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Faith–Health Collaboration to Improve Community and Population Health

PROCEEDINGS OF A WORKSHOP

Theresa M. Wizemann, *Rapporteur*

Roundtable on Population Health Improvement

Board on Population Health and Public Health Practice

Health and Medicine Division

The National Academies of
SCIENCES • ENGINEERING • MEDICINE

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PLANNING COMMITTEE ON EXPLORING THE ROLE AND POTENTIAL OF FAITH-BASED COMMUNITY ASSETS IN IMPROVING POPULATION HEALTH: A WORKSHOP[1]

GARY GUNDERSON, Wake Forest Baptist Health
TERRY ALLAN, Cuyahoga County Board of Health
MUHAMMAD BABAR, KentuckyOne Health
HEIDI CHRISTENSEN, U.S. Department of Health & Human Services
BARBARA HOLMES, United Theological Seminary of the Twin Cities
SANNE MAGNAN, University of Minnesota
PRABHJOT SINGH, Mount Sinai Health System

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ROUNDTABLE ON POPULATION HEALTH IMPROVEMENT[1]

SANNE MAGNAN (*Co-Chair*), Adjunct Assistant Professor, University of Minnesota
JOSH M. SHARFSTEIN (*Co-Chair*), Associate Dean for Public Health Practice and Training, Johns Hopkins Bloomberg School of Public Health
PHILIP M. ALBERTI, Senior Director, Health Equity Research and Policy, Association of American Medical Colleges
TERRY ALLAN, Health Commissioner, Cuyahoga County Board of Health
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CATHY BAASE, Chair, Board of Directors, Michigan Health Improvement Alliance; Consultant for Health Strategy, The Dow Chemical Company
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GEORGE R. FLORES, Senior Program Officer, The California Endowment
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ALAN GILBERT, Director of Global Government and NGO Strategies, GE Healthymagination
MARTHE GOLD, Senior Scholar in Residence, The New York Academy of Medicine
MARC N. GOUREVITCH, Professor and Chair, Department of Population Health; New York University School of Medicine
GARTH GRAHAM, President, Aetna Foundation
GARY R. GUNDERSON, Vice President, Faith and Health Ministries, Wake Forest University
WAYNE JONAS, Executive Director, H&S Ventures
ROBERT M. KAPLAN, Professor, Stanford University
DAVID A. KINDIG, Professor Emeritus of Population Health Sciences and Emeritus Vice Chancellor for Health Sciences, University of Wisconsin–Madison
PAULA M. LANTZ, Associate Dean for Academic Affairs and Professor of Public Policy, University of Michigan
MICHELLE LARKIN, Associate Vice President and Associate Chief of Staff, Robert Wood Johnson Foundation
THOMAS A. LAVEIST, Professor and Chair, Department of Health Policy, Milken Institute School of Public Health, The George Washington University
JEFFREY LEVI, Professor, Milken Institute School of Public Health, The George Washington University
SHARRIE MCINTOSH, Vice President for Programs, New York State Health Foundation
ROBERT MCLELLAN, Chief, Section of Occupational and Environmental Medicine; Medical Director, Live Well/Work Well; Professor, Medicine, Community and Family Medicine, and the Dartmouth Geisel School of Medicine at Darmouth, Dartmouth-Hitchcock Medical Center
PHYLLIS D. MEADOWS, Senior Fellow, Health Program, The Kresge Foundation

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BOBBY MILSTEIN, Director, ReThink Health
JOSÉ T. MONTERO, Director, Office for State, Tribal, Local and Territorial Support; Deputy Director, Centers for Disease Control and Prevention
MARY PITTMAN, President and CEO, Public Health Institute
PAMELA RUSSO, Senior Program Officer, Robert Wood Johnson Foundation
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Consultant
THERESA M. WIZEMANN, Rapporteur

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This Proceedings of a Workshop was reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise. The purpose of this independent review is to provide candid and critical comments that will assist the National Academies of Sciences, Engineering, and Medicine in making each published proceedings as sound as possible and to ensure that it meets the institutional standards for quality, objectivity, evidence, and responsiveness to the charge. The review comments and draft manuscript remain confidential to protect the integrity of the process.

We thank the following individuals for their review of this proceedings:

Ann Ellison, Fairview Health Services
Amy Gyau-Moyer, Kaiser Permanente of the Mid-Atlantic States
Roselyn Hicks, Independent Contractor
Wayne B. Jonas, Samueli Integrative Health Programs

Although the reviewers listed above provided many constructive comments and suggestions, they were not asked to endorse the content of the proceedings nor did they see the final draft before its release. The review of this proceedings was overseen by **Georges C. Benjamin**, American Public Health Association. He was responsible for making certain that an independent examination of this proceedings was carried out in accordance with standards of the National Academies and that all review comments were carefully considered. Responsibility for the final content rests entirely with the rapporteur and the National Academies.

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Introduction[1]

Many workshops held by the National Academies of Sciences, Engineering, and Medicine (The National Academies) Roundtable on Population Health Improvement have showcased examples of how faith-based organizations (particularly hospitals and health systems, but also faith-based community organizations) contribute to population health. The roundtable saw the need to hold a workshop focused on collaboration between the faith and health sectors, and to highlight the unique opportunities these collaborations offer to help improve population health outcomes. However, the roundtable did not set out to explore such aspects of the relationship between faith and health as the efficacy of prayer, or of congregation-based health interventions. Nor was the workshop on faith–health collaboration intended to examine the roles of faith-based hospitals and health systems (that are largely part of the health care sector), but the unique contributions of communities of spirit, such as congregations or faith-based networks.

The workshop was held on March 22, 2018 in Boyd Chapel on the campus of Shaw University in Raleigh, North Carolina. Johnny Hill, dean of the School of Divinity at Shaw, welcomed participants and highlighted Shaw's proud heritage of seeking health and wholeness, in both body and soul. He noted that Shaw's medical school was the first in the nation to offer a four-year medical curriculum. Paulette Dillard, interim president of Shaw University, expanded on the history of Shaw to set the backdrop for a discussion of collaboration between faith organizations and the health sector. She shared the story of how, after the end of the Civil War, Union soldier and Chaplain Henry Martin Tupper traveled to Raleigh and founded what is now Shaw University, with the intent of teaching freed slaves to read and interpret the Bible. As the first historically black university in the Southern United States, Shaw enrolled both men and

[1] This workshop was organized by an independent planning committee whose role was limited to identification of topics and speakers. These proceedings were prepared by the rapporteur as a factual summary of the presentations and discussions that took place at the workshop. Statements, recommendations, and opinions expressed are those of individual presenters and participants and are not necessarily endorsed or verified by the National Academies of Sciences, Engineering, and Medicine; the Health and Medicine Division; or the roundtable, and they should not be construed as reflecting any group consensus.

women,[2] and Dillard noted that women had access to the full curriculum, not just home economics. Freed slaves in the South faced particular challenges accessing services such as medical care. To address this need, in 1880 Tupper established Leonard Medical School,[3] which educated African American physicians for nearly 40 years. Shaw graduates went on to found other historically black colleges and universities (HBCUs) in the state of North Carolina, and carried on the work of championing "those who need someone to stand in the gap for them," Dillard said. More recently, in 2009, Shaw's Institute for Health, Social, and Community Research was awarded a grant from the National Institutes of Health (NIH) to study health disparities in the state of North Carolina. Dillard pointed out that the university is geographically situated between areas of booming economic growth and the poorest zip code in Wake County. Shaw has an opportunity to stand in the gap not only for Raleigh, but for the nation, and to call to consciousness the needs of the community as a whole, she said, and especially those who are disenfranchised.

WORKSHOP OBJECTIVES

To introduce the Roundtable on Population Health Improvement and its work, Sanne Magnan, senior fellow at HealthPartners Institute, stated that the group holds workshops for members, stakeholders, and the public to discuss issues of importance for improving the nation's health. The roundtable's vision is of a strong, healthful, and productive society, which cultivates human capital and equal opportunity. This vision rests on the recognition that outcomes such as improved life expectancy, quality of life, and health for all are shaped by interdependent social, economic, environmental, genetic, behavioral, and health care factors, and that achieving these outcomes will require robust national and community-based policies and dependable resources. The roundtable considers multisector partnership to be a vehicle by which to achieve this vision and improve population health.

Magnan observed that faith-based assets are often overlooked when identifying sectors to partner with in communities. Faith-based assets are often the roots in a community, she said, and roots are often invisible until they are made visible. The topic of faith–health is enormously broad, Magnan acknowledged, and there are many worthy subtopics that the roundtable could consider. This workshop was intended to explore collaboration between community faith entities and health-sector entities, and to highlight effective practices that can improve population health. She clarified that the workshop was not intended to explore the relationship between individual spirituality and health, and it would also not consider how health care entities can undertake specific components of spiritual practice, or how religious congregations can take steps to improve the health status of their members.

The agenda for this workshop was developed by an independent planning committee chaired by Terry Allan and including Muhammad Babar, Heidi Christenson, Gary Gunderson, Barbara Holmes, Sanne Magnan, and Prabhjot Singh. (The planning committee's Statement of Task is provided in Box 1-1). The workshop was designed to meet the following objectives:

[2] Shaw University was the first historically Black university in the South to enroll women.
[3] Dr. Dillard later stated that Leonard Medical School was established in 1881 rather than 1880.

- Showcase examples of effective collaboration between faith-based (or religious) health assets,[4] such organizations and social structures as congregations and religious community service networks, and the health sector, such as governmental public health agencies, hospitals, and health systems;
- Explore opportunities and challenges in helping faith–health collaborations come together and thrive (e.g., building trust, creating a space where collaboration can occur when needed and appropriate);
- Discuss how faith–health collaboration can build common ground for public policy; and
- Highlight how "scientific wisdom" can work alongside or in concert with "faith wisdom" to achieve improved health outcomes and develop community capacity.

ORGANIZATION OF THE WORKSHOP AND PROCEEDINGS

The first session of the workshop set the context for the discussions, with a keynote presentation by Prabhjot Singh, offering his perspective on the foundations of faith–health collaboration (Chapter 2). This was followed by three panel sessions that considered the roles of faith–health collaboration in addressing the social determinants of health and improving community health (Chapter 3), in building common ground for public health policy (Chapter 4), and in addressing public health priorities (Chapter 5). During the lunch break, a moderated Twitter chat kept the conversation flowing[5]. The workshop concluded with an interactive participant exercise designed to draw out important principles and lessons learned from the workshop discussions (Chapter 6 and Appendix B), followed by observations and reflections shared by the roundtable members, speakers, and participants (Chapter 6).

[4] For the purposes of this workshop, the planning committee used the term "faith-based health assets." Note that in the international context, the term "religious health assets" is more frequently used. Other similar terms are used in the peer-reviewed and grey literature (e.g., organizations and interventions have been described as faith-based, faith-inspired, faith-oriented, faith-placed, and other variations).

[5] The PopHealthRT Twitter discussion that took place on March 22, 2018 in association with the workshop can be viewed at https://twitter.com/hashtag/pophealthrt (accessed May 29, 2019)

BOX 1-1
Planning Committee Statement of Task

An ad hoc committee will plan and convene a one-day public workshop that will explore challenges and opportunities for health-sector actors that engage with "faith-based health assets." These organizations and social structures, in the form of congregations and religious community service networks, collaborate with others in communities, including health systems and public health agencies, to improve the conditions for health and well-being. The workshop will (1) provide an overview of faith-based assets in communities and their relationship to population health and the work of health improvement; (2) highlight areas where faith-based health assets are using evidence to inform their work and demonstrating effectiveness in improving health outcomes; (3) provide examples of effective partnerships involving faith-based health assets; and (4) share lessons learned from working with faith-based assets that could contribute toward principles of engagement for health care organizations and public health agencies. Workshop proceedings and proceedings in brief will be prepared by a designated rapporteur in accordance with institutional guidelines.

2

Collaboration at the Intersection of Faith and Health

National Academies roundtable workshops are designed to open up a subject for consideration, said session moderation Gary Gunderson, vice president for Faith and Health at the Wake Forest Baptist Medical Center, professor of Public Health Science at the Wake Forest University School of Medicine, and professor of Faith and the Health of the Public at the Wake Forest University School of Divinity. This workshop was intended to open up the discussion of the potential for collaboration at the intersection of faith and health. He added that such collaboration must occur within the context—grounded in the Constitution—of the separation between structures of faith and public structures. (Highlights of this session are presented in Box 2-1.)

To inform the discussion of faith–health collaboration Gunderson shared a matrix from the African Religious Health Assets Program that lists examples of tangible and intangible religious health assets relative to the continuum of proximal and distal health outcomes (see Figure 2-1). He encouraged participants to identify religious health assets that could be relevant to the population scale challenges that the roundtable is seeking to address. For example, a clinic, a prayer group, a recovery shelter, or a needle exchange program in a church are all both tangible and intangible assets and have health effects that are both proximal and distal. It is important to consider who owns or influences a religious health asset, he said, and the optimal alignment of that asset with other equally complex, relevant health assets. He also offered the term "communities of spirit" as a more inclusive alternative to "religion" when discussing these social structures of faith.

THE FOUNDATIONS OF FAITH–HEALTH COLLABORATION[1],[2]

Continuing the theme of "opening up the conversation" about population health and faith-based assets, Prabhjot Singh offered a perspective on the foundations of faith–health collaboration. Singh is a physician, director of the Arnhold Institute for Global Health, and chair of the Department of Health System Design and Global Health at the Icahn School of Medicine at Mount Sinai.

Singh began by noting that in its 40-year history, Leonard Medical School at Shaw trained 400 doctors, among them Clinton Caldwell Boone, a 1910 graduate. After graduating, Singh narrated, Boone went to work as a medical missionary and pastor in the new Republic of Liberia, helping to bring high-quality care to a nation that was formed by freed slaves. After noting the lack of dental care in Liberia, Boone traveled to New York City to be trained as a dentist as well. Boone built a congregation in Liberia, Singh said, and that congregation formed the base of social support for his medical work. The congregation served as a means to organize the community, and to begin the challenging work of building institutions that could serve in both invisible and material ways, he said.

This story could have taken place in nearly any corner of the world, at any time in history, with any set of people who faced their human condition and realized that they needed to look beyond for the strength to move forward, Singh observed. Somehow, he continued, people find the spirit to organize, to act, and to build a better future. The resulting communities of spirit, to use the term of art introduced by Gunderson, are "intangible and powerful field[s] of human energy that drive voluntary associations across the population, and in service of it." By elevating the idea of communities of spirit, Singh said, all individuals can find themselves to be part of the discussion, regardless of how they come to it. Communities of spirit are often involved in building public health and health care institutions, he said, bringing the core values of justice and compassion together with scientific rigor, to improve population health. Singh highlighted the work of John Hatch (who was present at the workshop), who he said intuitively understood the concept of communities of spirit and built a movement that led to the development of community health centers across the country. Singh also referred to the foundational work on faith-based health assets that was carried out by James Cochrane (also present at the workshop) of the International and African Religious Health Assets Program. Cochrane surveyed countries across Africa to better understand how faith and health institutions productively aligned to serve people.

Singh described his own journey toward understanding the relationships between faith and health as unexpected. Singh said that after he earned Ph.D. and M.D. degrees and completed postdoctoral work in economics, his thoughts were focused on deciphering diagnoses and solving problems, and he was not always thinking about the people in his care. That changed during his first year of medical residency when a patient named Ray died in his care. Singh lived

[1] This section is the rapporteur's synopsis of the presentation by Prabhjot Singh, and the statements are not endorsed or verified by the National Academies of Sciences, Engineering, and Medicine.

[2] Singh's presentation drew heavily upon an unpublished lecture by Gary Gunderson, available at http://ihpemory.org/good-news-for-the-whole-community-reflections-on-the-history-of-the-first-century-of-the-social-gospel-movement/ (accessed January 24, 2019).

in the same neighborhood in Harlem in New York City as Ray had, and Ray's daughter invited him to the funeral. Singh shared the story of that experience, which changed his perspective (see Box 2-1).

Years later, Singh was motivated to write about his experience at Ray's funeral after his own relationship with his Harlem neighborhood changed significantly. While out walking at dusk, Singh (who describes himself as a visible member of the Sikh faith tradition) was attacked by about 20 to 30 men who called him a terrorist and fractured his jaw. After sharing his story with local media, he said he was unprepared for the thousands of letters and e-mails he received that both expressed sorrow for what had happened and affirmed his identity. As a physician, he had felt that he was supposed to take care of a community, yet in this case, he felt the power of the community taking care of him and saw firsthand how the invisible bonds that connect individuals locally and nationally were made visible in the community's response.

In an effort to learn more about those bonds, Singh traveled across the country. In Minneapolis, for example, he said he learned how a faith-based community organization, ISAIAH, had used a health impact assessment to change transportation policy. In Dallas, he learned how the Parkland Health Center worked with many faith-based organizations to develop shared technologies that support their most vulnerable clients. Singh said he was inspired by these and other movements of people across the country, and how they are thinking about faith–health collaborations on a very large scale.

To provide context for this scale, Singh said that in the United States, there are approximately 350,000 social entities identified as congregations. Faith identities are diverse and include some that do not identify as formal religions. To put the number of congregations in context, he said there are about 250,000 neighborhoods or geographic communities in America. Singh said that faith-based assets form a connective tissue of social infrastructure that supports, connects, and protects neighborhoods, and that is also well-positioned to be a partner in health.

As public health and health care institutions endeavor to work in concert to improve population health, Singh said, they are finding common ground in neighborhoods. The science of population health is identifying how clinical and nonclinical factors shape people's health. This increasingly includes an emphasis on the social context of people's lives, including the availability of social support, financial stability, food security, and housing.

Although the science of population health can identify these social factors, public health and health care institutions cannot address them alone, Singh said. He added that, as the health sector grapples with decreasing life expectancy, the costs of health care (which can destroy people's lives), income inequality, and social injustice are all growing, and "the moral voice of our allied health professions is difficult to hear." Singh noted that the relationship between the health sector and faith institutions has not always been positive, with a history of sometimes disrespectful interactions. However, "people's lives hang in this balance," he said, and it is incumbent on both fields to acknowledge this history and deploy "the wisdom of faith and the methods of science" in facilitating dialogue and building partnerships.

In closing, Singh emphasized three areas for consideration at the workshop.

1. **Understanding the role of faith communities in the larger community.** A better understanding is needed of the nature of the social connective tissue that faith-based assets have with their populations, not only within their congregations, but across

other non-faith-based organizations and institutions in their communities, Singh said. He added that Robert Putnam and other social and behavioral scientists have "documented how the social fabric influences the ability to survive and thrive, and how faith communities play an important role in health in measurable and well-described ways." Health-sector institutions need to embrace new approaches and technologies that can help them be better partners.

2. **Recognizing the value of faith-based assets for health.** The growing understanding of faith-based assets can be used in practical ways, Singh said. There are many examples of faith–health partnerships across the nation that call for larger investments in children, the dismantling of racist housing policies in neighborhoods, the protection of undocumented immigrants, and helping to address social isolation and loneliness among older adults.
3. **Communicating relevant health messages through trusted partners.** It is important to work with faith leaders to ensure that key public health messages and health care recommendations are more relevant to communities of spirit. For example, the polio eradication campaigns worldwide required deep partnerships with faith leaders to reach the last mile. Today, misinformation about health spreads faster than evidence-based information, he said, and partnering with congregational leaders is key.

The workshop presentations will provide practical, tangible examples of important partnerships forming between faith communities and health institutions, and of the role of policymakers who are forging a new dialogue while respecting the separate roles of faith and government, Singh said. He encouraged participants to identify practical insights they could take back to their respective communities, and to identify what research is needed to better understand faith–health relationships and build better collaborations.

DISCUSSION

In the discussion that followed, participants considered the role of faith-based assets in bringing an understanding of the whole individual and their context to the health arena. Participants also discussed approaches to establishing genuine partnerships among health and faith organizations, and raised specific issues around religious exemptions to vaccines, and overcoming the barriers to providing mental and behavioral health services.

Understanding the Whole Person and Their Context

Matt Guy with the Communities of Spirit Hub of 100 Million Healthier Lives highlighted the general lack of focus on the individual person in health care, despite current patient-centric efforts, and the role of faith in focusing on the individual. Singh agreed that this is a foundational concept for the workshop dialogue. He shared that the most profound result of his speaking with people in faith communities was learning to understand the whole person and their context. He also recognized that there are real limits to being able to develop that understanding in his role as a health professional. This is a journey of humility, he said—of recognizing that everyone holds

a piece of the puzzle and no one can see the whole picture. The challenge is to design institutions and systems that can provide pathways to understanding those individual perspectives. This is an opportunity to see how each puzzle piece fits into the bigger picture.

Eva Powell of CommonPurpose Health noted an opportunity for the faith community and traditional health entities to work more collaboratively on a macro level as well. What happens at the individual level is constrained by decisions that have been made around investments and priorities, she said. When a service is not available for an individual, it is the direct result of decision making on behalf of people who are often not at the table. She suggested that discussion is needed on how the faith community can be active in decision-making circles in order to provide input to help hospital boards, public health entities, and legislatures.

Angeloe Burch of the Interdenominational Ministerial Alliance of Durham emphasized the need to have the "right conversations" that demonstrate an understanding of the specific context in each case. For example, Missionary Baptists and Primitive Baptists are split over the issue of conducting missionary work, and understanding this is important. It is also important to consider how to best communicate with different populations. Regarding vaccines, for example, African Americans are often wary of immunization due to a long history of abuses and unethical treatment that has led to a lack of trust with regard to the health care system. Finally, Burch noted, health providers need to acknowledge that patients know themselves better than a provider can. Providers interact with patients briefly, and having the right conversations with the patient is critical to providing quality care for that individual.

Singh agreed with the need to be aware of the historical and personal depth of these issues, and to build the dialogue needed to move toward a common purpose. In this regard, Gunderson raised the concept of "healthworlds," which was proposed by Cochrane and colleagues. James Cochrane, professor from the University of Cape Town in South Africa and a codirector of the African Religious Health Assets Program, expanded on the concept of healthworlds.

An early research project done by the African Religious Health Asset program for the World Health Organization (WHO) was focused on mapping assets owned by religious entities that might have clinical relevance. Cochrane said that WHO was interested in tangible assets that could be measured, such as personnel, equipment, materials, and transportation. This information was intended to inform decisions by national health ministries about where to prioritize resources, including finances and personnel. It became very clear to researchers that there was a need to also understand intangible networks and assets. In the philosophical and scientific literature there is a concept called the lifeworld, Cochrane said. The lifeworld is the taken-for-granted assumptions that affect the way people make decisions and behave in the world. These go far beyond the rational, calculated decisions that one makes between benefit and cost. Unless these elements of the lifeworld are understood, it is not possible to understand what is happening with the applicable technical, scientific, and instrumental capacities. Cochrane highlighted treating patients with HIV in southern Africa as an example. Medications are available, but there are complex dynamics that impact whether and how people take their medicines. For example, said Cochrane, if a patient with HIV receives medication and has a sibling or parent who is HIV positive but does not have medication or is unable to even acknowledge his or her own status, the

patient will share their medication with them, which negatively impacts the medical protocol designed for the patient.

Expanding on the notion of lifeworld, Cochrane and colleagues coined the phrase "healthworld" to encompass the way that people construct their own sense of health and then behave accordingly (Germond and Cochrane, 2010). Every individual makes decisions based on whether they like the advice they received or not, or whether they trust it or not, Cochrane said. Even when an individual accepts the medical advice they receive, they frequently choose other alternatives anyway; one field where this happens not infrequently is cancer treatment. Cochrane and colleagues have argued that it is critical to understand the interface between the self-understanding of individuals and how those individuals are embedded in families with traditions, cultures with traditions, and religions with traditions, and the impact of this interface upon the practice of health science.

Establishing True Partnerships

Ella Auchincloss of ReThink Health (participating via webcast) asked about approaches that clinical organizations might take in reaching out to and engaging faith-based organizations, so that the faith-based organizations are true partners and not simply venues or assets. Drawing on his prior experience working at the Carter Center, Gunderson said that one theory of collaboration is built around limited domain collaboration, in which the area of partnership is not the sovereign space of either partner. The art of creating that collaborative space, he continued, is to define the limited domain in such a way that it has both integrity and potential efficacy for the goals of all of the partners. The limited domain also excludes aspects that are not specifically included. In other words, it is a safe space where the partners know that they are not buying into every possible implication of the collaboration; it is restricted to the limited domain (Gunderson, 1997).

Religious Exemptions to Vaccines

Robert McLellan, chief of Occupational Medicine at the Dartmouth-Hitchcock Medical Center in New Hampshire, raised the issue of exemption from vaccination based on religious or deep philosophical commitment, and suggested that this is one very practical area where there is friction between the faith and health communities. He noted that public health law is constructed for the good of the population and sometimes finds itself at odds with the principle of individual autonomy. He reiterated Singh's comment about how health organizations need to work with communities of faith to connect with people in relevant ways. Singh agreed that this issue around vaccination is a vital, practical area of work. Gene Matthews of the Network for Public Health Law and the University of North Carolina at Chapel Hill said that the challenge is how to encourage, but not coerce, those who are hesitant to receive vaccines. He mentioned recent research that found that parents who were hesitant to have their children vaccinated scored the moral value of liberty as being very important to them (i.e., they do not want the government telling them what to do). He suggested that one approach might be to emphasize to them the need to be able to free their children from having vaccine-related illnesses. Another moral value

emphasized by parents hesitant to vaccinate was sanctity (e.g., not polluting one's body). A different approach would be needed to encourage these parents.

Meeting Mental and Behavioral Health Needs

Mylynn Tufte, State Health Officer for North Dakota, shared that the governor and first lady of North Dakota have been focused on efforts to reduce the shame and stigma associated with addiction. She added that there is limited access to behavioral health services in rural areas of the state. She asked about leading practices or evidence related to tapping into faith-based assets for mental and behavioral health as they relate to decreasing the shame and stigma of addictions. Gunderson called on Melissa Stancil of CareNet Counseling to share an example. CareNet is an affiliate of Wake Forest Baptist Health, Stancil said, specializing in spiritually integrated psychotherapy and community-based work. The challenge of meeting behavioral health needs in rural settings can be daunting, she said. Collaboration with community partners usually starts with a mutual education process, she explained. People want to help, she observed, but they just do not know how. There is a lot of misinformation about substance use disorders, even within the health care professions, and a lot of internalized stigma in the health care industry around working with individuals who are living with addiction. Trust is essential, and CareNet works with congregations on educational events and relationship building with the goal of developing sustainable partnerships. There are also specific best practices that can be shared (e.g., needle-sharing programs, and leveraging unused facilities for addiction recovery services). Amy Moyer of Kaiser Permanente said that Kaiser is looking to work with faith-based organizations as an integral part of a collective impact plan, working with synagogues, temples, churches, pastoral associations, and others to understand the total health of the community and

BOX 2-1
Key Points Made by Individual Speakers and Participants

- People find the spirit to organize, to act, and to build a better future. Such communities of spirit can serve as a means for organizing the community, and for beginning to build institutions that can serve in both invisible and material ways. (Singh)
- Faith-based assets form a connective tissue of social infrastructure that supports, connects, and protects neighborhoods, and they are in an important position to be partners in health. (Singh)
- Working with faith leaders can help ensure that key public health messages and health care recommendations are more relevant to communities of spirit. It is also important to become knowledgeable of the context (e.g., of an individual, group, or community of faith) for optimal communication with different individuals and populations. (Burch, Singh)

NOTE: This list is the rapporteur's summary of the main points made by individual speakers and participants (noted in parentheses), and does not reflect any consensus among workshop participants, or endorsement by the National Academies of Sciences, Engineering, and Medicine.

the social determinants of health. She expressed interest in hearing more discussion on how to

BOX 2-2
Lessons from a Patient's Funeral

"As I listened to Ray's eulogy along with his family members, I could feel the thick social structure of the community. The wooden pews held Ray's fellow veterans in uniform and his grandchildren, all dressed in dark blue. There were clusters of generations leaning on canes or hunched over smartphones. One of his nieces started talking to me and told me that he never learned how to read. That is something I did not know when I gave him written instructions.

"I paid my respects to the well-dressed man in the coffin. I recognized him from his exposed ankles, located between the short pants socks and neatly pressed beige dress pants, where his skin was darkened and wrinkled from years of blood pooling in his legs. I had seen his exposed chest prior to [his] being transferred to the ICU. Now, I saw a cream-colored silk tie rest upon a dark brown vest with an unwound pocket watch frozen at ten past two.

"I realized I did not really know anything about him or his life. In the hospital, this fact did not seem important. In front of him now, it felt disrespectful. If the health care system and neighborhood both care about his well-being, why are they so evidently disconnected? Before I left the funeral, I spoke to his pastor about his perspective on the health of his congregation. As I waited, I wondered for the first time how anyone who could not read manages multiple medical conditions. How many times had I scribbled a phone number for a referral or handed out information pamphlets to a patient assuming they could read it without checking to make sure? For the 32 million adult Americans who are illiterate and many more who don't fully understand their conditions, staying on a healthy path is impossible without being able to read the signposts along the way. The medical institutions around us are not the only ones that give those signposts.

"When the pastor arrived, he gently explained how part of his job is to support his congregation when he senses trouble. He is worried about obesity in kids and how to counsel young couples when a spouse needs to start dialysis. He explained that his congregation does not always make the distinctions between spiritual support and clinical decision making and he had to manage it all."

SOURCES: Singh presentation, March 22, 2018, excerpts read by Singh from Singh (2016).

formulate private, nonprofit, and governmental relationships around faith-based initiatives in mental health.

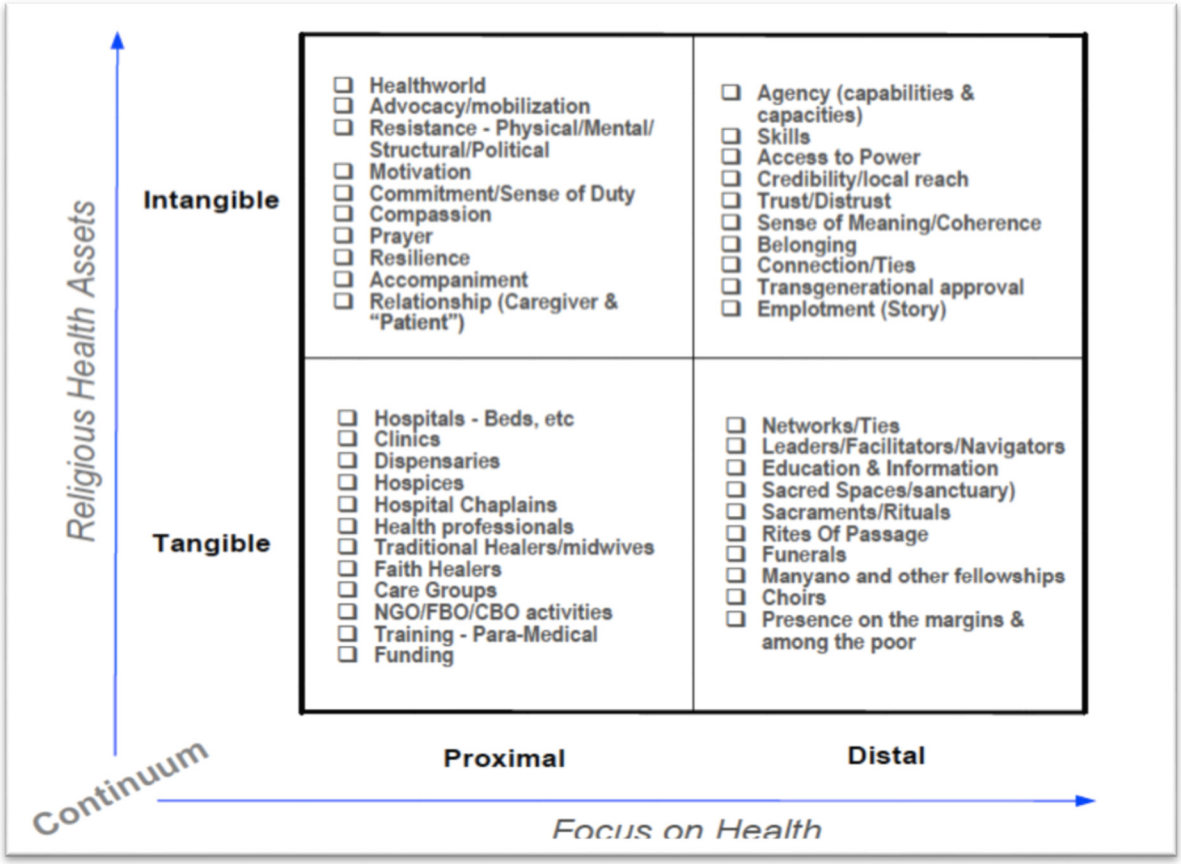

FIGURE 2-1 Religious Health Assets (RHA)/Health Impact Matrix.
NOTE: NGO = non-governmental organization; FBO = faith-based organization; CBO = community-based organization.
SOURCE: Gunderson presentation, March 22, 2018; developed by James Cochrane, African Religious Health Assets Programme.

3

Faith–Health Collaboration to Advance the Social Determinants of Health

Kathy Gerwig, vice president of Employee Safety, Health, and Wellness at Kaiser Permanente, moderated the first panel session, which explored the intersections among health, health care, and faith communities for the purposes of addressing the social determinants of health and improving community health. She noted that Kaiser Permanente has a deep appreciation for the limitations of health care in improving the health of communities. Although critical for health, only a fraction of what constitutes health comes from an encounter in a clinical setting, she said.

Kirsten Peachey, director of Congregational Health Partnerships for Advocate Health Care and co-director of the Center for Faith and Community Health Transformation (the Center), addressed participants via web conference. She described the Center's founding, leadership style, and ongoing work as an example of a faith–health collaboration focused on social determinants of health.

Paul Wong, chair of the board of UMMA Community Clinic[1] in Los Angeles, discussed UMMA as a model of taking a faith–health approach to providing services to a community in crisis. (Highlights of this session are presented in Box 3-1).

[1] Established in 1992 as the University Muslim Medical Association Community Clinic.

THE CENTER FOR FAITH AND COMMUNITY HEALTH TRANSFORMATION

The Center for Faith and Community Health Transformation in Chicago is a joint initiative of Advocate Health Care, a large faith-based health care system serving northern Illinois, and the Office for Community Engagement and Neighborhood Health Partnership at the University of Illinois at Chicago. It is a virtual center, with no actual physical location, Peachey noted.

A Foundation of Relationships

The work of the Center is rooted in relationships, Peachey said. Some of the foundational relationships stemmed from the REACH 2010 project (Racial Ethnic Approaches to Community Health). The Chicago Department of Public Health and the Neighborhoods Initiative at the University of Illinois at Chicago (now the Office of Community Engagement) had grant funding from REACH 2010 and saw faith-based engagement as a key focus area. Because there was an existing relationship, they invited Advocate Health Care to be a partner and help them to engage faith communities. The Center also began to work with other partners such as the American Cancer Society, the American Heart Association, and other organizations that were interested in reaching out to faith communities. Peachey also recognized the work by Gunderson and the Institute of Public Health and Faith Collaboration initiative of the Interfaith Health Program as being instrumental in the development of the Center's work. That initiative, she explained, was a Centers for Disease Control and Prevention (CDC)-funded activity to bring together public health and faith partners to discuss working together more effectively on the root causes of health disparities in ways that would transform communities and bring the strengths of public health and faith together. Another key relationship that Peachey described was with Healthy Chicago, a collaborator with the Chicago Department of Public Health, on a community health needs assessment and strategy implementation plan. The idea for the Center for Faith and Community Health Transformation was formally written into the strategy plan (the Illinois Project for Local Assessment of Needs, or IPLAN) as an approach to reaching into priority communities that were identified in the needs assessment. Around the same time, another organization in Chicago, the Faith and Health Consortium, was developing related projects and conferences, and ultimately the Consortium and the Center merged. Peachey described these relationships as a faith and health movement because it is not just individual organizations working on their own, but coming together to align, merge, and leverage their work.

In response to a question, Peachey said that formalization of the Center within IPLAN provided resources and helped the Center leverage relationships with other health departments. For example, as a result of the strong formal relationship with the Chicago Department of Public Health, the Center was also able to work with the Cook County Department of Public Health. She noted that Chicago is part of Cook County, but that there are two separate health departments because of the geography and population size. The alignment with public health has been critical for sustainability, for establishing a track record, and for showing that the Center is accountable and can be a partner to public health on faith-based projects.

An Organic Approach to Leading

There are four approaches that the Center uses to move its work forward and lead change: visioning, convening, hosting, and practicing.

The Center is an engine for visioning, Peachey said. Within the field of health equity and justice, the Center and its affiliates work to define what faith can bring that will help to address the root causes of inequities in a different way. The language used is intentionally faith-based, she noted, and chosen so that people with a variety of religious backgrounds can relate to the discussions. For example, when discussing an issue such as food insecurity in the communities, what is the moral imagination that people of faith can bring to this issue? Another part of the vision is the idea of spirit power. This grew out of community organizing concepts, which point to two main sources of power: people power and money power. Jim Benn, an early partner in the foundation of the Center, suggested that in addition to money and people, there is also a need for spirit—for a conviction from within drawn from one's religious experience and spiritual practices. Spirit power is the power to hope for things that seem impossible. Indeed, Peachey said, every movement toward social justice, equality, or equity has been driven in part by some element of spirit power. The last part of the vision is the concept of love as a force for change. Sometimes the Center needs to use the scientific language of cohesion, social capital, social connection, and the associated indicators, she noted. However, when talking to people of faith in the community, they understand the language of love, and are practicing this kind of love.

The second key approach the Center uses is convening. Peachey said that there are no projects that the Center works on alone. For all issues to be addressed, the Center plays a role in convening a broad group of stakeholders around that issue. For example, there is a lot of focus and engagement on the issues around trauma, adverse childhood experience, and resilience, strength, and vitality (discussed further below). The Center is developing mental health support services for people in congregations, along with anti-stigma efforts. There is also a faith-based community-engaged research network, convened to support and connect the research on faith and public health.

The approach of hosting is associated with convening. When convening stakeholders, Peachey explained, the Center is hosting partners and colleagues in a process of identifying what needs to be done, and who has the strengths and the resources to take on which tasks.

Finally, Peachey said that the Center strives to actually practice what it is visioning, convening, and hosting for. Myriad relationships are intentionally nurtured. What the Center creates will be influenced by the quality of those relationships, the ability to manage conflict in those relationships, and the ability to share resources and to see possibilities together. A source of creative work is people getting to know each other and being able to see opportunities for connection, she said.

The Vision in Practice: The Trauma-Informed Congregations Network

As an example of a faith–health collaboration to advance the social determinants of health, Peachey described the Trauma Informed Congregations Network. In January 2016, the Center convened and hosted a summit to discuss what faith could offer in the area of trauma and

resilience, and four key work areas were identified. Stakeholders highlighted the need to identify what already exists, develop a common curriculum, expand restorative justice practices, and build a community of practice.

Identifying what already exists was deemed essential so that stakeholders could form a network. Peachey said that a survey is being completed of activities and programs in faith-based settings—formal or informal—that foster resilience and address trauma. Stakeholders also felt they needed a common curriculum that could be used across different faith traditions. The curriculum would use theological language, spiritual practice, and faith perspectives to prepare congregations to address trauma and resilience. An existing curriculum was identified—Risking Connection in Faith Communities—and 15 facilitators who have broad reach within their communities are now being trained to teach that curriculum. Another group is working to develop a strategy for a more intentional expansion of restorative justice practices into faith communities. Finally, a community of practice is being established to help people develop relationships, network, learn together, and renew one another's spirits. Peachey highlighted an upcoming Community Practice meeting that was to focus on the reality that faith communities, in addition to being places of healing and support, can also be places of trauma (including abuse, judgment, exclusion, and demeaning or frightening theological ideas). It is important to be honest about this aspect of faith congregations as well.

In response to a question, Peachey elaborated on the common curriculum, Risking Connection in Faith Communities. Risking Connection is an evidence-based curriculum from the Sidran Institute. In adapting it for use in faith communities, organizers intentionally made it multifaith. The curriculum includes spirituality as an element of healing, which fits well with the Center's focus on connectedness as the driver for transformational change in the community. It focuses on the strength of a community as a place of resilience. The curriculum also focuses on vicarious trauma, that is, the trauma that is experienced by faith leaders or community leaders as they support people who have been through a traumatic experience. Peachey noted that negotiations were still underway regarding payment to Sidran for the use of the curriculum. She referred participants to the curriculum book, which is available for purchase online[2] . With regard to dissemination of the curriculum, each person who has been trained as a teaching facilitator commits to providing 2-day workshops at least twice per year for others within their network. Peachey noted that 15 people are in the process of being trained, and there is a waiting list of others who would like to be trained as facilitators. All of this is coordinated under the umbrella of the Trauma Informed Congregations Network, and there will be indicators and outcome measurements developed to determine if the curriculum is achieving the intended impact.

[2] See https://www.sidran.org/shop/books/risking-connection-in-faith-communities-a-training-curriculum-for-faith-leaders-supporting-trauma (accessed May 20, 2019).

UMMA COMMUNITY CLINIC[3]

The UMMA Community Clinic is a Federally Qualified Health Center in South Los Angeles (LA).[4] The community of South LA faces significant health issues, Wong said, as well as significant health disparities. South LA is in close proximity to some of the most affluent neighborhoods in the United States, yet 31 percent of the residents of South LA live below the federal poverty line and the community is negatively impacted by a range of social determinants of health. There is a lack of affordable quality housing and there is poor access to safe parks and quality fresh foods. About one quarter of adults in South LA cannot afford necessary health services, and nearly half have difficulty accessing care. There are high rates of obesity, cancer, diabetes, heart disease, and low birth weight.

In 1992, in the wake of the Rodney King riots, UMMA was founded as the University Muslim Medical Association by medical students from the University of California, Los Angeles (UCLA) and what was then King-Drew University (now the Charles R. Drew University of Medicine and Science). Wong noted that Drew University is a historically black university that was founded in 1966 in response to the Watts Riots. This is a community that has experienced a lot of trauma, he said. The students founded the clinic on the premise of their faith and with the simple goal of providing services to a community in crisis. An abandoned daycare center was acquired and refurbished and, with the help of a local councilwoman, the students collected donated equipment and raised more than $1.3 million in funds.

Currently, the population being served by the UMMA clinic is about 70 percent Latino and 25 percent African American. Less than 2 percent of patients are of Muslim faith. This is important to note, Wong said, because UMMA was founded by Muslim medical students, most of whom grew up in the suburbs of Los Angeles, far away from South LA. UMMA is the first Federally Qualified Health Center in the United States founded by Muslim Americans. He added that the donor base for the clinic is also largely Muslim. The clinic brings resources into the community that would otherwise not be there. This has resulted in South LA becoming a place of collaboration where faith, health, and well-being come together. Wong said that UMMA is a model of interfaith relationships and people working together. He pointed out that he is chair of the board, and his family is Methodist and Episcopalian. He said his faith compelled him to work in a community in crisis and that faith compels action for many people. This breadth of relationships has afforded UMMA the opportunity to engage in a variety of innovative partnerships.

Fremont Wellness Center

One example of an innovative faith–health partnership that UMMA has entered into is the Fremont Wellness Center and Community Garden. In partnership with the Los Angeles Unified School District and the Los Angeles Neighborhood Land Trust, a clinic and community garden were established at Fremont High School. These serve both students and the surrounding

[3] This section is the rapporteur's synopsis of the presentation by Paul Wong, and the statements are not endorsed or verified by the National Academies of Sciences, Engineering, and Medicine.
[4] For more information see UMMAClinic.org.

community. The garden provides food and a safe, comforting space to this community in need, Wong said. The clinic provides behavioral health services and counseling for the school students, to address concerns such as dropout rates and community trauma, and it provides primary and preventative care, addressing issues including obesity and diabetes. Students are also provided with information about food and there are leadership opportunities for the students at the community garden. It is very easy to get fast food in South LA, he said, and very difficult to get fresh fruits and produce.

Fremont Market

The Fremont Market distributes free fruits and vegetables at an every-other-week event held at the Fremont Wellness Center. The market is run in partnership with Food Forward, a nonprofit organization that recovers fresh produce and fruits from farmers' markets and wholesalers. Wong said that 2,000 to 3,000 pounds of food is given away every other week at every market event. An additional 15,000 pounds of food is distributed to other local organizations to be given away. Health, wellness, and eating well are interconnected, Wong emphasized, and the population of South LA faces a variety of obstacles to obtaining healthy foods. These include some people being fearful of the government, having limited education, or simply being hampered by a lack of transportation.

UMMA's partnerships with these different organizations come about because UMMA brings together people who are willing to commit their time, effort, and energy—not because they necessarily share the same faith, but they share the same desire to put their faith in action. UMMA has ongoing collaborations with community partners, universities, and local schools, and there is a robust culture of volunteerism. Students come to UMMA for medical rotations in the clinics and for volunteer opportunities. The hope is that future doctors, public health workers, and other students will view South LA as part of their neighborhood and not a place to be feared. Many of the medical students have continued on to primary care in urban environments, despite the higher-paying jobs that might be available in the suburbs, Wong said. UMMA believes that if students get to know the residents of South LA, the students will not be afraid of serving there.

Care Coordination

In partnership with the California Hospital Medical Center, UMMA has implemented a care coordination program in South LA designed to break the cycle of emergency department readmissions by providing comprehensive care to chronic-care patients after a hospital discharge. Wong described the pilot project, which involves making a follow-up appointment at UMMA for within 72 hours after discharge from California Hospital. The clinic helps to ensure that a patient's chronic health care and comprehensive health care needs are both being addressed (e.g., dentistry, mental health). The program aims to improve care coordination, increase medication adherence, and reduce 30-day readmissions by 15 percent. Results thus far have been very positive. Wong observed that hospitals have often viewed community health centers as competition. The pilot program has shown that care at both partners improves as a result of the

partnership. Hospitals are able to care for the sickest, neediest patients, while community health centers focus on preventive care and chronic care.

Discussion

Following Wong's presentation, the audience discussed the engagement of local communities and the many roles, historical and current, that a community health center has.

Engaging the Community

André White, of Durham Parks and Recreation, asked about community buy-in and any challenges faced by UMMA in rolling out the program to the community. Wong responded that, over the last 25 years, South LA has changed from being a largely African American population to a largely Latino immigrant population. As part of that cycle of change, UMMA has had to learn to work with different community partners. For example, English is not the first language for many of the current residents. They speak a local dialect of Spanish and often do not understand the Castilian Spanish that many English speakers learned in high school. Wong emphasized the importance of remembering that UMMA and similar organizations should behave as partners offering help and assistance to the community (not as outside experts who think they have the answers). UMMA works in a culturally sensitive manner consistent with its beliefs, but it does not impose those beliefs upon anyone who seeks help. He also noted that first names and no titles (e.g., Dr.) are used among the UMMA board members when interacting with each other, in an effort to foster a sense of equality among the members, whether they are industry, community, or consumer members.

In response to a question, Wong expanded on the model for the board of directors of community health centers, which requires that 50 percent of the board members must be consumers of the community health center or clinic itself. This is an important detail, noted Wong, because, as with many Federally Qualified Health Centers, many people who might work for or with the clinic do not live in the local area. Board members who are members of the community and who take advantage of the clinic services bring a different perspective to the discussions and help to shape the provision of care. He reiterated his rule of board members addressing each other by first name. If we cannot be equal on name, then we have already created barriers, he said.

The Roles of Community Health Centers

A question was raised about whether UMMA is addressing socioeconomic opportunity as well. Wong shared that UMMA is part of a literacy program and is involved in issues of social justice. For example, UMMA sponsors a Tax Day in partnership with several tax accountants, to help people with filing their taxes, and a Law Day, which is a legal clinic in partnership with a number of attorneys. The clinic also has a strong behavioral health program.

A participant acknowledged the history of hospitals and community health centers viewing each other as competitors and added that, in the 1960s, community health centers were also established as a result of racial discrimination. Federal funding to state health departments

was distributed primarily to white communities, and community health centers were built to meet the needs of the underserved. Wong agreed and said that, historically, health departments viewed community health centers as interlopers. He added that is it helpful when state and local public health officials are supportive. UMMA and a California state assemblyman hosted a hearing at the Freemont site on the issue of community trauma. This hearing in the community brought together different voices than would have assembled in a hearing room in the capitol and it has started different alliances.

McLellan asked what a faith-based mission and the associated donor passion brings that would not otherwise be part of the initiative if it were fully funded by other mechanisms (e.g., the government). Wong said that the majority of UMMA services are paid for by patient fees and reimbursements. Additional funding comes from government grants, foundation grants, and donations. Not being 100 percent reliant on federal funding allows UMMA to engage in more innovative projects, including policy initiatives and implementation of strategies to address the social determinants of health. As an example, he mentioned a study done with the Susan G. Komen® foundation on health disparities in breast cancer awareness, treatment, and follow-up among Muslim women. Not relying solely on fees from services affords UMMA excess capacity to take on different projects. This makes UMMA an attractive partner as it is not only a health center but also has the ability to engage on legislative activities and health policy.

BOX 3-1
Key Points Made by Individual Speakers

- Spirit power is the power to hope for things that seem impossible, and it is an element of every movement toward social justice, equality, or equity. (Peachey)
- It is important to acknowledge that faith communities, in addition to being places of healing and support, can also be places of trauma (including abuse, judgment, exclusion, and demeaning or frightening theological ideas). (Peachey)
- Faith–heath partnerships bring together people who are willing to commit their time, effort, and energy, not necessarily because they share the same faith, but they share the same desire to put their faith in action. (Wong)
- Organizations should behave as partners offering help and assistance to the community, not as outside experts who think they have the answers. (Wong)

NOTE: This list is the rapporteur's summary of the main points made by individual speakers and participants (noted in parentheses), and does not reflect any consensus among workshop participants, or endorsement by the National Academies of Sciences, Engineering, and Medicine.

Wong reiterated that UMMA's donors are largely from outside of the local community and reminded people of faith that they are not limited to their local environment when actuating their faith and their belief in service.

4

Faith–Health Collaboration on Health Policy

Terry Allan, health commissioner at the Cuyahoga County Board of Health in Greater Cleveland, Ohio, noted the impressive depth and breadth of the partnerships discussed thus far at the workshop, especially those geared toward addressing the social determinants of health. Faith-based institutions are well positioned in their mission to address the social determinants of health and well-being by giving power and voice to those who have been marginalized by society, Allan said. In this session of the workshop, the discussion focused on how faith–health collaboration can help to build common ground for public health policy.

Mandy Cohen, secretary of the North Carolina Department of Health and Human Services, shared her perspective on how the health of the community is much broader than the provision of health care, and on the need to bring community resources and health care resources closer together.

Donna Weinberger, member of the board of Greater Cleveland Congregations (GCC), discussed how faith–health collaboration can build bridges for health-promoting public policy. The discussion was moderated by Allan. (Highlights of this session are presented in Box 4-1).

A PERSPECTIVE ON HEALTH POLICY: HEALTH BEYOND HEALTH CARE

Cohen described several examples of how she brings a broader lens to the work of the North Carolina Department of Health and Human Services. She began by sharing her personal

story of how she came to think differently about health and health care. When she was nearing the end of her training as a primary care physician in Boston, she saw a 24-year-old woman who was losing weight, losing her hair, and generally not feeling well. The patient was a full-time college student and was insured. Cohen took a standard patient history and ordered laboratory tests, thinking perhaps the patient might have anemia, Lyme disease, or a thyroid disorder. However, all of the patient's laboratory test results were normal. Upon seeing the patient again, Cohen asked some additional questions and ordered a CT scan of the patient's abdomen, now considering cancer or another serious illness as the cause. The CT scan was normal, however. At the patient's third visit, 8 weeks after Cohen has first met her, the patient still looked and felt ill. As Cohen was conferring with her mentor about which specialist she should refer the patient to, the medical technician who had taken the patient's vital signs suggested to Cohen that she really needed to ask the patient if she was getting enough to eat. This was a very difficult, humbling, and embarrassing moment, Cohen said. After eight weeks conducting expensive tests, Cohen had not asked this very important question about the patient's health. It also occurred to Cohen that she did not know what to do if the answer was that the patient did not, in fact, have enough to eat. After asking the patient if something was going on at home, Cohen found out that the patient had recently fled a violent relationship and was living out of her car because all of her money was going toward tuition. The patient did not know who or where to ask for help (and felt she could not ask her family). Like Cohen, the patient had not made the association between her personal life and her health. Cohen realized that she had only been focused on health as health care (ordering lab tests and imaging, referring to specialists), and said that this experience shaped her perspective on health, moving forward.

In her current position, Cohen is charged with the health and well-being of the population of North Carolina. The health status of North Carolina's population is below average nationally, she said. There is a range of statistics indicating poverty and care needs in this area; for example, one in four children in North Carolina go to school hungry, and 48 percent of women in North Carolina have experienced some sort of intimate partner violence. Cohen said she wants to think differently about what health means for North Carolina. Although most of her budget is committed to purchasing health care, health is more than that, she said. She added that all elected officials have a responsibility to think about health.

The North Carolina Department of Health and Human Services (NC DHHS) is looking at ways to bring the health care sector and community resources closer together. Cohen highlighted transportation as one element in the community that is closely linked to health. Transportation can impact whether or not an individual gets the health care they need or whether they can get to their job. Transportation also includes greenways where people can bike and walk for health. Resources are limited, and health care already comprises a significant portion of the state budget, she said. The challenge is to sit together with other sectors who interact with the same residents and identify ways to meet the needs of residents differently and better.

The NC DHHS is also focused on early childhood, particularly ages zero to five years. The department pays for half of the births in the state, pays for childcare subsidies, runs the North Carolina Pre-K and Smart Start programs, and administers Child Protective Services. She reiterated that the focus is not on creating something new, but on working differently and better

across the domains, and being more thoughtful about how the state is helping children to get the best start possible for being successful, regardless of the zip code they are born in.

As a result of reforms to the health care payment system, health systems are starting to think differently about how they interact with the community, Cohen said. For example, the Medicaid program in North Carolina is now asking patients standardized questions about food insecurity, housing insecurity, lack of access to transportation, and interpersonal violence. Cohen said she hopes to also deploy this screening tool to the Medicare Advantage population and the commercially served population in North Carolina, and she is working with other payers and health systems to make that possible.

Once these questions about the social determinants of health have been asked, there must be a way to guide patients to resources, Cohen said. The NC DHHS is developing a platform that will bring together community resources and health care resources. The platform will link to the electronic health record so that, for example, when a provider enters that a patient has screened positive for food insecurity, they will see a list of community resources they can refer the patient to. Through the platform, the provider could send a message to the foodbank to tell them to expect the patient, and to alert the provider if the patient does not go so the provider can follow up.

Finally, Cohen said, it is important to pilot interventions to learn what works best for patients who have essential health needs that are not necessarily traditional health care needs. As an example, Cohen described a pilot program in which carpeting was replaced, and air filters installed, in the homes of children with asthma who were frequent visitors to the emergency department. It was not surprising, she said, that the number of emergency department visits for these children declined. As a result, the children were not missing school, and the parents were able to stay at work. An emergency department is the most expensive place for care, she added, so this intervention also saved health care dollars and resources. Another example is interventions in the homes of elderly residents to reduce their risk for falls. Other home-based interventions might target women with high-risk pregnancies, or children who are experiencing chaos, violence, or trauma in their life. The next step is to take successful pilot programs to scale.

Discussion

Allan highlighted the purchase of replacement carpet and air filtration equipment with health care dollars, noting that such spending is not common, but is the type of creative thinking needed to make a difference. He asked how Cohen was able to move beyond the status quo and convince others to come together and try such innovative interventions. Cohen observed that there is a lot of division around health care, and it has become a partisan and contentious issue. However, there is alignment around wanting individuals and communities to be healthy. The legislature is concerned about rural health, access to care, and the issues of food deserts, transportation, and broadband internet access. This is also alignment around keeping children healthy and safe, and providing access to learning. With regard to health care, payment for health care is changing, and hospital systems are thinking differently about their emphasis (e.g., moving away from keeping hospital beds full, and moving toward engaging community partners). Cohen was hopeful that there is growing alignment across sectors and stakeholders around goals, and

more openness to intentional partnerships. She emphasized that money and priorities drive change, and she highlighted the need to take advantage of the new opportunity that is being driven by health care payment reform to drive these partnerships.

Allan asked Cohen for her perspective on the challenges and opportunities for governmental, public health, and faith-based institutions to work together around real transformational initiatives. Cohen reiterated the value of different sectors coming together in the same room. Although similar efforts might have failed in the past, this is a different moment, she said, and it is important to engage different partners, beyond traditional public health partners. Phyllis Meadows of The Kresge Foundation supported Cohen's optimism that the time is right to start bridging these conversations across sectors. She asked what might be different now than in the past that would allow for success. Cohen gave several examples. First, the pressure around resources is real for everyone. That pressure pushes people to a creative place, which is good for partnerships. Health care payment reform has also driven stakeholders to think differently about health care more broadly. This combination of tight budgets and changes to payments is forcing people to be creative, she said. North Carolina is aligned around health and is prioritizing resources accordingly. The state is working to take innovations to scale and to create the infrastructure to allow collaborations that bring the pieces of the puzzle together (health systems, payors, providers, social services, community resources).

Stancil asked about innovative interventions for the prevention of trauma and intimate partner violence. Cohen said that prevention involves factors related to substance abuse disorder, overall stress related to poverty, and the lack of job opportunities, for example. The goal is to move upstream to the root of these factors to make investments. Prevention is multifactorial, and the department is approaching it from many different directions. In addition to prevention, the department is focused on making children and families more resilient. Trauma will be a part of the human experience, she said. What tools can be provided to help people ascend beyond that trauma? What is it that makes some people who experience trauma resilient? In this regard, the department is looking to academic partners for help.

BUILDING FAITH–HEALTH BRIDGES FOR HEALTH-PROMOTING PUBLIC POLICY

Greater Cleveland Congregations (GCC) is a county-wide, multifaith community organizing group of 43 congregations in Cuyahoga County, Ohio. GCC unites people across race, class, and religion to fight for the common good, Weinberger said. In its short six-year history, GCC has had major victories in Cuyahoga County in criminal justice reform, gun violence reduction through its national "Do Not Stand Idly By" initiative, education, and employment. Its first, and one of its most important victories was to help bring Medicaid expansion to the state of Ohio in 2013, which provided desperately needed health care to more than 700,000 previously uninsured Ohioans, she said.

GCC and Medicaid Expansion in Ohio

A principle of community organizing is that it takes organized people and organized money to effect change. Weinberger noted that Medicaid expansion was one of GCC's first campaigns, and it was a true test of the organization's resilience, relationships, and strength. Weinberger suggested that the first lesson of community organizing is to always be looking for opportunities, and she described how the opportunity to influence Medicaid policy presented itself.

In July 2012, through the work of its criminal justice team, GCC was able to influence Governor John Kasich and the Ohio legislature to pass and sign a major collateral sanctions reform bill. The bill signing took place at a member congregation, Elizabeth Baptist Church. Weinberger reminded participants that, in late June 2012, the U.S. Supreme Court upheld the Patient Protection and Affordable Care Act (ACA) and ruled that Medicaid expansion under the ACA was optional for states. After the collateral sanctions bill was signed, Kasich spoke with GCC members at length about the recent Medicaid expansion decision. The governor is a religious man, Weinberger said, and in his subsequent speeches on Medicaid he spoke of the morality of the expansion and "bringing people out of the shadows." Although the governor hinted to GCC that he was open to expansion, he also expressed concern about the impact on the state budget, and he referred GCC to both the Medicaid director and the director of the Office of Health Transformation for the state for further conversations.

After hearing the governor's potential openness to expansion, GCC began to research the possibility of taking on the issue. At that time there were an estimated 600,000 uninsured Ohioans at the bottom of the income spectrum who would get health insurance if Ohio moved forward with Medicaid expansion. This included 80,000 people in Cuyahoga County, many of whom were in GCC member congregations. The uninsured individuals included unmarried, childless adults earning less than $15,000 per year, and parents earning between $20,000 and $30,000. Expansion would also help the ex-offender population, a large population in Cuyahoga County that is represented in GCC member congregations. GCC also learned that Medicaid expansion would cost very little in the first three years and would slowly increase in cost, but it was estimated that expansion would bring in $1.43 billion over 8 years. This made the pursuit of expansion seem like an obvious choice, Weinberger said. In its conversations with the State Office of Health Transformation, GCC learned that the administration was also considering the potential of Medicaid expansion to be a key component of driving health care reform. The state was interested in a front-end financial investment that would lead to a focus on primary health care, mental health care, and prevention (all of which GCC member clergy and faith communities were very interested in). Finally, GCC's research suggested that a campaign for Medicaid expansion was winnable, she said.

Having decided to campaign for Medicaid expansion in Ohio, GCC began the process of assembling a diverse coalition of organizations that became known as the Northeast Ohio Medicaid Expansion Coalition, or NEO-MEC. Weinberger said that establishing this coalition was probably the most important role that GCC played in the expansion. She felt that GCC, as a group of leaders from faith-based organizations, was probably the only organization in town that could bring all of the stakeholders to the same table. There were, for example, competing

hospital systems that did not otherwise interact that joined the coalition. Weinberger added that NEO-MEC served as the model for five other similar coalitions throughout the state of Ohio.

Throughout the fall and winter of 2012, the coalition strategized and in January 2013, word spread that the governor was becoming more and more open to Medicaid expansion. GCC and NEO-MEC members publicly gathered to show their strength and their support for expansion. GCC organized a health care assembly of about 1,300 people in one of the member churches. The event included testimonials from uninsured Ohioans, providers, small business owners, and senior leadership from all four major hospital systems. GCC and NEO-MEC also participated in almost weekly "lobby days" in the state capitol. GCC trained citizens to take action, and to participate in the democracy that is supposed to represent them, Weinberger said. Congregants learned how to present messages to legislators, how to work as a team, and how to handle a range of reactions from legislators and their aides.

These efforts paid off, Weinberger said, and on February 5, 2013, Kasich announced that he would include Medicaid expansion in his 2 year budget. This was not the end, however. The Republican-led legislature was very resistant. In April of 2013, the Ohio House of Representatives stripped Medicaid expansion from the budget. GCC took five buses filled with members of its congregations and joined other coalitions throughout the state at a rain-soaked rally on the statehouse steps. The intent was to put the legislature on notice that they could strip expansion from the budget, but the coalitions were not going away, she said. GCC kept applying pressure with additional lobby days and press. GCC also canvassed in three strategically targeted swing districts in Northeast Ohio, urging voters to contact their state legislators to support expansion. In the spring, the legislature added a line item in the budget prohibiting Medicaid expansion, but the governor struck it out before signing the budget. In community organizing, Weinberger said, the key is persistence, persistence, persistence.

Following the summer legislative recess, GCC worked with Kasich in a coordinated state effort to get Medicaid expansion on the ballot for a vote. In this way, GCC pushed the legislature to either come to a vote themselves, or face the prospect of putting the issue before the voters. GCC member congregants, trained by GCC's union partners, were instrumental in getting petitions signed to get the issue on the ballot. After about six weeks, however, it became clear that the governor had made a deal. On October 21, 2013, Kasich did an end run around the legislature and brought the matter of Medicaid expansion to the Ohio Controlling Board. In a deal to stop the ballot petitions, the Ohio House Speaker agreed to replace two members of the Controlling Board with sympathetic members right before the vote. The Controlling Board voted five to two to accept $2.55 billion in federal money to cover the cost of expanding Medicaid in Ohio through July 2015. It was thought that once this funding was in place, it would be very difficult to remove the entitlement later. Again, victory was not quite assured, Weinberger said, as lawsuits were immediately filed with the Ohio Supreme Court challenging the legality of the Controlling Board vote. Finally, on December 21, 2013, the Ohio Supreme Court deliver a ruling that cleared the way for expansion of Medicaid to uninsured Ohioans.

Current Status of Medicaid in Ohio

In addition to providing health insurance coverage for about 750,000 people, Medicaid expansion in Ohio has reduced the homeless population, reduced food insecurity, and dramatically increased access to mental health care, Weinberger said. Ohio has been devastated by the opioid crisis, and expansion has provided real treatment opportunities for those who previously could not access care. Medicaid expansion has also provided additional resources to cities and towns throughout Ohio. Expansion has been crucial to the economy as health care is the second largest industry in the state of Ohio after agriculture, she continued. The Cleveland Clinic is the second biggest employer after Walmart.

Since its passage, there have also been numerous threats to Medicaid expansion, mainly focused on eligibility restriction (e.g., bills that would require drug testing, cost sharing, or work requirements). The faith community has risen up when needed, Weinberger said, by successfully stopping these bills in the legislature or persuading the governor to veto them. She noted, however, that this governor's term ends in November 2018 and it is not known what will happen after that.

Lessons Learned

Weinberger shared several lessons learned. First, community organizing is all about relationships, she said. Public relationships (e.g., coalitions) are vital to effecting change. A community organizing principle is that there are no permanent friends and no permanent enemies. Ordinarily, for example, GCC might be on the opposing side of the Cleveland Clinic regarding their lack of investment in the surrounding community, or on the opposite side of Kasich when it comes to his record on guns. However, both were GCC partners in Medicaid expansion and success would not have been possible without them. The second lesson is that power is not a dirty word. It takes a willingness to understand power, and how to wield it when necessary, in order to win. Politics can be dirty and nasty, she said, and this can be difficult for clergy and people of faith to deal with. Finally, GCC had to remind itself often that it was working with the world as it is, not the world as they wished it would be. In a perfect world, politicians would do what was right and moral. In the world as it is, politicians are immersed in the world of dirty money and primaries. It behooves activists to understand what is in the self-interest of politicians and to move forward from there. Sometimes that self-interest can be surprising, she added, and it is not always about money and reelection. For example, Kasich told GCC that his brother had a severe mental illness, and when he talked about getting people out of the shadows, he was thinking of his brother.

Moving forward, GHCC has been able to use its relationship skills and coalition-building skills to work on other issues, including mental-health crisis centers to keep people with severe mental illness out of jail.

Remembering Why We Do This

In closing, Weinberger shared a brief story that reminded her why GCC does the work it does. After the Supreme Court ruling, she and the other two health care cochairs went out to celebrate. Upon ordering drinks, the waitress asked if they were celebrating something. They said yes and explained that they had been working on Medicaid expansion for a long time and were finally victorious. Most people become disinterested when the talk turns to Medicaid, but the waitress nearly had tears in her eyes as she said she had been waiting for this day for years. At age 26, she had not had health insurance since she was 18. She told of sharing an asthma inhaler with her mother because she could not afford one, but how that ended when her father was forced to take early retirement and then had no insurance either. She cobbled together her health care using the community health center and the dental school, but that usually required many hours of lost work time, and so she usually skipped health care all together. The waitress wanted to by their drinks but they declined. In the end, the waitress did buy their coffee, and Weinberger realized that it was important for her to feel bonded with them in this victory. The victory, they reminded themselves, is for the people like this waitress.

DISCUSSION

Michelle Ries of the North Carolina Institute of Medicine asked about the involvement of GCC in spreading the word about Medicaid expansion and eligibility and in recruiting those who might be eligible. Weinberger said that after the expansion was passed, GCC made sure that the navigators were visiting their congregations and that enrollment was taking place. GCC moved on to other issues, returning to Medicaid as threats emerged.

Weinberger was asked to expand on what GCC is taking on next, and how it is using its faith–health relationships. She responded that GCC's criminal justice team is currently working to get persons with mental illness out of prison. The goal is to have two mental-health crisis centers built, one on the east side and one on the west side of Cleveland, where law enforcement can drop off persons with mental illness. Thus far, GCC has brought together a coalition of judges, the Mental Health and Addiction Board, and the county prosecutor's office. She emphasized that the respect GCC earned during the Medicaid expansion process has led these organizations to want to help on other issues as well. GCC's coalition-building skills have also been essential in this process.

Allan asked about the key considerations for sustaining a broad-based coalition. The main approach to maintaining these relationships, Weinberger said, is to not be reactionary. There were times, for example, when one hospital system would say that they did not want to work with the coalition anymore. It was easy to be reactionary and to feel as if the entire effort was going to fall apart. She had to keep reminding herself that every organization involved had a self-interest in the outcome, and it made no sense for them to walk away. Being faith-based, GCC opens all activities with a prayer and that helps everyone to settle down and focus on the wider good in that moment, rather than their ego or self-interest.

Angeloe Burch of the Interdenominational Ministerial Alliance asked about the involvement of African American churches. Weinberger replied that the coalition includes a

number of African American churches. She acknowledged that there is somewhat of a political split because some of the churches do not want to ally themselves with GCC. She observed that the pastors who do work with GCC tend to be on the younger side and see this kind of coalition as very powerful because it is interfaith. Burch questioned why this might be the case, suggesting that African American and Latino pastors are often wary of Caucasians coming into the community trying to help. He emphasized the need to engage the African American and Latino pastors at the start, rather than later when organizers realize there are few people of color at the table. Weinberger agreed and noted that of the three health care cochairs in GCC, two are African American.

BOX 4-1
Key Points Made by Individual Speakers

- Innovative interventions are needed for patients who have essential health needs that are not necessarily traditional health care needs. Community health is broader than health care. (Cohen)
- Although there is a lot of division and partisanship around health care, there is alignment around wanting individuals and communities to be healthy. (Cohen)
- The combination of tight budgets and changes to health care payments is forcing creativity, which is good for partnerships. (Cohen)
- A lesson of community organizing is to always be looking for opportunities to effect change. (Weinberger)
- Public relationships are vital to effecting change, and faith-based organizations might be the only organizations in town that can bring all of the stakeholders to the same table. They can help partners focus on the wider good, rather than their ego or self-interest. (Weinberger)
- It takes a willingness to understand power, and how to wield it when necessary, in order to win. Power is not a dirty word. (Weinberger)

NOTE: This list is the rapporteur's summary of the main points made by individual speakers and participants (noted in parentheses), and does not reflect any consensus among workshop participants, or endorsement by the National Academies of Sciences, Engineering, and Medicine.

5

Faith–Health Collaboration on Public Health Priorities

The final panel session discussed examples of partnerships between faith entities and clinical health care providers in addressing public health priorities. One example of a current public health priority is the ongoing opioid epidemic. The Trump administration's recently announced initiative to stop opioid abuse aims to address the many factors fueling the opioid crisis—including over-prescription, illicit drug supplies, and insufficient access to evidence-based treatment and recovery support services—said Heidi Christensen, public affairs specialist for the Center for Faith-Based and Neighborhood Partnerships (known as the Partnership Center) at the U.S. Department of Health and Human Services (HHS). At its root, she said, the opioid epidemic is a crisis of hope. A critical and particular asset of people of faith and their communities and organizations is a shared narrative of hope, belonging, and community that they can bring to bear to foster behavioral change. Faith communities also have a history of and experience in providing the wraparound services that help people to restore and rebuild their lives, bringing hope and healing to their neighbors in need.

Brandon Lackey, chief program officer at the Foundry Ministries in Alabama, described how the Foundry has created a collaborative continuum of care by working with clinical and other partners in the community.

Teresa Cutts, assistant professor of Social Sciences and Health Policy at the Wake Forest University School of Medicine, and Joy Sharp, director of Community Health Programs at Baptist Health Care in Florida, described the Congregational Health Network (CHN) in Memphis, Tennessee as an example of faith and health system collaboration. The session was moderated by Christensen. (Highlights of this session are presented in Box 5-1.)

FOUNDRY MINISTRIES

The Foundry Ministries began in 1971 as the Bessemer Rescue Mission in Bessemer, Alabama (a suburb of Birmingham). In 1996, when Reverend Bill Heintz became executive director, his vision was to create a place where individuals with drug and alcohol addiction could be invested in their own life recovery, Lackey said. Heintz called it the City of Hope, and years later it became known as the Foundry. Today, the Foundry Ministries operates facilities in six different zip codes, Lackey said.

Heintz sought to provide a healthy, faith-based community environment where the cycles of poverty, addiction, and incarceration could be broken. The Foundry's mission centers around rescue, recovery, and reentry, and the Foundry is best known for its recovery programs, Lackey noted. Program components include counseling, case management, education, employment readiness, and aftercare. The Foundry has a long history of collaboration, he added.

Upon joining the Foundry, Lackey served as director of one of their homeless transitional facilities. He immediately realized that he had much to learn about homelessness, and he set out to better understand the needs of the clients and how best to meet them. He developed what he called a "life plan" (Figure 5-1) that illustrates the four main areas that program participants progress through. When rebuilding their life, there are elements related to earning a living (e.g., writing a resume, getting a driver's license, setting up bank accounts), learning (from formal education to reading books, including the Bible), everyday living (e.g., getting an e-mail address, insurance, and phone service), and moving beyond simply surviving to thriving (e.g., counseling, smoking cessation, joining a church).

Creating a Collaborative Continuum of Care

Once Lackey had laid out the pathway, he acknowledged that he personally was not expert on many of the elements. His role was as a "connector of persons and resources," he said. He began look at the needs of the clients being served and then identified people in the community who could help meet those needs. The Foundry calls this a collaborative continuum of care. Clients at the Foundry can receive up to 40 months of care, but the Foundry itself cannot meet every need that people have. For example, the Foundry does not give legal or medical advice. The Foundry is one of the wraparound services mentioned by Christensen. He had observed, however, that communication among the various agencies, services, and organizations was lacking. The Foundry works with high-risk populations, and as Lackey was not getting the information he needed, he went out to find it. Thus far he has taken his management team to visit 26 outside agencies to build relationships. He acknowledged that different organizations might

do things differently and there are some disagreements, but it is good to have the conversations and to hear a different perspective, especially when it benefits the clients.

Lackey highlighted some of the collaborative efforts and accomplishments of the Foundry. The Foundry Clinic is a community clinic that is staffed by the University of Alabama at Birmingham (UAB), School of Nursing. The Foundry Dental Center is a teaching clinic that donates $2 to $4 million worth of dental services to recovery program participants every year. The Huffington Post worked with the Foundry on a story about the role that faith communities play in meeting mental health care needs when services are scarce[1].

The local health department provides naloxone training for Foundry staff and others. He added that an agreement was just signed for the UAB School of Nursing to open a clinical site at the Changed Lives Christian Center.

One of the key outcomes of the collaborative continuum of care approach is a reduction in the recidivism rate for men coming out of the Alabama Department of Corrections and through the Foundry recovery program, Lackey said. Recidivism has been reduced by approximately 40 percent by providing the next "right choice" and by walking clients through that choice and wrapping the necessary services around them. From a harm reduction standpoint, because of the continuum of care and the partnerships that provide services, 75 percent of the people who walk through the doors of the Foundry stay for at least 12 weeks. Fifty-two percent of clients stay for at least 24 weeks, 40 percent stay for 40 weeks, and 27 percent stay for an entire year. This is an option that the state of Alabama and other states in the country cannot provide, Lackey said.

Faith-based communities, volunteer organizations, and ministries, are equipped to walk the extra mile with those who need a friend, Lackey concluded. He urged participants to get out of their offices and meet each other. Faith-based providers should go to meet clinicians, and clinicians should take their team to a faith-based organization.

THE CONGREGATIONAL HEALTH NETWORK: THE MEMPHIS MODEL

Cutts and Sharp described the Congregational Health Network (CHN), a collaborative partnership among congregations, community organizations, and Methodist Le Bonheur Healthcare in the Memphis, Tennessee area. Cutts noted that CHN has come to be known as the "Memphis Model" of faith and health system collaboration, and has been adapted for implementation in other areas, including in North Carolina where she currently works (see Cutts et al., 2017).

Guiding Principles of Faith–Health Collaboration

Cutts highlighted the guiding principles of faith–health collaboration that she said drove the work and the success of the Memphis Model.

- **Asset based.** Start with assets, not gap analyses or deficits. A community cannot be built based on what it does not have, Cutts said. This theory stems from the African

[1] Available at https://www.huffingtonpost.com/entry/alabama-faith-based-mental-health_us_59a753cee4b07e81d3551906 (accessed May 20, 2018).

Religious Health Asset Program model (discussed by Gunderson and Cochrane in Chapter 2), which makes the assets that are already available in a community visible through mapping, aligning, and leveraging them in partnerships where there is not a power differential.[2,3]

- **Community scale.** The intersection of faith and health is more than the provider–patient dyad, Cutts said. Build networks and capacity at community scale, in the broader population. Build for sustainability.
- **Building trust.** Building trust among community members is key. This might require repairing trust first, and then nurturing and holding that trust, which can be very difficult, Cutts noted.
- **Humble leadership.** Building trust and true partnership requires humble leadership across stakeholders. From the health systems side, Cutts said, leadership needs to clearly value community intelligence.
- **Community-based participatory research principles.** The works should be driven by community-based participatory research principles. This entails bringing people and partners to the table at the beginning to cocreate the model design from the start, Cutts said. A participatory process includes transparency; ongoing participatory analysis of data, programs, and outcomes; and shared risks and benefits.
- **Person-centric, not hospital-centric**. A person-centric focus is based on a person's journey of health, Cutts said. This is not the same as [only] patient-centered care. Where an individual works, lives, plays, or worships has more impact on health outcomes than what happens at a health care facility
- **Integrative strategy.** Blend traditional clinical or biomedical care with community caregiving. The health system is the disease management entity, Cutts said, and the community is the health care entity.
- **Shared-data protocol.** Data will range from qualitative (e.g., community mapping, congregational caregiving) to quantitative (e.g., metrics from hospitals). A shared-data protocol is needed that includes indicators of value to all stakeholders.

The Memphis Model

Establishing the CHN

Memphis is a city of assets and disparities. Cutts described Memphis as the city of four kings. B. B. King, the blues, and Beale Street are huge assets in Memphis, as are Elvis, the "King of Rock and Roll," and Graceland, which is one of the top tourist attractions in the country, she said. The most important king in Memphis is Christ, the King, and about 85 percent of the more than 2,000 congregations in Memphis are Christian. Finally, Dr. Martin Luther King, Jr. was assassinated in Memphis in 1968, and the city still struggles with significant racism, elitism, and disparity. For example, Cutts said that African American families earn about half the median income of white families; black residents have twice the rate of cardiovascular disease than white

[2] Cutts later stated she meant "partnerships designed decrease the power differential."
[3] Cutts later added "Also, our aim is to move the hospitals' thinking that a person is only of interest to them when they become a patient inside their walls."

residents; the incidence of breast cancer mortality in African American women in Memphis is the highest in the country among the 25 U.S. cities (Whitman et al., 2012); and there are significant disparities in limb amputation due to unmanaged diabetes.

The origins of CHN date back to about 2004, when Methodist South CEO, Joe Webb, and his pastor, T. O'Neill Crivens, started a health ministry. Webb had read the Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (IOM, 2002), Cutts said, and had noticed that the fastest-growing businesses in the Methodist South area were dialysis clinics. In 2005, Methodist Bonheur Healthcare CEO, Gary Shorb, hired Gary Gunderson to bring his background in interfaith health programs and the asset mapping process to Memphis. Gunderson then tapped the chaplain at Methodist South Hospital, Bobby Baker, to be Director of Faith and Community Partnerships. Cutts called Baker the spiritual, emotional, and intellectual leader of CHN. In 2006, Methodist Le Bonheur Healthcare partnered with congregations and community organizations in Memphis with the goal of improving access and health status for all. Gunderson showed the leadership at Methodist how these communities and congregations were not a liability (uninsured people filling emergency departments) but an asset. These communities are partners with whom the health system can build capacity and work together toward a greater good.

Structurally, the CHN director oversees a paid staff of 12 navigators who establish formal covenants with the congregations. The covenant model was developed in collaboration with 25 pastors and it outlines the roles of Methodist Healthcare and the pastors in the partnership. Trained volunteer liaisons (more than 700) in the congregations work with the navigators to support and assist CHN members as needed. Cutts noted that more than 20,000 people are registered CHN members. The health system's electronic medical record vendor, Cerner, helped build a navigation pane for CHN. Upon admission to the hospital, patients are asked if they are a CHN member and, if so, would they like to opt in to have their congregation notified that they are in the hospital. If the patient agrees to the notification, the system then alerts the CHN navigator, who contacts the congregation, the clergy, and the liaisons.

Outcomes

Cutts shared data from a cross-sectional snapshot at 25 months into the work of CHN. CHN members and controls who had come through the hospital at the same time were matched for age, gender, and diagnosis-related group (DRG). All patients in the Methodist Le Bonheur Healthcare system receive standard clinical inpatient care. CHN members also receive community caregiving delivered by unpaid volunteers (the liaisons). She acknowledged that CHN is an intervention and was not built to be a research protocol. She noted the challenges of concurrently building out and developing CHN, while tracking and determining evaluation and methodology to be able to ascertain impact.

The length of hospital stay for CHN versus non-CHN patients was the same, however the readmission rate of CHN members was lower and the mortality rate of CHN members was about half that of non-CHN members. Aggregate charges were about $4 million less for CHN members compared to nonmembers (n = 473 patients). Per capita costs were less for CHN versus non-CHN across the diagnoses of congestive heart failure, septicemia, stroke, and diabetes. A subset

of 50 CHN members was identified who had been admitted to the hospital previously, prior to becoming CHN members. For this subset, utilization was compared pre- and post-CHN membership. Admissions per patient, readmissions per patient, and average charge per patient were significantly reduced, post-CHN (Cutts, 2011).

For a more rigorous analysis, CHN worked with Priscilla Barnes, an associate professor at Indiana University's School of Public Health, and a team of statisticians from Indiana University to conduct Cox's predictive modeling for the three years before CHN implementation and three years of CHN (Barnes et al., 2014). Regardless of diagnosis or condition, CHN members had significantly longer time to readmission than matched non-CHN patients (median time to readmission was 70 days longer). This was impressive, Cutts said, because the top diagnosis for this population was congestive heart failure, which can be managed but not cured. On average, CHN members had a significantly lower mortality rate. In addition, navigation to home health services was significantly higher for CHN members, and CHN members were more likely than the general population to be discharged to hospice.

In 2010, charity care costs at Methodist Le Bonheur Healthcare led Cutts and colleagues to use geocoding technology to identify hotspots of health care utilization, and then target CHN and hospital resources to these communities to improve health. Cutts noted the high rate of comorbidity in Memphis, with most people suffering from four or five different chronic conditions. It was found that ten zip codes accounted for 56 percent of total system charity care (Cutts et al., 2014). Patients from the 38109 zip code accounted for nearly 65 percent of total charity care costs.

Methodist Healthcare CEO Shorb was interested in the hotspotting results and toured the 38109 community with his leadership group. Cutts and colleagues then began to conduct focus groups in the community. Community members wanted all of the same things everyone wants, Cutts said (e.g., health care for themselves and their children, access to dentistry). Importantly, many emphasized that they wanted health care access that treated them with respect. Executives at Cigna, one of the large payors in Memphis, were also interested and awarded CHN a large community grant, which enabled CHN to hire its first place-based navigator, Joy Sharp, who then launched the Wellness Without Walls and Familiar Faces initiatives in the 38109 area.

Faith-Centered Navigation

The focus of CHN had been working with congregations to enable them to help their own members, Sharp said, however, some in the community living in proximity of a church might not be congregants. She highlighted the eight strengths of congregations that can be leveraged to build communities as outlined by Gunderson in his book, Deeply Woven Roots (Gunderson, 1997). Congregations accompany, convene, and connect; tell stories and give sanctuary; and bless, pray, and endure. With these strengths in mind, Methodist Le Bonheur Healthcare initiated a faith-centered navigation approach in the 38109 zip code. With the grant funding from Cigna, liaisons and volunteers in 10 congregations within this zip code were trained to guide individuals who were outside of their congregation to appropriate health services and resources. The vision of this faith-centered navigation approach was to align local hospitals, congregations, community organizations, and associated resources to positively impact health disparities in high-need areas,

such as 38109. Sharp pointed out that this initiative elevated trust for the church in the community as a health asset and resource. This is important, she explained, because even if Methodist needs to step back due to a lack of funds to stay in the community, the church endures.

Wellness Without Walls

Methodist Healthcare launched Wellness Without Walls to further address the needs in 38109. The initiative consists of pop-up wellness clinics that are held within the community to provide education, resources, health screenings, and follow-up navigation. The goal is to help local residents modify their lifestyle as needed to promote their individual wellness.

Sharp highlighted the value of developing relationships in the community beyond the church and congregation members. It is helpful to get to know the people that live across the street, as well as down the street, and at the corner store, and to gain their trust. She shared a story of when Cutts lost her car keys while working at a Wellness Without Walls event in a high-crime area of the community. As Sharp went to enter her car she was stopped by a man who said he had heard from the pastor that they were holding an event there. He said he needed to know what the event was about and give his approval, showing her the boundaries of the local gang territories and explaining that she was in his territory. Following this exchange, Sharp told him a colleague had lost some keys and to please not let anyone bother the car across the street as they would be returning later with spare keys to get the car. When Cutts returned later, Sharp said, the keys were on the ground next to the car. Sharp suspected that he had found out who had picked up the keys and ordered them to put them back, because he had met her and trusted her. After that encounter, this man would arrive at clinics with a van full of people to get flu shots. Wellness Without Walls also helped him to get his mother into hospice.

Wellness Without Walls will partner with anyone who wants to partner, Sharp said. As an example, she described how they were approached by a pastor to run a summer camp for 25 children. Ultimately, 185 children participated, and an additional $14,000 was raised within a week from partners and associates, to cover the costs of uniforms, a pair of tennis shoes, and vaccinations and physicals for all of the children.

Familiar Faces

The Familiar Faces initiative was launched by Methodist Healthcare to better address the health needs of the highest health care utilizers in 38109. These are the people who present at the emergency department regularly with unmanaged comorbid chronic conditions.

Once identified for the program, patients are assigned a community health navigator who works to build a trusting partnership with them. Together, they develop a plan to modify the patient's health behaviors and reduce health care utilization. The community navigator provides nonclinical support to help patients overcome the socioeconomic barriers to good personal health and chronic disease management. This might include scheduling appropriate physician appointments, arranging transportation to and from appointments, securing a warm meal or groceries, or filling prescriptions.

The results from the first cohort of Familiar Faces participants have been extremely positive, Sharp said. Within the first year, the cost per patient decreased by 45 percent relative to the preprogram baseline. The executive team at Methodist wanted to confirm that the results were due to the program, and not due to the fact that Sharp excels at engaging patients and running the program. A second cohort of patients was enrolled and managed by a different navigator, and Sharp reported that the results were even better.

Discussion

To start the discussion, Christensen observed that the stories shared, in witness to the importance of faith–health collaboration, demonstrate how complicated the networks of trust and influence are, and how detailed and granular this work is at the intersection of community and health care. Participants then discussed the funding of faith-based programs, including reinvestment of savings to the health system from community wellness programs, and the importance of developing relationships and gaining the community's trust before expecting them to avail themselves of the health services offered.

Funding

Robert McLellan, chief of Occupational Medicine at the Dartmouth Hitchcock Medical Center, asked about any reinvestment of the savings that the system or payers reaped from the Familiar Faces program. Sharp said that these programs are saving the payors a lot of money. She mentioned that, at the time she left Methodist, they were negotiating a cost-savings agreement with BlueCare Medicare, but she did not know the outcome. Cutts said that Cigna was pleased to be saving money in the 38109 community and was invested in trying to put that money back into CHN community programs. She said it is important to look at different stakeholders in terms of where the money flows. She added that the costs savings of these programs are important, but it is also important to recognize that these programs ameliorate suffering and improve a patient's overall quality of life.

Christensen asked how any savings might be reinvested in faith-based providers, such as supporting the extended-stay recovery programs at the Foundry Ministries that were discussed by Lackey. What does that case management partnership look like? Lackey said that the costs for the Foundry and the agencies it partners with are significantly less than costs in a clinical situation. In many cases, he added, the Foundry is more qualified than the emergency department or the legal system in addressing some of the extenuating circumstances that have contributed to the core problem. The Foundry does partner with businesses and corporations. He hoped that foundations would put savings back into evidence-based and efficacious programs. Now is the time to have these conversations, he said, because the dollars will disappear if we do not say where to invest them.

Sharp reminded participants that the reimbursement structure for Medicare requires hospital systems to invest in population health. As the new payment structure is implemented, more money will reach the community. She suggested that health systems would prefer to have

infrastructure ready and waiting than have to create something new that could potentially fail, once implemented. In many cases, faith-based programs already have the trust of the community.

With regard to funding, Christensen alerted participants to the possibility that faith-based recovery services providers could indirectly secure funds through the 21st Century Cures Act. States will receive funds for substance use treatment and recovery and may be able to use those funds to award vouchers so that individuals can access faith-based recovery services.

The Role of Trust in Overcoming Barriers to Care

A participant observed that there are many misconceptions and stigmas around hospice care, and in the hierarchy of needs, hospice falls near the end. He asked how CHN was able to bring people to access hospice services earlier. Another aspect of CHN, Cutts said, was adult education. The curriculum was based on what the congregations wanted to learn, which helped to build trust. During one session, hospice staff taught about end-of-life care and engaged with the participants. Through that process the people in the community came to know and trust the hospice providers so that, when they needed hospice, they knew who to ask.

With regard to home health care, Cutts said, one reason that people in the 38109 neighborhood would not sign up for home health is because they are older and frail and are afraid to open the door for a stranger. To address this, someone from the congregation would be with the patient when the nurse or case manager was coming for the initial home-health visit. This increased the rate of home care uptake significantly, she said. By listening to the concerns of the patients, CHN could take action to add value for people in the community.

Lackey noted that there are similar barriers to mental health care. There is a high correlation in the Foundry client population between substance abuse disorder and homelessness, and mental health. Clients are unlikely to accept a referral to care on the first day, but they might accept a hot meal or a cold drink. Relationships are built over time and then expand access into people’s lives.

BOX 5-1
Key Points Made by Individual Speakers

- A key asset that people of faith have is a shared narrative of hope, belonging, and community that they can bring to bear to foster behavior change. (Christensen)
- Communication among agencies, services, and organizations is often lacking. Get out of the office and build relationships. Faith-based providers should go to meet clinicians, and clinicians should take their team to a faith-based organization. (Lackey)
- Successful faith–health collaborations leverage assets; are built for sustainability at community scale; nurture trust; have leadership that values community intelligence; are person centric,
- transparent, and participatory; integrate traditional clinical with community caregiving; and share data. (Cutts)
- Bring stakeholders and partners to the table at the beginning to cocreate the model design from the start. (Cutts)
- Faith-based programs already have the trust of the community and the infrastructure to reach out to the community, making them ideal partners for population heath initiatives. (Sharp)

NOTE: This list is the rapporteur's summary of the main points made by individual speakers and participants (noted in parentheses), and does not reflect any consensus among workshop participants, or endorsement by the National Academies of Sciences, Engineering, and Medicine.

FIGURE 5-1 The life plan, illustrating the four main areas that Foundry recovery program participants progress through, with examples of tasks to be completed in each area.

SOURCE: Presentation, Brandon D. Lackey, www.foundryministries.com .

6

Reflections on the Day

After the final panel session, participants engaged in an interactive Liberating Structures exercise designed to draw out potential principles and lessons learned from the workshop discussions. The activity was moderated by Emily Viverette of Wake Forest Baptist Health. Each participant was asked to share a personal thought about a potential actionable idea for forging productive collaborations among faith-based organizations, public health, and health care systems by writing it on an index card. Each idea was read and rated by five participants (i.e., five rounds of rating, meaning each card was seen by five members of the audience). Some of the ideas provided by anonymous individual participants are listed below. Exercise instructions and the full list of individual responses are provided in Appendix B; a selection of the responses (i.e., those rated highly by each of the five individuals who read the idea) are provided in Box 6-1.

Following the exercise, Sanne Magnan and Josh Sharfstein, associate dean of the Bloomberg School of Public Health at Johns Hopkins University, reflected on the workshop presentations and discussions, and called upon roundtable members and participants to share their final observations.

Reflecting on the workshop discussions, Sharfstein shared his six observations on what makes a faith–health partnership successful:

- The faith organization can bring energy and resources to a particular problem. Sharfstein referred to Wong's discussion of UMMA as an example.

- The faith organization brings structure and a network to the problem (e.g., they often have the connections to help people obtain jobs or get legal assistance).
- Faith organizations excel at social outreach. Some of the factors that affect illness are outside the medical realm. Faith organizations are naturally working in these areas to help people.
- Faith organizations have the trust of the community.
- In a true partnership, the organizations respect each other's expertise. In the successful partnerships, the faith organizations listen to the evidence and treatment advice provided by the health and medical partners in response to their needs. Sharfstein highlighted Methodist Healthcare as an example, in that they first listened to what the community wanted, and then offered relevant evidence-based approaches that were accepted by the community.
- There is potential for advocacy work by the faith community using approaches, tools, and connections that health organizations typically do not have access.

Magnan reiterated the eight strengths that communities of faith bring to a faith–health partnership, which Joy Sharp presented from Gunderson's work. They are the ability to accompany, convene, connect, tell stories, give sanctuary, bless, pray, and endure. Magnan also emphasized the theme of seizing opportunities. In the discussion of the work of Greater Cleveland Congregations, Donna Weinberger said that the first lesson of community organizing is to always be looking for opportunities. Magnan was reminded of a quote from Otto von Bismarck, who said, "The statesman's task is to hear God's footsteps marching through history, and to try to catch on to His coattails as He marches past." In essence, Greater Cleveland Congregations is catching onto those coattails and making history, she said. Faith-based allies in communities can be collaborators for helping the health sector bring peace, healing, health, and well-being to communities, she said.

Terry Allan highlighted UMMA as an example of how the power of faith and mission are independent of denomination. As discussed by Paul Wong, UMMA was organized by Muslim medical students and the majority of donor funding comes from the Muslim community, yet only two percent of the people who come to the clinic are of Muslim faith.

A participant noted the importance of promoting and expanding access to mental health and behavioral health services. She recalled the comments by Kirsten Peachey about aligning with public health services and fostering trauma-informed congregations. She hoped this would happen within her state. Increased awareness around adverse childhood experiences is very important, she said, especially for the work being done at the faith–health intersection within the Native American community in her state.

Davis Kindig of the University of Wisconsin observed that several participants had mentioned hope as a powerful strength of faith-based organizations. He did not know whether hope was unique to these organizations, or just that hope was very strong within them. He noted that he had not previously considered hope as a factor or input in the promotion of health.

A participant recalled the comment, by Prabhjot Singh, that there are about 250,000 neighborhoods in the United States, and about 350,000 congregations. This would seem to present great opportunity, but he was concerned that congregation memberships are dwindling in

some areas. In his area of New England, he said that church attendance is low, and he wondered what that might mean for faith–health initiatives.

Phyllis Meadows of The Kresge Foundation highlighted the notion of faith communities as assets and emphasized the value of the faith community as an anchor institution in communities. They have history and longevity, and their emphasis on service minimizes the sense of competitiveness that often occurs when different entities serve the same population. She said she valued the church's role as a safety net but hoped it would become more vocal and involved in the institutional and societal challenges that community members face, including issues of race. She was inspired by the example of Medicaid expansion in Ohio as it really is a civil rights issue. The power of the church can begin to shape what is happening politically and contextually in these communities, she said. She observed that faith-based institutions that function as human service providers are struggling with the same issues that the broader human service sector is struggling with. There is greater demand than what they can supply, and sustainability is a persistent challenge.

James Cochrane felt that many of the examples discussed were quite powerful and provided a sense of some of the phenomena of faith–health or religious health assets. Having worked with these phenomena for more than 20 years in Africa and Europe and elsewhere, he said he was disturbed by frequent attempts (in general, not at the workshop) to claim a sort of privilege for faith, to regard it as having a position that others do not have. This is not always the case, he said. He suggested that there was somewhat of a selection bias in what was presented at the workshop, and that while participants could be inspired by that, they could also mislead. These phenomena (i.e., the partnerships between faith and health entities) are very diverse, are not always positive, and are sometimes highly ambiguous he said. It cannot be claimed that the health sector should be working with faith communities simply because they are communities of faith. Rather, what is it that binds, drives, or unites those that the health sector should be working with? What unites the phenomena behind the individual examples? What are the conditions that allow these phenomena to emerge that need to be understood and encouraged? Little has been discussed about conceptual or theoretical understandings of the phenomena that have been described. Much of what has been described still reflects what has been called the Cartesian split between empirical science and practical wisdom, in which we create categories that we separate things from, he said. We cannot avoid a siloed approach or properly address questions of alignment as long this split persists. There is a direct reflection of this in the language of health and of medicine, which is a language of "proximal and distal," and "upstream and downstream," Cochrane said. This language separates the activities involved when, in fact, they are in the same stream. The ambiguities in faith are rich and deep, Cochrane continued, but this is also true of medicine. The ambiguities of medicine and of health care practice are not adequately addressed at this time. There is also the question of how to prioritize resources and allocate funds to the various activities discussed at the workshop. Resource allocation can be done, for example, vertically, in terms of population groups or patient groups, or horizontally, in terms of different kinds of illnesses or diseases. The fundamental flaw is that this approach creates a disconnect. There is a systemic involvement of these aspects at all levels. How can the system be prioritized, instead of prioritizing one or another aspect? An engagement of faith–health could begin to explore this more deeply. In working with faith–health and religious health assets, Cochrane said

he has learned the critical importance of the intangible. A focus on the tangible and measurable is essential and important, but it is so dominant and powerful that it takes attention away from the intangible, he said. For example, the health field does a far less adequate job than the field of economics at taking sentiment into account. Sentiment is not empirical and yet it plays a significant role in economics. The intangible is very important in understanding what it means to be a human being who claims to have a faith, and to understanding where they fit in their world and what that means for how they behave (e.g., whether they follow a treatment protocol or not). This must be understood far more deeply, he said. Finally, none of this can be understood unless we go back to the beginnings of medicine and public health, Cochrane said. Why do we do this? For what purpose and toward what end? What is the moral imagination that drives us to engage in this in the first place, and which easily gets lost and allows us to ignore the people that we are ultimately there to serve?

Drawing from the discussions, a participant asked, "how do we make the invisible things that connect us visible?" She noted the need to take advantage of this moment and build the infrastructure at the community level to be able to leverage new payment models and approaches to measurement and quantification of value. She added that achieving quality and value should not be at the expense of the intangible. She suggested that telling stories, such as those shared at the workshop, is one way to show the value of the intangible and make it more visible. She also observed that the day's discussions were focused on the positive contributions of faith organizations, however, there is also a dark side to the church that no one likes to talk about. The faith–health movement is a good place to begin having those difficult discussions.

George Isham of HealthPartners suggested that, in promoting better health in populations, there is a moral tension between the large amount of resources dedicated to health care and health care institutions, and the relatively smaller impact of health care and health care institutions on health. Many health care institutions have been or are currently governed by faith-based organizations from many faith traditions. Does the moral imagination mentioned by Peachey include self-examination of the behavior of the institution with regard to this imbalance, Isham asked, as reflected in the impulse to acquire resources and market share in communities at the expense of resources for other key determinants of health, such as adequate housing, education, and so forth?

A participant highlighted the need to think about what we put our faith in. Some, like Mandy Cohen, expressed optimism and faith in new ways of conveying value and paying for health services, and in seeing entrenched institutions and industries perhaps moving in a direction that rebalances investments and resources, as suggested by Isham. American culture places a lot of faith in markets, medicine, trickle-down economics, and technologies, in which there are both good and harm, he said. Communities driven by faith can put faith in people, in cultures, and in a process of learning together through common work and reaching across differences. These might be the only ways of correcting some of the harms that have accumulated by placing our faith in entities that are disconnected from that which fuels health and well-being, he said. The participant also observed a theme around flattening hierarchies of power in order to enable discussions and partnership. He highlighted UMMA and Medicaid expansion in Ohio as examples of what can happen when there is "power with" as opposed to "power over." Finally, in addition to the eight strengths that faith organizations bring, the

participant suggested that faith fuels the courage to ask the difficult questions and to face the facts. Scientists and practitioners need the courage to ask the difficult questions about a system that is not working very well, and then to do the hard work needed to remake it.

BOX 6-1
Some Ideas for Faith–Health Collaboration Provided by Individual Participants in the Interactive Exercise

Presented by Emily Viverette

- Power is not a dirty word; it is useful in obtaining resources for those who need it. Do not be turned off by people who want it or have it. You can partner for the greater good. Pray with your feet!
- Approach community partners with respect, truth, and humility.
- Work with community members to identify specific health needs, then collaborate with health care to offer and refine those services.
- Include people who reflect the community that is being served.
- Engage partners deemed to be important stakeholders from the beginning of the process, to build trust and get genuine interest and involvement.
- To build trust, identify common interests.
- Make sure that each group is involved in the partnership from the beginning.
- All the work revolves around relationships. We need to expand our ability to build relationships across systems and communities, and particularly across racial lines. There is a lot of painful history to overcome to build trust.
- Faith-based groups are trusted in communities and may be the only groups that can get competing organizations and interests to the table together.
- The single most important lesson is: Listen to discover the needs and what we can do together to meet those needs.
- Faith-based partnerships can change the tone of policy debates without being “above the fray” (e.g., the role of Greater Cleveland Congregations in Medicaid expansion in Ohio).

SOURCE: Comments submitted by anonymous participants, as summarized and reported by Viverette during the workshop exercise, March 22, 2018. (See Appendix B).

A

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B

25/10 Crowdsourcing Participant Activity

To draw out potential actionable items from the workshop discussion, participants engaged in the 25/10 crowdsourcing activity described by Lipmanowicz and McCandless in their book The Surprising Power of Liberating Structures: Simple Rules to Unleash a Culture of Innovation (Lipmanowicz and McCandless, 2014).

Participants were instructed: In light of what you have heard today, what is the single most important principle or lesson learned about forging productive collaborations between faith-based groups, public health, and health care systems?

Participants were given two minutes to write a single response on an index card, one idea per person, anonymously. Similar to a game of musical chairs, cards were passed around randomly and rapidly among the participants while music played. When the music stopped, participants rated the idea on the card in their hand from 1 (low, "OK") to 5 (high, "fabulous") and marked their rating on the back of the card. This cycle was repeated four more times. Participants were instructed not to look at the previous ratings on the back of the card before deciding on their rating. After five rounds total, the last person holding the card totaled the five scores. The top-scoring responses were then read aloud, starting with responses that received 25 points and working downward.

The top-scoring responses are presented in Box 5-1 and below as part of the full list of responses.

1. Power is not a dirty word; it is useful in obtaining resources for those who need it. Do not be turned off by people who want it or have it. You can partner for the greater good. Pray with your feet!
2. Approach community partners with respect, truth, and humility.
3. Work with community members to identify specific health needs, then collaborate with health care to offer and refine those services.
4. Include people who reflect the community that is being served.
5. Engage partners deemed important stakeholders from the beginning of the process, to build trust and get genuine interest and involvement.
6. To build trust, identify common interests.
7. Make sure that each group is involved in the partnership from the beginning.
8. All the work revolves around relationships. We need to expand our ability to build relationships across systems and communities, and particularly across racial lines. There is a lot of painful history to overcome to build trust.

9. Faith-based groups are trusted in communities and may be the only groups that can get competing organizations and interests to the table together.
10. The single most important lesson is: Listen to discover the needs and what we can do together to meet those needs.
11. Faith-based partnerships can change the tone of policy debates without being "above the fray" (e.g., the role of Greater Cleveland Congregations in Medicaid expansion in Ohio).