The major purpose of this project was to test the feasibility of recruiting and training volunteers as lay health educators who could coordinate and reinforce the educational efforts of health care providers. A committee of health care professionals designed a 16-hour program. Twenty-five volunteers from 11 religious institutions and 4 retirement communities completed the 8-week program. The program was successful in identifying, recruiting, and training volunteers from racially and religiously diverse institutions. Favorable outcomes included participants’ satisfaction and success in organizing numerous educational and screening programs in their communities.

Key Words: Volunteers, Religious institutions, Illness management

Project REACH: A Program To Train Community-Based Lay Health Educators

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The dramatic increase in the number of older adults during the 20th century has brought with it significant challenges for medical professionals and institutions (U.S. Bureau of the Census, 1992). The chronic illnesses most common in old age often require years of medical care, and generally the goals of treatment are control of symptoms and slowing of illness progression rather than cure (Kane, Ouslander, & Abrass, 1994). Additionally, the desire to contain the accelerating escalation of health care expenditures over the last decade has led to drastic alterations in the delivery of medical care. There have been significant increases in the types and numbers of outpatient services and significant decreases in the average hospital length of stay and utilization (National Center for Health Statistics, 1995). It is likely that these trends will continue for the foreseeable future. Simultaneously, as the reimbursement system for medical care evolves from a fee-for-service to a capitated payment system, there is a greater incentive for teaching people how to stay healthy and, when they do become ill, how to utilize medical services in a timely and appropriate fashion.

These changes in the patterns of illness and in the delivery of health care services are placing increasing burdens on patients, their families, and their caregivers. Each group must assume greater responsibility for the ongoing management of chronic diseases as well as the episodic management of acute illnesses. All need more information about chronic conditions and medical care, and they need to be more actively involved in various health-related decisions and actions.

One of the greatest challenges that medical institutions and professionals now face is finding effective methods of delivering important information about illness prevention and illness management directly to the people who need it most. One alternative that holds promise is the use of lay health workers. Lay volunteers have been utilized in a variety of community-based health and social programs, frequently serving as both educators and links between the formal health care system and the community (Eng & Young, 1992).

The purpose of this project was to recruit and train lay leaders from religious organizations and senior communities to serve as health educators and health care liaisons for their own groups. The objectives of this project were to determine whether or not (a) volunteers interested in serving as unpaid “lay health educators” for their congregations and communities could be identified; (b) a broadly focused training program would be useful; and (c) community-based educational programs would be conducted by the volunteers who had completed the training program.

Method

Background

The project was carried out in Volusia County in north central Florida. This county has approximately 400,000 residents of whom 23% are 65 years of age or older (Bureau of Economic and Business Research, 1995). At the time this project began, there
were approximately 86,000 persons 65 and over enrolled in Medicare (Health Care Financing Administration, 1995).

The director of the Center for the Study of Aging (WDH) and the chair of the Psychology Department (CDC) at Stetson University, a small private university located in Volusia County, were requested by a local charitable foundation to develop a program that would address some of the health care needs of the community. Because Stetson University does not offer degree programs in any of the health professions, it was decided to design a program that emphasized education and utilized local health care professionals as advisers and instructors.

Implementation

Survey of Community Needs. — During the Fall of 1992, 20 local health care professionals known to the two initial investigators (WDH and CDC) as active, community-minded professionals were formally interviewed to assess the perceived need and potential support for a community health education program to be focused on multiple health issues of concern to older adults. The interviewees included 10 physicians, 5 health care administrators, 3 nurse practitioners, and 2 pharmacists. They were asked three questions: Is there a need for a proactive, community-based health education program for older adults? Would they be willing to participate in such a program? What topics should be covered?

All of the professionals responded affirmatively to the first two questions, with many offering to serve as advisers and instructors for the training program and others offering to give lectures to congregations and retirement communities. In response to the third question, it was suggested that volunteers be given basic information on the prevention, management, and treatment of the following disorders: heart disease, hypertension, cancer, dementia, depression, diabetes, and arthritis. Other suggested topics were: home health services, accident prevention, community resources, medication management, and advance directives.

Identification of Consultants and Sponsors. — After determining that there was strong support from local health care professionals, we decided to seek the assistance of experienced medical educators and researchers. Faculty from the Division of Geriatric Medicine and Gerontology at the Johns Hopkins University School of Medicine were consulted and asked to assist in further conceptualizing the program, in designing the curriculum, and in evaluating the program. Halifax Medical Center, a 500-bed community hospital in Daytona Beach, FL, offered to provide financial support for the project and to serve as host for the workshops.

Development of the Curriculum. — In the summer of 1993 an advisory committee to assist in the preparation of materials and in the training of volunteers was established. This committee included four physicians (representing family practice-geriatrics, cardiology, oncology, and neurology), a hospital administrator responsible for home health and hospice services, a pharmacist, and an attorney. The committee decided that the best format would be a 16-hour training program, with participants meeting for 2 hours each week. This would be followed by a dinner funded by the hospital at which participants would be recognized and awarded certificates. Members of this committee also agreed to write brief (2- to 4-page) summaries of the assigned topics, review materials from other organizations that might be appropriate for participants, serve as instructors for some of the training sessions, and assist in recruiting other professionals to serve as speakers at community programs. We selected the Health Belief Model (Rosenstock, 1974) as a guide for all materials and presentations. This model postulates that people are most likely to take steps to prevent or control illness when they believe (a) that they are susceptible to a disease, (b) that the disease would have severe personal consequences, and (c) that certain actions would be beneficial to them and that the benefits of their actions would outweigh their costs. Following this model, we sought to provide volunteers with information that would demonstrate the significant benefits of adopting health-enhancing behaviors, avoiding health-compromising behaviors, participating in screenings, utilizing medical services in a timely and appropriate manner, and adhering to treatment recommendations. Once persuaded, the volunteers could then use this information in their efforts to persuade members of their congregations and communities to adopt effective illness prevention and illness management practices.

An outline of the Community Health Education Program curriculum workshop schedule developed by the advisory committee in the winter of 1994 is provided in Table 1.

Recruitment of Participating Organizations

Leaders of 18 religious institutions and retirement communities were invited to attend a meeting in May 1994 to learn more about the Community Health Education Program. The institutions and leaders selected for the meeting were identified by local religious and medical professionals who were aware of

<table>
<thead>
<tr>
<th>Week</th>
<th>Topic</th>
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<tbody>
<tr>
<td>1</td>
<td>Introduction to the goals and objectives of the Community Health Education Program</td>
</tr>
<tr>
<td>2</td>
<td>Heart disease and hypertension</td>
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<tr>
<td>3</td>
<td>Cancer</td>
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<td>4</td>
<td>Depression and dementia</td>
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<td>5</td>
<td>Medication management</td>
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<tr>
<td>6</td>
<td>Home health services and community resources</td>
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<td>7</td>
<td>Advance directives</td>
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<tr>
<td>8</td>
<td>Strategies for community education programs</td>
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Table 1. Session Titles for Eight-Week Curriculum To Train Lay Health Educators
the goals of the program. At this meeting they were given a description of the program that included not only the goals and objectives, but also information on the two major responsibilities of clergy and administrators. The first responsibility would be to carefully recruit from their congregations or communities one or two lay leaders who would be willing to attend weekly meetings and then serve as "lay health educators." It was explained that these individuals would be trained to serve primarily as educational coordinators and facilitators rather than as teachers. Therefore, they were encouraged to select people who had good organizational skills and who were comfortable assuming leadership positions. The second responsibility of clergy and administrators would be to provide strong support for the lay health educators once they were trained and began coordinating educational programs. This would include helping them as they arranged educational programs and then assisting in publicizing the programs.

The leaders were then invited to ask questions and offer suggestions. All of those in attendance expressed interest in the program, and most felt they could find volunteers to participate. A suggestion offered by one leader and endorsed by several others was that videotapes of the workshop presentations by health professionals be made and given to the lay health educators for use in their programs. The group also recommended that the training sessions be held in the late afternoon and begin in September. Two concerns were voiced by those in attendance. The first was skepticism about the degree to which the hospital and local physicians would actually support the program. Several clergy said that few physicians and hospitals seemed to recognize and appreciate the potential value of religious institutions and leaders. The second concern was that many potential volunteers would be reluctant to participate in a program that was perceived as primarily a research project. We were advised to emphasize the community service aspect of the program and to make minimal requests for data collection.

Following the advice of the institutional representatives, the training sessions began in September 1994. All training sessions were held in a conference room in the administrative wing of the hospital. Representatives from 10 churches (3 of which were predominantly African American in membership), one synagogue, and 4 retirement communities attended the first training session.

As a demonstration of the hospital's support for the program, a hospital administrator attended the first meeting to welcome participants and to give them small gifts. Also attending the first meeting were two physicians from the advisory committee. Both spoke briefly and offered a strong endorsement of the program.

**Training Sessions.** — The format utilized in most of the training sessions was two 30-45-minute presentations by physicians or other professionals, followed by 15-20-minute question-and-answer periods. Materials prepared or recommended by workshop leaders were distributed the week prior to the presentation in order to allow participants to better prepare themselves for the workshops. All workshop leaders strongly encouraged participants to ask questions or offer comments.

**Evaluation and Follow-up.** — Participant satisfaction was assessed by asking volunteers in attendance at the last training session to complete a brief evaluation form. Information on the number and topics of programs conducted by volunteers was collected at 10, 14, and 24 months after the training sessions ended.

**Results**

**Participant Retention.** — All 25 volunteers, representing 11 religious institutions and 4 retirement communities, completed the 8-week training program. All of the organizations that accepted the invitation to participate in the project were represented throughout the program. The one volunteer who moved out of town during the program was replaced by her minister.

**Participant Satisfaction.** — Participant satisfaction forms were completed by the 23 volunteers in attendance at the last training session. The results indicate a high level of satisfaction with the overall program and with specific aspects of the program, including the topics chosen, the presentations by workshop leaders, and the materials provided. Many participants reported that they would have liked more time for questions and discussion.

**Follow-up Meetings and Evaluations.** — Eighteen participants, representing 10 religious institutions and retirement communities, attended the first follow-up meeting at the hospital. Representatives from the other five organizations were unable to attend but were contacted by phone. It was found that 10 organizations had held educational programs during the 10-month period. Representatives from three organizations reported that they had begun planning educational programs to be held during the upcoming months, while representatives from two organizations, one a church and the other an apartment complex for low-income elderly, reported that they were still interested in serving as lay health educators but had encountered obstacles they were unable to overcome. In the former case, they were not able to obtain the cooperation and support they needed from the professional staff members, and in the latter case the volunteer's personal medical problems combined with the lack of support from other residents prevented her from coordinating any educational programs.

When participants were contacted 4 months later, it was found that the three churches that had been planning educational programs had indeed conducted at least one program and had plans for addi-
tional community workshops. Follow-up contacts another 10 months later revealed that 25 educational programs, many involving volunteers and members from more than one church, had been held during the 2 years following the training of the volunteers. Additionally, in the Fall of 1996, 11 of these organizations responded to a request by the county health department to assist in a county-wide program seeking to increase the number of older adults receiving influenza vaccinations. Videotapes and printed materials were distributed by the lay health educators, and several of the churches and retirement centers were utilized as vaccination sites.

The formats of the programs have varied extensively. Several lay health educators held their programs during or immediately following regularly scheduled meetings or events. In such cases, clergy usually introduced and endorsed the programs. Others scheduled their programs as special events. Attendance at these programs ranged from a low of 12 to a high of 230. The lay health educators reported that they served primarily as program coordinators, arranging for guest speakers, scheduling screenings, and publicizing the programs.

Discussion

This program has demonstrated that volunteers from churches, synagogues, and retirement communities can be recruited and trained to serve as health educators and liaisons with the medical community. We were able to identify volunteers from a racially and religiously diverse group of institutions and provide them with enough information and resources that they felt prepared to assume leadership roles in developing health education and illness prevention/management activities in their own communities. Participants were satisfied with the training they received, and during the 2 years following the training were able to organize numerous educational and screening programs in their congregations and communities.

There were two further indications of the program’s success. First, shortly after the training sessions ended, we received requests from 14 religious institutions and retirement communities to offer another series of workshops. Clergy and lay leaders had heard of the program and wanted their congregations and communities to participate. In response to these requests, two additional 8-week training sessions were offered. A total of 34 volunteers participated in these sessions. A second indication of the success of the program is that, at the end of the first year, the majority of participants from the initial training program expressed interest in continuing and even expanding their efforts. To reflect a greater sense of community ownership of the program, a new name was chosen — Project REACH (Reaching out through Education to Advance Community Health).

Interviews and discussions with volunteers indicate that at least three important factors contributed to the success of the program. First, the strong support of respected medical professionals and a major medical center gave volunteers confidence in the quality of the program. Second, we were careful to maintain the altruistic nature of the program. We were perceived by volunteers as holding true to our goal of empowering people through information. Third, we were able to attract volunteers who were respected in their communities and who already had good organizational skills.

Although we were successful in meeting our objective of developing a community-based health education program, certain limitations and problems should be noted. First, a limitation of our investigation is that the churches and retirement communities selected for the program had traditions of strong leadership and active involvement in social programs. Thus, we need to be cautious in assuming that similar programs will work in churches without such traditions. Second, although the African American churches became active participants in the program, they did not respond to our initial invitation. Follow-up calls and visits were necessary to enlist their participation. However, it should be noted that once in the program, their level of involvement was as great as that of other participants. Third, many of the clergy, both White and Black, initially expressed skepticism about the program. Since they questioned the extent of commitment by hospital administrators and physicians, special efforts were made to demonstrate the interest and support of health care professionals. Comments by participants during follow-up interviews indicated that we were successful in overcoming this initial skepticism.

In spite of these limitations and challenges, the development of a network of trained volunteers to serve as community-based health educators offers numerous advantages for hospitals, health maintenance organizations, and other health care systems. There are many significant health-related issues, especially among the elderly and minority groups, that more traditional programs have not dealt with as extensively or as successfully as desired. For example, in spite of the widespread acceptance of the value of advance directives, a relatively small proportion of older adults have completed the appropriate forms and expressed their wishes to their physicians (High, 1993). Recent research indicates that even intensive efforts to improve communication between seriously ill hospital patients and their physicians about end-of-life decisions have had little effect (The SUPPORT Principal Investigators, 1995). These investigators recommended that efforts to increase patient involvement in decision making occur earlier and in different settings. Community-based health education programs, led by respected lay leaders, might offer an earlier opportunity for patient involvement.

Community-based lay health educators also have the potential to help health care systems overcome some of the cultural and educational obstacles that limit medical treatments. Recent research has documented the problem of inadequate functional health literacy (Williams et al., 1995). These researchers found that many patients lack the basic reading skills...
necessary to function effectively in health care settings. Community-based health education programs, led by lay health educators who are aware of the limitations of members of their community, might utilize appropriate instructional modalities and materials and thus reduce some of the barriers to effective treatment. Such programs also could be used to address the difficult and costly problem of noncompliance with recommended treatment regimens, which often results in drug-related illnesses and hospitalizations (Isaac, Tamblyn, & the McGill-Calgary Drug Research Team, 1993; Rich et al., 1995).

In summary, Project REACH demonstrates that volunteers recruited from religious institutions and retirement communities can be trained to establish community health education programs that were judged to be useful by community and health care leaders. Future research must determine whether such programs will affect outcome measures such as quality of life, hospitalization rates, or mortality.

References


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ERRATUM

The Gerontologist would like to apologize for the misprinting of Dr. Buchalter’s title in “The Wellness Group: A Novel Intervention for Coping with Disruptive Behavior Among Elderly Nursing Home Residents,” which appeared in the August issue (Vol. 37, No. 4, pp. 551-556). The author’s title was printed as “DD” instead of the proper “DO.” The Gerontologist is grateful for Dr. Buchalter’s contribution to the article and would like to offer their apologies for the unfortunate error.