). Therefore, strategies aimed at combatting chronic diseases must reflect cultural awareness and incorporate cost-effective approaches.

As communities age and become more ethnically diverse, their residents are more at risk of being diagnosed with a chronic disease. Further, the majority of these diseases require that day-to-day monitoring and care be provided by patients and their families in their homes and communities. This presents issues of behavior change, engagement, education, awareness of resources, and the ability to navigate through the health system, also known as health literacy (Baker 2006). Many studies have shown that low health literacy, a social determinant of health, is likely to lead to poor health outcomes (Berkman et al. 2011). Therefore, if a positive intervention to help combat chronic diseases is to be pursued by medical institutions, they must be able to reach patients in the community and tackle issues related to health literacy.

Lay health educators (a term synonymous with community health educator) can provide a cost-effective means of impacting the health of a community (Gibbons and Tyrus 2007; Viswanathan et al. 2009). Further, training lay health educators to serve their religious congregations can be a way to offer programs that are culturally sensitive, reflecting the language, values, and traditions of a community. Additionally, older adults (who have the highest prevalence of chronic diseases) and minorities (who tend to have worse significant social determinants of health) are more likely than younger and non-minority groups to regularly attend religious services (Boscarino and Chang 2000; Gallup 2000). Several studies have shown the positive health impact of having lay health educators implement simple awareness strategies at religious institutions (Hale et al. 1997; Erwin et al. 1999; Yanek et al. 2001). However, how these relationships began, the challenges that were faced, and interventions that failed as well as succeeded have not been described in detail.

We describe a prospective observational reporting of the health efforts of lay health educators at two religious institutions with a predominantly minority membership over the last 4 years: St. Matthew, which serves an African-American population, and Sacred Heart of Jesus, which serves a Latino Spanish-speaking population. Table 1 displays a few demographics on the congregations, and Fig. 1 outlines the timeline of events.

Table 1 Brief summary of St. Matthews and Sacred Heart of Jesus

Congregation	Denomination	Language(s) spoken	Distance from hospital[a] (miles)
St. Matthews	African Methodist Episcopal	English	4.33
Sacred Heart of Jesus	Roman Catholic	English, Spanish	0.77

[a] Hospital: Johns Hopkins Bayview Medical Center

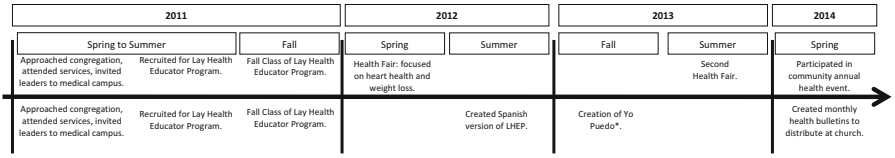

Fig. 1 Timeline of a few events highlighting the work with St. Matthews (*top row*) and Sacred Heart of Jesus (*bottom row*). *LHEP* Lay Health Educator Program. *"Yo Puedo": an initiative that involves scheduled meetings with community members, exercise routine, and diet information in an effort to combat non-communicable diseases, such as hypertension and type 2 diabetes mellitus

The Lay Health Educator Program

The Lay Health Educator Program (LHEP) is a 12-week course hosted at Johns Hopkins Bayview Medical Center, whereby community members learn about common health concerns and how they can help their community (in this case, congregations) promote health and wellness. The lay health educators were volunteers from local congregations with no background in health care. Each class was held once a week for 2 hours, with a significant amount of time allowed for questions from the lay health educators. Courses were taught by internal medicine physician residents, with the list of topics displayed in Table 2. At the end of the 12-week course, a graduation ceremony was held to celebrate the graduates of the program. The LHEP is supported by Healthy Community Partnership and Medicine for the Greater Good, two distinct programs at Johns Hopkins Bayview Medical Center focused on community health initiatives.

St. Matthew United Methodist Church

St. Matthew United Methodist Church is an African-American congregation in Turner Station of Baltimore, Maryland. The church provided a significant challenge in that Turner Station has a difficult history with the medical institution we represented (Skloot 2010). To

Table 2 List of topics from the 2011 Lay Health Educator Course

Diabetes mellitus
Hypertension
Chronic obstructive pulmonary disease
Depression
Cardiovascular disease
Dementia
Cancer
Congestive heart failure
Flu and pneumonia
Talking with your doctor
Advanced directives
Managing your medications
Accidents and falls

overcome this initial concern, the congregation's spiritual leader was approached. Meetings regarding the overall goal of establishing medical–religious partnerships were held, both at the church and at the hospital. These meetings included administrative leaders and physicians, both faculty and residents, who were eager to help in creating a partnership with the congregation. We introduced the minister to the concept of Lay Health Educators, and with his help recruited a member from his congregation to join the inaugural class. Additionally, in order to better understand the congregation and to forge a strong relationship built on familiarity and trust, representatives from our hospital frequently attended worship services and special church programs.

After the Lay Health Educator Program was completed, the graduate from St. Matthew United Methodist Church expressed great interest in heart health. The graduate discussed that the majority of the congregation was overweight and many suffered from heart issues. After several weeks of contact, the graduate requested two events: a speaker for "Red Dress Sunday" (a health event in Baltimore held in February where awareness is raised about heart health) and that we hold a health fair targeting heart disease that was informative and interactive.

Red Dress Sunday was held in February in 2012. A physician came to the congregation to discuss during the morning worship service the importance of heart health and what the congregation could do to take control of their health (e.g., diet and exercise). Visuals were also included, specifically ones that highlighted how much sugar is found in common food items. After the 30-min presentation, which included time for questions from the congregation, the minister strongly encouraged his members to heed the doctor's advice, even challenging them to begin to change their diets.

The health fair was held in the late spring of the same academic year. It was 3 hours long with four lectures: coronary artery disease, diabetes, hypertension, and nutrition. Further, the lectures discussed "how to read a food label," "how much exercise should one do based on age and health issues," and "how to measure your body mass index." Each lecture was led by a physician, who also allowed for questions to be asked by the congregation. At the end of the health fair, the congregation was given a task to try and lose 1000 pounds by the next year. This cause was further encouraged and supported by a congregation member—a nurse—who wanted to see this health initiative through.

With the support of the minister and the lay health educator graduate, we returned the following year to lead another "Red Dress Sunday" and health fair. The success of the prior year's events was evident. The minister and lay health graduate remarked on how motivated much of the congregation was toward their health: Many participants began to walk to church and provide healthier meals for after-church programs, and, over all, more people were talking about their health. The second health fair had different health goals, as requested by the congregation. The minister, lay health graduate, and community were again pleased with the sophomore events of both "Red Dress Sunday" and the spring health fair. Further, with these consecutive successes, the minister requested we participate in the community's annual spring festival in order to try and spread our health message to the entire community.

The partnership continues today, with the hospital staff continuing to help with health initiatives requested by the congregation, through the voice of the lay health educator. Discussions of a larger goal in regard to obesity management with lifestyle interventions continue, largely in part from the congregation's strong interest in this health concern.

Sacred Heart of Jesus

Unlike St. Matthew, we were approached by a member of the Sacred Heart of Jesus Catholic Church after she heard about the Lay Health Educator Program from an event at the hospital. The parishioner received encouragement from the church's spiritual leadership to participate in the course. After visiting the church and meeting with its leadership, we came to discover the church provides services to two distinct populations: an all-English speaking, older age group, and an all-Spanish speaking, younger age Latino group. During the course of the program, the lay health participant often noted how many non-communicable diseases were of greater prevalence in the Latino population (e.g., type 2 diabetes mellitus).

The lay health graduate of Sacred Heart of Jesus felt that a similar model to the Lay Health Educator Program would be appropriate for the all-Spanish-speaking members of the church. Further, the graduate and priest believed that the Church would be the ideal venue for the course. Six months after graduating from the fall course, the lay health graduate and an internal medicine resident physician introduced the Spanish version of the Lay Health Educator Program, "Embajadores de Salud." A distinction from the original model, the Spanish version allowed any and all members of the church to attend, all of whom had no prior training in medicine. The lectures were focused on understanding main health concerns of the Latino demographic (heart disease, renal disease) and how to (a) prevent or (b) manage these comorbidities appropriately. Other topics requested by the congregation included "how to acquire health insurance," "how to shop for healthy foods," and "how to talk to a physician" were discussed as well.

In an attempt to reach the entire population that attended the church, the priest requested monthly printouts to be inserted in the Sunday bulletins that coincided with the health talks. The pamphlets were less than 300 words total, but written in Spanish and with contact information if the community member desired more information. The Embajadores de Salud is now continuing into its third year, and monthly pamphlets continue to be handed out. The congregation requests the health topics that are to be covered 6 months in advance. Ongoing communication continues with the priest and the initial graduate of the program.

Of note, Embajadores de Salud has yielded two more health initiatives in the community: "Yo Puedo" ("I Can") and the Asthma Initiative for Parents, both of which were supported by the lay health educator graduate and spiritual leadership of the church. "Yo Puedo" is an initiative in which the community members engage in exercise routines and receive diet information in an effort to combat non-communicable diseases, such as hypertension and type 2 diabetes mellitus. The Asthma Initiative teaches parents of children with asthma at a local elementary school how to prevent asthma exacerbations, properly use medications (e.g., inhalers), and how to talk with their doctor regarding asthma. Yo Puedo is entering its second year, with over 100 participants. The Asthma Initiative will be a 5-week course scheduled for the summer of 2015.

Discussion

In this review of health efforts at two religious institutions, we highlight the importance of the influence well-trained volunteers on the health of a community when these volunteers work in collaboration with the leaders of their faith community and a local hospital. In both

churches, it took only one volunteer, neither of whom had formal training or experience in health care, to design and implement far-reaching health programs. Working with churches and lay health educators provided a unique way to overcome economic, cultural, and language barriers. Further, this work emphasizes the significance of establishing a relationship built on an ongoing commitment, which was vital in order to establish a sense of dedication by the medical institution.

Addressing health issues toward minorities is a major concern, with significant literature reporting on minorities and poor health outcomes over a spectrum of diseases (Berkman et al. 2011; Schmotzer 2012; Priddy et al. 2006; Kirk et al. 2007; Mays 2012). Sacred Heart of Jesus represents a community that is on the rise in Baltimore: the Spanish-speaking Latino community. The Latino community is unique in that they are the largest immigrant population undergoing acculturation. Acculturation of the Latino community has an impact on health outcomes, often negative, especially when it comes to eating a healthy diet and access to mental and physical health care (Lara et al. 2005; Mainous et al. 2008; Freeman and Lethbridge-Cejku 2006; Kafali et al. 2014; Ayala et al. 2008). These issues are thought to be due often to poor access to healthy foods, cultural insecurities, and socioeconomic status (Ayala et al. 2008). Training community health workers, especially in Spanish, and using the church as the place to hold weekly health talks were keys to help facilitate a healthy relationship between Sacred Heart of Jesus and our medical institution. The health workers helped to overcome language and cultural barriers that are seen as issues to healthier lifestyles for immigrants, especially Latino populations.

St. Matthew United Methodist Church's congregation was of minority status, African-American, as well; however, it posed another cultural issue: trust. St. Matthew is found in Turner Station, the same location where Henrietta Lacks grew up (Skloot 2010) and where significant trust issues toward medical organizations exist (Skloot 2010). Misrust and suspicion of healthcare institutions unfortunately are often widespread among minorities, especially with respect to mental health care (Mays 2012; Pierre et al. 2014; Hale and Bennett 2000). We were faced with issues of trust initially when approaching the congregation, with a concern over "being treated like a charity" and having a transient relationship. Again, the support of the leaders of the congregation in conjunction with lay health educators from the congregation helped to overcome these issues and create successful health initiatives.

The Lay Health Educator Program has already shown promises of impacting the medical community. Physicians, especially physicians in training who are molding their professional identity, appear to benefit greatly from participating in this community health initiative in regard to understanding the health needs of the community (Galiastatos et al. 2015). Moving forward, now that trust has been well established with specific congregations in the community, we wish to begin to collect data in regard to the impact these efforts have on the community. Data will consist of methods measuring health literacy of the community, especially if they participate in educational classes with specific health information (e.g., the Asthma Initiative as previously described). Further, we have partnered with the Department of Health and Mental Hygiene in Baltimore City to access data on heart disease, diabetes, and mortality for the zip codes these congregations reside in, as well as demographic information. Future large-scale data will aim to report the before and after impact of our health initiatives in these communities.

A limitation of this report is in the inability to report specific demographics, such as age and sex distribution, as well as an understanding of the overall comorbidities of the congregation. Race, ethnicity, and faith were established by speaking with the spiritual leaders of the church. However, it was stressed to approach the congregation as "people

and not test subjects"; therefore, collecting the aforementioned details may have interfered with creating a trusting partnership. Further, we tried to abide by prior recommendations in approaching congregations, which emphasized relationship building and communication rather than data collection (Hale and Bennett 2000). Therefore, we refrained intentionally from collecting such data, as we believe this would have done more harm than benefit in regard to the relationship we were creating. Ultimately, when we wish to report data in regard to specific health outcomes, we will revisit this issue and approach it in the best way possible in order to preserve the established partnership.

In conclusion, establishing a viable and beneficial medical relationship with the community, especially with specific minorities, takes time and assistance from established organizations in the community, such as religious institutions. We report a four-year timeline in which lay health educators of the churches played significant roles in health initiatives. Future studies should further address the long-term role of lay health educators, religious organizations, and their impact on the overall health of a community. Finally, medical institutions that wish to partner with the communities they serve may benefit from exploring faith-based organizations and creating lay health educator programs to overcome cultural, economic, and educational barriers.

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