AHRQ HEALTH CARE
INNOVATIONS EXCHANGE
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Service Delivery Innovation Profile

Church-Health System Partnership Facilitates Transitions from Hospital to Home for Urban, Low-Income African Americans, Reducing Mortality, Utilization, and Costs

Snapshot

Summary

A partnership between Methodist Le Bonheur Healthcare and 400 churches in Memphis, the Congregational Health Network supports the transition from hospital to home for church members. Enrolled congregants are flagged by the health system's electronic medical record whenever admitted to the hospital. A hospital-employed navigator visits the patient to determine his or her needs, and then works with a church-based volunteer liaison to arrange postdischarge services and facilitate the transition to the community. The liaisons and clergy members also receive training and other benefits from the health system, thus allowing them to serve as role models and provide education to congregants. The program has reduced mortality, inpatient utilization, and health care costs and charges, while improving satisfaction with hospital care.

Evidence Rating (What is this?)

Moderate: The evidence primarily consists of comparisons of key outcomes among 473 participants and a group of similar individuals who did not participate, including mortality rates, health care costs and charges, and patient satisfaction. Additional evidence includes pre- and post-implementation comparisons of various measures of inpatient utilization and charges in a subgroup of 50 participants.

Developing Organizations

Congregational Health Network; Methodist LeBonheur Healthcare

Date First Implemented

2006

Patient Population

The program serves the entire Memphis community, but 86% of early adopter members are urban, lower-income African Americans.Race and Ethnicity > Black or African American; Vulnerable Populations > Impoverished; Racial minorities; Urban populations

What They Did

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Problem Addressed

Low-income African Americans disproportionally suffer from cardiovascular disease, diabetes, and other conditions that lead to frequent hospitalizations. Once hospitalized, they often have difficulty navigating the system and arranging for postdischarge services, which frequently leads to readmissions. They also lack education about healthy lifestyles that could prevent the development or exacerbation of chronic disease. Churches represent a potentially effective but underused resource in promoting health and facilitating transitions in this population.

- **Greater risk of getting, dying from chronic illness:** African-American adults face twice the risk of being diagnosed with and dying from diabetes than do White individuals.[1] They also face greater risks related to heart disease. Overall, African Americans are 1.5 times more likely to have high blood pressure (a risk factor for the disease) than the average White person, while African-American men are 30 percent more likely to die from heart disease than White men.[1] African Americans also face greater risk of obesity; women in particular are affected, with obesity rates of nearly 40 percent.[2]
- **More hospitalizations and readmissions:** Care disparities lead to higher rates of hospitalization and re-hospitalization.[1] For example, African Americans with diabetes are almost twice (1.7 times) as likely as diabetic Whites to be hospitalized,[1] while African-American Medicare beneficiaries with heart disease are hospitalized more frequently than White and Hispanic beneficiaries (with hospitalization rates of 85.3, 74.4, and 73.6 per 1,000 beneficiaries, respectively).[3] Care transitions from hospital to home can be difficult for low-income populations, leading to higher rates of readmission; for example, low-income, ethnic minorities with diabetes are more likely to experience unscheduled readmissions.[4]
- **Limited access to support:** Low-income Americans and racial/ethnic minorities have limited access to wellness services and education about healthy lifestyles. They also tend to live in environments that support and even promote unhealthy lifestyles.[5,6]
- **Largely unrealized potential of churches:** The church is often the most respected and socially powerful organization in low-income African-American neighborhoods. Clergy and other church representatives can promote better health by serving as role models, creating and encouraging use of community-based activities and programs, helping individuals adopt healthier lifestyles, and serving as a link between congregants and the health system.[7] However, many churches in minority communities do not proactively play these roles, nor do they work closely with local health systems to promote improved community health.

Description of the Innovative Activity

A partnership between Methodist Le Bonheur Healthcare and 400 churches in Memphis, the Congregational Health

Network (CHN) supports the transition from hospital to home for church members. Enrolled congregants are flagged by the health system's electronic medical record (EMR) whenever admitted to the hospital. A hospital-employed navigator visits the patient to determine his or her needs and then works with a church-based volunteer liaison to arrange postdischarge services and facilitate the transition to the community. The liaison and clergy members also receive training and other benefits from the health system, thus allowing them to serve as role models and provide education to congregants. Key program elements include the following:

- **Covenant between health system and churches:** Health system and church leaders sign a covenant to formalize their partnership. The health system agrees to provide training at no charge (see below) and to share aggregate performance data. Clergy agree to be good health role models for their congregations and to help design and test program initiatives and tools. Congregations are classified according to level of engagement:
  - Level 1 congregations sign a covenant only.
  - Level 2 congregations sign a covenant and train liaisons.
  - Level 3 congregations sign a covenant, train liaisons, and participate in data analysis and program development.
  - Level 4 congregations sign a covenant, train liaisons, participate in data analysis and program development, and share narratives from members.
- **Enrollment of congregants:** Once a church signs a covenant, congregants can register for the CHN program. Interested individuals complete a form that complies with the *Health Insurance Portability and Accountability Act* (HIPAA), with information from the form being loaded into the health system's EMR, which flags the individual as a program participant. To date, more than 12,000 congregants from the 400 participating churches have signed up as members of the program.
- **Support during and after hospitalization:** Health system navigators and church-based liaisons work together to ensure that program members have a smooth transition from the hospital back to the home after discharge. To that end, they provide support during and immediately after a hospitalization, as outlined below:
  - **Identifying participants at admission:** The admission staff identifies participating individuals through the notation in the EMR. Staff verbally confirm participation with the patient and verify that he or she would like the congregation notified about the admission. (HIPAA requirements make this "opt-in" step necessary at each admission.)
  - **Navigator notification:** The EMR triggers a consult with the navigator assigned to the patient's congregation. The navigator visits the patient and alerts the church's health liaison that the member is in the hospital.
  - **Liaison support during stay:** The liaison visits the patient in the hospital to offer spiritual and emotional support and ask about needs and concerns. The liaison works within the church's existing resources (e.g., visitation teams, fellowship groups, volunteers) to arrange for friends to visit the patient in the hospital and to take care of issues at home, such as pet care, errands, housework, lawn maintenance, and other needs.
  - **Arranging and providing postdischarge services:** When the patient is ready for discharge, the liaison and navigator work together to ensure a smooth transition to the home, including arranging for home health care and other community-based social services that might help, such as Meals-on-Wheels. Liaisons arrange for congregational support, including visits from fellow church members and clergy, meal preparation, grocery shopping, medication pickup, and transportation to follow up medical visits. The services provided vary depending on patient needs. For example, to alleviate the security concerns in low-income, urban neighborhoods, a liaison might wait with a patient for a home health provider, thus avoiding the need for the patient to open the door to a stranger while in the house alone.
- **Free training offered by health system:** The health system offers free training for clergy, liaisons, and congregants, including sessions on hospital visitation, caring for a newly discharged or dying patient, and mental health "first aid." Clergy can also obtain free clinical education through the health system, while enrolled congregants can participate in certain health system–sponsored training programs (e.g., computer skills training) free of charge. The health system's educational program has been accepted for certification by two local universities, enabling participants to obtain college credits upon completion.
- **Church-based health education:** Trained liaisons educate church members on topics related to healthy lifestyles and disease prevention through educational sessions, posting of information on the church bulletin board or in church newsletters, and/or arranging for outside experts to come to the church to speak about chronic conditions.
- **Additional benefits for clergy and congregations:** Clergy receive a 60-percent discount on out-of-pocket inpatient care costs at Methodist Le Bonheur. Clergy also work with human resources staff to identify employment opportunities within the health system for parishioners.
- **Participation and feedback from clergy and liaisons:** Clergy and liaisons can participate in data analysis and program development, and some also share stories from members in order to provide anecdotal support of the program.

References/Related Articles

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Contact the Innovator

Teresa Cutts, PhD

Director of Research for Innovation

Methodist Le Bonheur Healthcare

Center of Excellence in Faith and Health

Memphis Professional Building

1211 Union Avenue, Suite 700

Memphis, TN 38104

(901) 516-0593

E-mail: Teresa.cutts@mlh.org

Bobby Baker, MDiv, BCC

Director of Faith and Community Partnerships

Methodist LeBonheur Healthcare

1265 Union

Memphis, TN 38104

(901) 516-8477

E-mail: bobby.baker@mlh.org

Gary R. Gunderson, MDiv, DMin

Senior Vice President, Faith and Health Division

Methodist LeBonheur Healthcare

1211 Union, Suite 700

Memphis, TN

(901) 516-0553

E-mail: gary.gunderson@mlh.org

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Results

The program has reduced mortality, health care costs and charges, and inpatient utilization, while improving satisfaction with hospital care.

- **Lower mortality:** A study of 473 participants found that their mortality rate was nearly half that of congregants of a similar age, gender, and ethnicity who did not participate in the program.
- **Lower utilization, costs, and charges:** The study referenced above found that participants had lower health care costs and charges than did nonparticipants, while a separate analysis of a subgroup of participants found that inpatient utilization and charges declined after enrollment in the program.
  - **Lower costs and charges:** On average, total health care costs among participants were roughly $8,700 lower than among similar nonparticipants, generating more than $4 million in cost savings to the system. Hospital charges among participants were significantly lower in 10 of the 12 most common diagnostic groups, including congestive heart failure, stroke, other cardiovascular diagnoses, and diabetes. Program leaders believe these savings stem from patients coming to the hospital before their conditions became highly acute.
  - **Reductions in utilization, charges in subgroup:** An analysis of 50 participants found that admissions, readmissions, patient days, length of stay (LOS), and hospital charges all fell significantly after enrollment. For example, these 50 patients experienced 159 total admissions during the 27-month period before enrollment, but only 101 during the 27 months after signing up. Similar declines occurred in readmissions (37 to 17), inpatient days (1,268 to 772), LOS (8.0 to 7.6), total charges ($6,396,111 to $3,740,973), and average charge per patient ($127,922 to $74,819).
- **Higher patient satisfaction:** At Methodist University Hospital (the largest hospital in the system), patient satisfaction among program participants is significantly higher than among nonparticipants.

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Moderate: The evidence primarily consists of comparisons of key outcomes among 473 participants and a group of similar individuals who did not participate, including mortality rates, health care costs and charges, and patient satisfaction. Additional evidence includes pre- and post-implementation comparisons of various measures of inpatient utilization and charges in a subgroup of 50 participants.

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Context of the Innovation

A faith-based system with 7 hospitals and roughly 1,000 inpatient beds, Methodist Le Bonheur Healthcare serves the Memphis area, with a market share of roughly 47 percent. The system cares for many low-income African Americans, since African Americans make up over half (54 percent) of the city's population and often live in one of many low-income Memphis neighborhoods. Residents of these poverty-stricken communities often face violence and poor health status, driven by high rates of cardiovascular disease, diabetes, and obesity. Memphis has roughly 2,000 churches, and nearly three-fourths of Methodist Le Bonheur patients belong to one of them. African-American clergy in the city have significant social status and power, and the church often forms the basis for the social infrastructure in the community.

The impetus for this program began in 2002. Deeply concerned about health disparities in the city, the chief executive officer

of Methodist South Hospital (Mr. Joseph Webb) and a the health system's director of Faith and Community Partnership (Dr. Bobby Baker) helped develop the CHN, a group of 12 congregations that provided health education to parishioners and assigned liaisons to assist congregants needing hospital care. On his arrival in 2006, the Senior Vice President of Methodist Le Bonheur (Reverend Dr. Gary Gunderson) suggested formalizing and expanding this concept. He felt that a larger network of churches and more formal relationships between the health system and local congregations could improve health and access to care across the service area.

Planning and Development Process

Selected steps included the following:

- **Committee to draft covenant:** The health system formed a committee to develop a written covenant that would delineate the relationship between the health system and congregations. Committee members included 12 community pastors, hospital representatives, and other community leaders. The process took 4 to 6 months, including discussing the respective roles and drafting and approving the language. The group also established roles and responsibilities for the liaisons and navigators. The committee functioned for about 2 years and then transitioned to a steering committee that currently oversees program operations and strategy.
- **Recruitment of local churches:** Health system leaders and pastors on the covenant committee met individually with church leaders to gauge their interest. As noted, interested congregations sign covenants with the health system.
- **Adjusting EMR:** The health system's information technology staff added a field in the EMR to indicate patient participation in the program.
- **Information sessions for admissions staff:** The health system held information sessions for admissions staff to explain the program and how to confirm participation at admission.
- **Hiring and training navigators:** The health system hired navigators via the organization's standard hiring process. Over time, the steering committee built a formal training program for newly hired navigators.
- **Appointing and training liaisons:** Pastors and/or congregations in each participating church appointed liaisons to work with the navigators. Liaisons attend a 2-hour training program, which addresses issues such as confidentiality and rules surrounding HIPAA compliance.
- **Introducing program to providers:** CHN was presented to the health system providers and other associates by CHN staff members. Presentations on the structure, function, growth and early data were made to the Senior Leader Strategy team, each hospital's operations team, and at a system-wide Quarterly Business Review meeting.
- **Developing other training programs:** The health system develops training programs geared toward program needs on an ongoing basis. Examples include programs on how to care for specific patient populations, including those recently discharged and those who are dying. Programs on the management of chronic diseases (e.g., diabetes, congestive heart failure, renal failure) are currently under development.

Resources Used and Skills Needed

- **Staffing:** The health system has eight full-time and two part-time navigators dedicated to this program, which has been integrated into the Faith and Health Division. This division also has a director of faith and community partnership, a director of research, 17 chaplains, and other staff and volunteers, all of whom support program activities. For example, chaplains within the division teach many of the training sessions. Other providers, including physicians, social workers, and case managers, also contribute to program activities. More than 500 volunteer liaisons participate as well. These individuals tend to be well-respected church members with good communication skills; roughly half have some form of clinical training, such as nursing or health education.
- **Costs:** Initial program development cost roughly $200,000, and the annual program budget averages about $500,000. As noted, the program also relies on significant commitments of volunteer time.

Funding Sources

Methodist LeBonheur Healthcare

MLH funds core staff (CHN director and navigators) to solidly lock them into the institutional infrastructure. The system also received grants to fund early program development (e.g., from Cigna for community work and Cerner Corporation, the system's electronic medical record vendor). Also, CHN has been able to attract significant philanthropy locally to fund research and other expansion efforts that support the network.

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Getting Started with This Innovation

- **Take broad view of health:** This model of care requires that program developers view health and health care as an ongoing, life-long focus, rather than as a transactional episode involving hospitalization.
- **Leverage local assets:** Program developers should clearly identify and then map the local resources so that existing assets can be mobilized.
- **Value intelligence of clergy:** Allowing the community's church leaders to design the program builds trust among both clergy and congregants. This approach becomes especially important in underserved areas, where the community justifiably may not trust the medical system.
- **Maintain community focus:** Helping the community improve health and access to care should be the driving forces underlying program activities and communications. Hospital-based staff and chaplains involved in the program should be seen as credible community partners, not as working on behalf of their employer.
- **Build partnerships one at a time:** Rather than making presentations at large events attended by clergy from multiple churches, health system leaders should visit with church leaders on an individual basis. This approach allows them to build trust by making connections and addressing questions and concerns. Building individual relationships will also generate positive word-of-mouth across congregations, making it more likely that other churches will proactively express interest in participating.
- **Hire navigators with passion for community:** Navigators should truly love the communities they serve; this passion will be readily visible and help to ensure the effectiveness of navigator-liaison partnerships.

Sustaining This Innovation

- **Seek regular input from church partners:** The health system should constantly seek input and feedback from the clergy and church-based liaisons to maintain trust and ensure that programming continues to meet community needs.
- **Track and share data:** While story-telling can be important, difficult economic times require quantitative proof that a program has a positive impact on quality and finances. By tracking and sharing data on the program's impact, program developers will be "speaking the language" of senior health system leaders, thus maximizing the chances of their continued support.

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