Protestant Congregations: Aligning and Leveraging Assets for Vulnerable Populations and Governmental Partners Who Care for Them

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Preface

This research project was commissioned by Urban Strategies in Arlington, VA, under a contract with the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) to reinforce and enhance CMS's efforts to partner with faith-based organizations. To that end, this paper examines the predominantly white Protestant faith community's views on health and health care and highlights health ministry work in Protestant congregations. The paper also makes recommendations to CMS regarding how to partner and engage with the Protestant community. Two other papers in this series focus more specifically on Hispanic and African American Protestant denominations.

This paper is one in a series of seven papers, each representing the unique views of different faith communities: Catholic, Jewish, Protestant, Muslim, Hispanic Catholic, Hispanic Protestant, and African American Protestant.

1. Introduction

Nearly all Protestant congregations in the U.S. understand themselves to be involved in the lives of members across the lifespan and particularly in the last quarter of their lives.[1] Likewise, congregations often provide care for the underserved, but few congregations report programs designed specifically for the health needs of elders or those who live in poverty. Even fewer congregations see themselves as acting in working partnership with public agencies such as the Centers for Medicare and Medicaid Services (CMS).

This paper outlines a potential model for shifting the relationship between church ministries and governmental programs from being two ships passing in the night into being collaborating partners. We outline this process in three conceptual steps:

- map what is currently known about the ecology of Protestant congregations in the U.S. and health status of those members;
- suggest alternative mapping of relevant tangible and intangible strengths of those congregations pertaining to the health of elders and the underserved; and
- point to some suggestive data emerging in a large-scale community collaboration in Memphis between a health system and hundreds of congregations working within a population that is mostly young Medicare-eligible women.

Finally, we suggest that CMS should focus on mapping, aligning, and leveraging its formal health-related capacities with the less formal care giving and broader "quality of life" assets of congregations in order to advance the lives of those they serve. Such an effort would reflect deeply shared values and common goals as well as instrumental cost savings.

2. Current Ecology of Protestant Congregations

There are roughly 300,000 Protestant congregations in the U.S. today, of which 59% (177,000) have fewer than 100 members.[2] About 9 million people go to those 177,000 churches, while roughly 25 million people attend the churches that have between 100 and 500 members. Only half of all churchgoers are part of a congregation larger than 350 people. These data[3] aggregate all Protestant worshipping communities and, thus, tend to hide dramatic variations based on denominational identity, cultural orientation (conservative to progressive, itself a difficult construct in the religious field), national geography, and relationship to an urban center.

These Protestant faith communities are subdivided in an increasingly complex typology of 217 denominations and a growing number of connectional modalities with variable levels of hierarchy and control.[4] Even in clearly hierarchical traditions, such as United Methodist, the social reality at local or parish level may be determined by a diverse range of personal, interpersonal, and political factors of which the formal connectional structure is only one influence.

According to the Pew Forum on Religion and Public Life's U.S. Religious Landscape Survey, in evangelical Protestant churches, approximately 45% of members are over the age of 50, and in mainline churches fully 51% of members are 50 years of age or older. Income distribution in the same national survey indicates that roughly one-third of evangelical Protestant members and one-

[1] Trinitapoli, 2005.
[2] Hartford Institute for Religion Research, 2006.
[3] IBID.
[4] IBID.

quarter of mainline members report incomes of less than $30,000 annually. In terms of racial composition of Protestant religious traditions, Whites are the decided majority at 81% of evangelical churches and 91% of mainline churches.[5] While the health status of the White non-Hispanic population in the U.S. is markedly better than that of minority populations, even that group is experiencing declines in health and quality of life over the past three decades. In fact, the CDC reports rising rates of obesity, diabetes, and stroke in whites; notably, obesity prevalence in whites escalated dramatically from 22.9% in 1998 to 34% in 2008.[6] In light of these statistics, we turn to examine health ministry work in congregations.

3. Health Ministry Work in Protestant Congregations

The most thorough and broad reaching study of health ministries in the U.S. was done by the National Council of Churches (NCC) in 2007. Although this study attempted to survey the whole church, it ended up with a sample that was 90% White and 98% English speaking.[7] However, this study is useful in going beyond the mere counting of health ministries to include a broader picture of Protestant congregational engagement in terms of advocacy, messaging in worship, counseling, and referrals to other sources of care.

The NCC study focused on broad health ministries, but most of what was found is relevant to vulnerable populations (e.g., elders, children, under-served). Just under 94% of congregations report health ministries, nearly entirely provided (87%) by people who are not paid. Moreover, 70% of congregations report some kind of direct health service, slightly less offer health education, and well over half hold health events. More than one-third engage in "advocacy," which may mean a policy-oriented sermon, but often includes explicit efforts to influence public policy. Efforts to effect policy change is one area where the small portion of African American congregations was distinctively different from the White congregation majority, which was far less active. This finding may have implications for CMS, not so much in terms of policy, but potential for partnership.

The NCC survey also found that the 80% of congregations offering one kind of health education are likely to offer multiple kinds that can impact members at all stages in their lifespan. Much of the education was elder-oriented: 28% of education is aimed at older adults explicitly, with another 24% on interpreting governmental programs and 23% on end-of-life, with 12% specifically on dementia. However, high-priority issues such as obesity, teen issues, children's health, uninsurance, HIV/AIDS, smoking, and family planning were offered in less than 10% of those reporting, which suggests gaps in care for children and youth. Churches report referral as the most common direct service (32%), just ahead of screening (usually blood pressure at 27%), emergency medical funding (25%), mental health counseling (22%), and support group (20%). Over half the congregations report offering these services to both members and non-member neighbors.

Predominantly White Protestant congregations tend to skew toward the older part of the age spectrum in terms of both their leadership and membership, which has significant implications for a CMS relationship. The mean age of United Methodist (a predominantly but not exclusively White denomination) clergy is 55 and rising slightly each year; even as its clergy retire, the replacements tend to enter ministry at older ages. Congregations like these, therefore, are familiar with the aging process. In many cases the members mostly involved in volunteer programs are themselves older

[5] The Pew Forum on Religion & Public Life, 2010.
[6] The Centers for Disease Control and Prevention, 2010.
[7] National Council of Churches, 2007.

and thus intimately know the journey older citizens face. Many caregivers and care-receivers attend the same Sunday School class—or did before frailty advanced to the point where attendance was impossible.

For decades, survey polls have found that about 40% of Americans claim to have attended a house of worship the previous week. Recent research suggests that actually about one in five Americans attend church, and the percentage may be less[8]. We contend that actual "sitting in the pew" type of attendance is less important, especially for elders and the underserved, than the sense of social connection, trust, and informal relationship that comes from attendance. Indeed, we believe that what is most relevant to life span health is not formal worship, but the dependability of resilient social relationships that are built over time in the countless informal ways that happen in congregations.

4. New Models for Understanding Congregations

How should we better understand such a complex array of activity and relationships, the vast majority of which is not funded beyond the internal resources of the congregation powered by unpaid human resources? The key may be to focus on engaging or operationalizing congregational services that seem similar to those provided by a specialized elder-focused or governmental entity to fill gaps in care.

As such, perhaps a more comprehensive "map" of congregations comes from the work of the International Religious Health Assets Program (IRHAP) group of dedicated interdisciplinary international scholars.[9] In the last decade, IRHAP has asked a similarly fundamental question prompted by the HIV/AIDS crisis in Africa.[10] One key conceptual leap was to distinguish congregations from nonprofit organizations. Congregations may offer many services, but they are, at root, "faith forming entities" (FFE) designed to form, nurture, and sustain people's faith. Such an entity is multi-relevant to health in ways that are tangible and immediate, as well as intangible and distal.[11] Sometimes FFEs create organizations specifically designed to provide a health or social service, a "faith-based organization" (FBO). But the root organization is mainly focused on faith first, providing services as a significant byproduct. The utility of the FFE for health, whether it is for those dealing with HIV/AIDS, unemployment, or aging, derives from its capacity to form relationships of trust (definitely an intangible asset) and caring over time, throughout a person's lifespan.

The elders and underserved who come to the attention of CMS as clients have usually been in the FFE's web of trust in earlier phases of their life and thus already in relationships of providing care that make receiving care dignified and natural. For example, when this paper's co-author Gary Gunderson's Methodist mother was visited in the nursing home by a Methodist pastor from a church she had never attended, it seemed appropriate to her because she had spent a lifetime visiting others in the same way. This visit reflected her core identity as a member of an FFE, not of her identity as a frail elder in need of services. Most of the health-related education and direct services identified in surveys are present to elders because they are offered through relationships of trust earned over many years. That trust is the most valuable health asset the FFE might lend to CMS.

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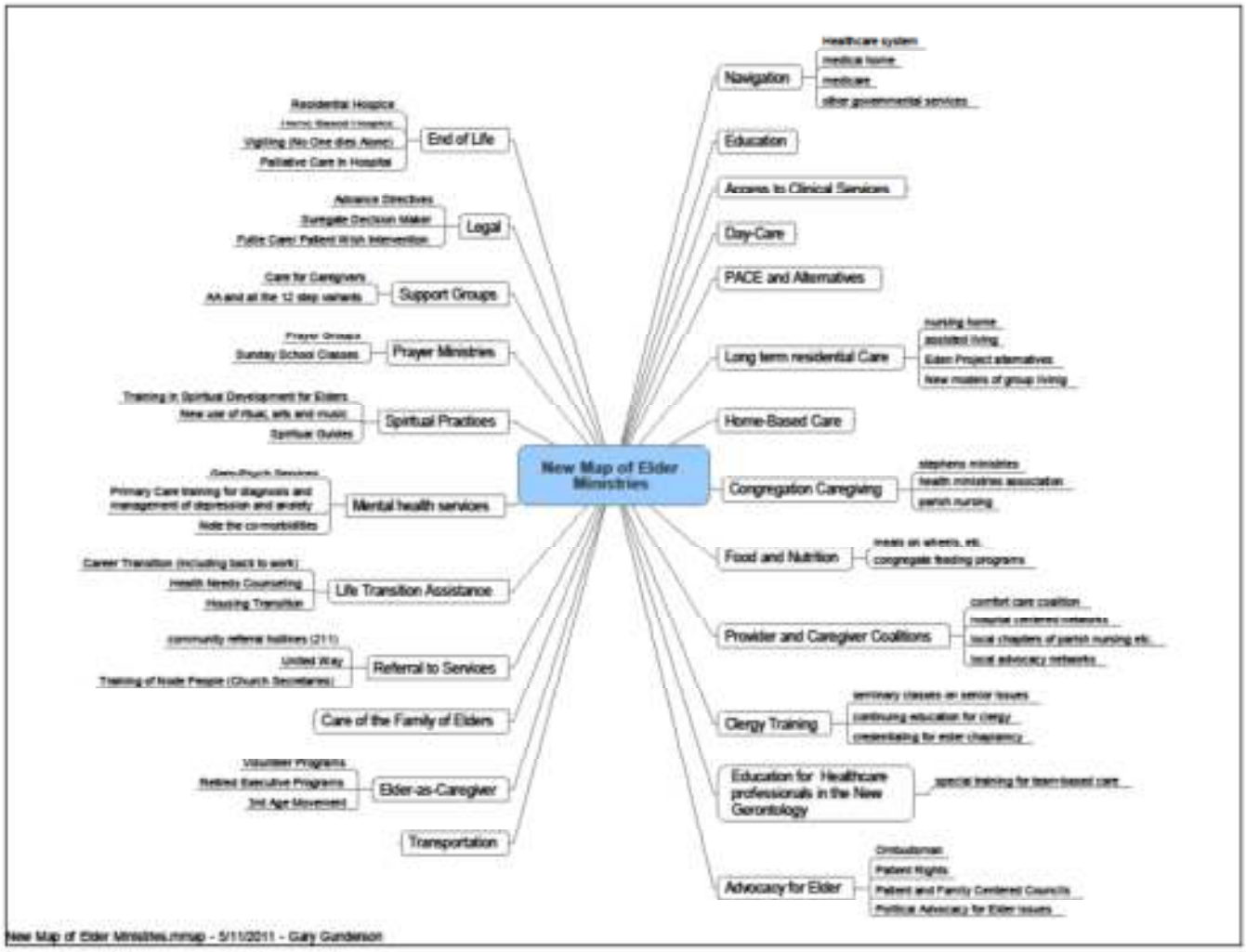
[8] Hadaway & Marler, 1998.
[9] ARHAP, 2006.
[10] Previously titled African Religious Health Assets Program (ARHAP).
[11] IBID.

Another helpful approach for understanding Protestant congregations' capacity to support their congregants and neighbors is to trace the pattern of programs and ministries. In the last generation a rich array of programs has emerged, promoted and supported by an array of national organizations and networks, as demonstrated in the mind map below.



The mind map above includes only a fraction of the most obvious models of ministry that affect the health and quality of life of elders. Every small branch of the map has at least one national organization with a website, annual meetings (often with regional and local gatherings), and training curricula with certification criteria. The programs relate to national religious bodies but also promote directly to clergy at congregational levels. So a congregation may think of itself as Baptist but also as a Meals-on-Wheels or Stephens' Ministry congregation. The involved members may well derive their guidance around health and elder issues from those networks rather than the denomination. A similar mind map could be drawn for congregational care of the underserved or children, including mentoring programs, support groups for single parents and unemployed, and emergency medical assistance funding. Congregations organically align, integrate, and leverage strengths (both intangible, like trust, and tangible, like programmatic food or utility assistance) to help members function optimally throughout their whole lifespan and across a wildly diverse landscape of life

milestones/events (e.g., childbirth, job loss). The congregation-level reality is shaped by the flow of information and influence of many sources woven together to function in the human and community ecology that may be slightly different. CMS is potentially one of the influences that can be more consciously woven into the fabric of care.

We now share a grounded example of how those tangible and intangible congregational assets are being mobilized to improve health status of elders and under-served in the Memphis-based Congregational Health Network (CHN).

Congregational Health Network: The Memphis Model for Connecting Congregational Caregiving and Traditional Healthcare

The Methodist LeBonheur Healthcare's CHN provides a novel model for mapping and aligning existing assets to build a person-centered health system of care, centered in the congregation, but extending to the broader community through the hospital and other care entities. The CHN hired nine in-hospital navigators that bridge care inside and outside of the hospital with over 500 trained volunteer congregational liaisons (health ministers) in CHN's 354 partner congregations. Although the CHN has only been in existence for 42 months, early outcome data suggests that this model can improve health in underserved and elder populations.[12]

To better understand CHN's ability to positively affect cost savings and health outcomes, CHN members were compared with control patients using an electronic medical record. They were matched on age, gender, ethnicity, and diagnostic-related groups who came into the hospital during the same time-frame as the first 473 CHN members. This cohort is predominantly female, African American, with a mean age of 60. Comparing CHN to non-CHN members, CHN patients saved $8,705 per patient per capita (total gross charges) and accrued almost $4 million dollars in savings to the hospital and payers (including CMS).[13] Reviewing the most frequent diagnoses (i.e., congestive heart failure, other cardiovascular diagnoses, stroke, diabetes) CHN members' charges were significantly lower in 10 of the 12 diagnostic-related groups. Re-admissions (readmits within a 30-day window post-discharge) were 10% lower with the CHN members. Lastly, crude mortality rates were half in the CHN vs non-CHN group who came into the hospital at that time. These data suggest that the leveraging of trust and connection/social support and other strengths of the faith communities is a very powerful intervention in itself in terms of enhancing health outcomes and managing multiple chronic conditions.

5. Summary and Recommendations

We offer a view of Protestant congregations informed by a deeper understanding of what affects health and quality of life over a lifespan, especially the particular dynamics affecting the last quarter of life. It is clear that these religious networks are of very large scale and are already highly present in the lives of most elderly and underserved citizens. Clearly, too, Protestant congregations are guided by a wide tradition, as well as modern influences, that view science, technology, God, prayer, ritual, and partnership with government in ways that differ quite dramatically and that are not easy to predict. Nevertheless, the concern for vulnerable people is deeply ingrained in Protestant faith groups. Protestants are distinctive in the emphasis they give to scriptural references to health and

[12] Cutts et al., 2011.

[13] We note the complexity of assigning costs and savings as every payer relates differently to the charge master. Likewise, the "co-pay" varies by type of coverage, including those with no coverage. Thus we prefer to have this data illuminate a gross effect the exact benefit of which remains to be detailed.

healing, especially the record of Jesus' ministry. Nearly one-third of all such scriptures directly relate stories of healing. Lutheran theologian Dr. Martin Marty, addressing a convocation at The Carter Center, expanded this straightforward view on Jesus' teaching on health by making the observation that when one understands healing in the mind and work of Jesus, this number is closer to "three thirds."[14] Thus, the work of improving the health and advancing the healing of vulnerable people is not something that congregations should solely regard as the work of CMS but as a shared moral imperative so deeply held that it would justify thoughtful engagement and collaboration.

Building on this faith-based moral imperative, CMS could look toward the Memphis model of CHN, as it integrates the traditional healthcare system (hospital) and the unpaid volunteer staff of congregational caregivers (liaisons) to improve health outcomes of our nation's most vulnerable populations. While CHN is adapted to the specific array of assets and challenges of Memphis, every community has its own assets that could be engaged and aligned using a similar program structure. In this landscape, CMS would find willing partners that bring new assets relevant to "hard-edge" issues such as reductions in hospital readmission and inappropriate utilization, as well as "soft-edge" issues relevant to long-term quality of life. IRHAP-developed tools for mapping these assets and the crucial connections between them[15] have been adapted to contexts in the U.S. and drawn heavily from mapping five underserved neighborhoods in Memphis.[16]

Finally, among Protestant networks, there exist health ministries and staff, familiar with CMS programs that care for vulnerable populations, who are tuned toward collaboration. For example, on a recent visit of HHS representatives to learn about the Memphis Model, the Agency on Aging staff immediately were able to envision how quality of life for elders could be improved, by leveraging church volunteers to help elders navigate and better utilize community and governmental resources. Similarly, HHS's Office of Faith and Community Partnerships has granted seed funds to the CHN over the past two years to explore building capacity of faith communities to assist in providing care to vulnerable populations during influenza pandemics and other disaster scenarios. Lessons learned from these efforts can most likely be adapted to build a system of care that integrates the assets of congregations with the resources of government agencies, such as CMS, to improve quality of life for all and fulfill the ecumenical faith mandate to care "for the least of these."

[14] Martin E. Marty, "The Tradition of the Church in Health and Healing," Second Opinion: Health, Faith and Ethics: The Church's Challenge in Healthcare, The Park Ridge Center, Chicago, Illinois, Vol 13: pp. 48-72, March 1990.
[15] ARHAP, 2006
[16] Cutts, 2011

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