

The Memphis Model: ARHAP Theory Comes to Ground in the Congregational Health Network

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INTRODUCTION

The Congregational Health Network (CHN) in Memphis began in 2004 under the leadership of then CEO at Methodist South Hospital, Joe Webb. In 2005, when Rev. Dr. Gary Gunderson came to Methodist LeBonheur Healthcare (MLH), he recognised the potential of this small group and sought to grow the network, centred in an area of Memphis with incredible health disparities, poor health status, and a community based hospital that often operated at a deficit. Gunderson's public health perspective, and decades of earlier work with the Interfaith Health Program, his think tank at Emory University, informed the design of the CHN. Additionally, tenets of the African Religious Health Assets Programme (ARHAP), especially the concept of leveraging already existing assets, have been a driving force in the design and logic behind the development and growth of CHN.

The CHN, at the time of writing, partners with around 340 local churches in Memphis (a continuously rising figure), many located in the epicentre of the most egregious poverty and violence corridors, using seven adult hospital navigators, and at least two health liaisons in each of its partner churches (Figure 1 below, produced when 280 congregations were affiliated). Through this partnership, MLH and its partner congregations are building a network of patient-centred care that begins in the congregation, moves into the hospital, and then back out into the congregational community.

The metaphor of the journey of life is useful here. CHN works with the more common journeys taken by its members: infant and maternal health, chronic diseases, mental health—including unresolved grief, violence and unremitting stress—as well as end-of-life issues. The CHN navigators, who connect with the trusted liaisons inside the congregations, serve as part of the social bridging capital to extend the work of care-giving outside of the hospital. The hospital, in this context, is seen as the

disease-care entity, and the congregations or communities as the health care entities, between which CHN strives to build the ‘human bridges’ and caring pathways that will support its members on their health journeys, for life.

Here I offer a brief description of the Memphis area, and an in-depth description of the Congregational Health Network (CHN), particularly its history, structure, roles, preliminary evaluation, outcome data, and the logic model driving CHN’s success.

THE MEMPHIS LANDSCAPE

Memphis is awash with disparity. Fifty-four percent of its citizens are African-American, and the financial and health disparities when compared to Caucasian communities are outrageous. Average median income for a Caucasian family in 2007 was \$61 000, while a comparable African-American income was \$31 500. Our Robin Hood Index (the difference between the haves and have-nots) is thus shockingly high (Atkinson and Micklewright, 1992). The average infant mortality incidence (due to high rates in some impoverished areas) is the same as that in Zimbabwe: 14 per 100,000 live births. African-American males between the ages of 18 to 54 have a 13 times higher likelihood of dying from homicide or suicide than their Caucasian counterparts. Memphis, the limb amputee capital of the Southeast, with African-Americans bearing the brunt of its high numbers, is also characterised by pandemics of chronic disease: cardiovascular, diabetes and obesity.

Many of these disparities can be traced to a legacy of racism and elitism, stemming from the rural Delta economy and culture. Memphis is the urban hub of concentrated Delta poverty from four areas: north Mississippi, east Arkansas, west Tennessee and the boot hill of Missouri—and the fourth largest centre for medicine in the country, providing care to rural people of the areas just cited.

The MLH, of which CHN is part, is a large, faith-based system comprising seven hospitals, with 1,000 beds and 47% of patient market share in the Memphis area. Flourishing since being established in 1918 by a Mississippi plantation owner, John Sherard, MLH provides the highest level of indigent care in the state of Tennessee, because of the concentrated poverty among the majority African-American population in the Memphis metropolitan statistical area. MLH is owned by the United Methodist Church conferences of Memphis, Mississippi and Arkansas, and it strives to live up to the call to ministry as a true faith-based system, not simply one with a religious name. Although MLH covers a predominant market share of indigent care, it also has a solid market share base of patients covered by private insurance. Thus it has survived tough economic times and flourished in good ones. But what makes MLH extraordinary is that the members of its senior leadership see the need to improve health status and access and to provide advocacy *outside* the walls of the hospital, as part of one social body – it must work to help all our citizens, not just those who come to our hospital.

Despite its disparities and problems, Memphis has many assets. Specifically, it has ‘church’ or ‘soul’. Roughly 2,000 churches are located in this area, and 70% of the indigent patients at MLH claim attendance at a place of worship at least once a month. Memphis is predominantly (estimated 85%) Christian. The power of the clergy and pulpit in Memphis should not be underestimated, and African-American clergy have tremendous social capital and status, especially among the under-served.

Memphis’ assets also include three large faith-based, not-for-profit organisations, that make up the triumvirate of safety-net care in the city: Church Health Center or CHC (donor based care for the under-served), Christ Community Health Services or CCHS (federally-qualified clinics and outreach) and Metropolitan Inter-faith Association (MIFA), which provides social services, including meals on wheels, congregate meals for elderly in high-rise housing, ombudsman services, transitional housing and life skills training, utility assistance, care-giving respite and much more. These partners are pivotal in aligning and leveraging the work of the CHN and covering gaps in care for the under-served. Additionally, many of the pastors involved in CHN attended the local Memphis Theological Seminary or MTS, another strong networking, pastoral care, academic and political partner. Coalitions and community organisations and hundreds of grassroots ministries and care-giving groups exist in the city to improve the health and well-being of all, although these are often siloed and their services fragmented.

THEORIES AND THE LOGIC MODEL

A primary tenet of the logic model of the CHN is tied to the social infrastructure afforded by congregations. Strengths of the *social infrastructure of congregations* inherently provide strong social ‘interventions’ to support health and healing (Gunderson 1997). In fact, congregations have positive effects on the life span of their parishioners, independent of and prior to any effect that may come from alignment with the formal health care system (Idler 2008). But the hospital, working in conjunction with the common social infrastructure of the congregation, supports the means of changing health status in a way that our fragmented and clinical-service-oriented healthcare system cannot.

Connecting the hospital system seamlessly to this social infrastructure, grounded as it is in already vital congregational ministries and partnerships, provides a means to impact conditions that drain health care resources. The CHN members believe that the collaborative partnership between the hospital and congregations allows it to gain the synergies of two different ways of advancing health that can produce additional value in the lives of patients, church members and neighbours, as well as the social networks at community level.

Importantly and explicitly, CHN is not trying to turn congregations into clinical sites or mere extensions of clinical reach and care delivery. Neither is it trying to hold

hospitals responsible for the spiritual nurture and care typically provided by congregations. With equal status, each collaborative partner in this system works synergistically all along the patient-centred journey of health.

The predominant trajectory of anyone's journey of health is located outside traditional hospital settings, and it includes care and behaviour that supports or undermines whole health centred within the family home or faith community. Ambulatory and inpatient hospital care settings are often seen as the epicentre of health. But CHN seeks to decentre the role of those traditional health care settings, to give equal credence and weight to care offered intrinsically within the community by non-medical personnel. Specifically, CHN does not name the hospital as the dominant partner, given the capricious, unreliable and fragmented nature of health care systems. Rather, CHN seeks to partner with already existing community groups, coalitions and ministries to strengthen the health status of all of Memphis as a whole, including both parishioners and neighbours in community.

An additional focus of the logic model underlying CHN is offering *transparent communication*—striving to be transparent to all partners and including them in any planning or development efforts at the outset. Thus a core group of pastors serve on the covenant committee as a design team, and have helped craft care pathway models, as well as refine the covenant agreement.

A further critical component of the CHN partner logic is a generous *flow of resources* between the hospital, the clergy and congregations. For instance, all the ordained CHN clergy partners have access to clinical pastoral education from MLH, receive a significant discount for inpatient care at MLH, and are connected to the human resource staff to help find employment for their parishioners at MLH (there are 11,000 employees across the seven-hospital system). CHN also provides micro-grants and 'seed money' to community-based groups that are trusted in specific communities and already have programmatic efforts or services underway. MLH human resource training, such as basic computer skills, is offered for no charge to CHN members. All other MLH training, such as care for the dying, is offered to pastors, health ministers or liaisons and congregation members at no cost. The clergy leaders covenant to be good role models for health in their congregations, as well as to help design and vet the CHN evaluation and tools as the Network grows and expands.

Emerging, organic leadership is also a key aspect of the guiding logic for CHN. *Building leadership models that rely on trust and allow open space* for emergent structures has been incredibly important for foundational work in CHN development, both at senior leadership and grassroots levels. Under Gunderson's leadership, the CHN was seen as a seed group that could expand into a huge asset to work within the community. Gunderson saw community not as a liability or simply a place to give money for health fairs, as had been the traditional hospital view, but as an asset and a

way to *build a transformative network of relationships* to support preventive efforts, community care-giving and ‘healing’ in the broadest sense of the word.

Shifting the imagination of members of MLH senior leadership to view community as an asset was no mean feat in a hospital environment. As such, ARHAP’s principles of focusing on assets, honouring and respecting indigenous intelligence, and promoting partnership rather than colonial strategies, were foundational to the design and nurturing of CHN.

In terms of high level leadership, senior leaders at the hospital have intentionally worked at allowing the CHN structures to emerge organically by holding the space open for them to do so. Often, community-based programmes are deprived of their vitality by the preconceived notions of hospital staff about what these groups should be doing, versus what their mission or passions actually are around enhancing health and well-being. A prescriptive model ensues, and, no matter how well-meaning one is, participants become ‘clients’, and the process guts the essence of what makes grassroots care most viable (McKnight 1996).

Gunderson’s leadership strategy is clear: ‘Don’t get between leaders who are trusted in the community and their constituents’ (personal communication). His ‘hands off’, generous leadership style promotes Director Bobby Baker, a well-respected and active Baptist minister, as the ‘face’ of this group, which has been critical to the success of the CHN in Memphis. This adaptable model of leadership has a potent resiliency and allows for resources, structures and partners to be introduced into the landscape of the work in a way that allows for ease of negotiations, but requires limited infrastructure and legal obligations. In fact, Gunderson has been adamant that MLH not brand CHN as their own through marketing, but allow CHN—in name, brand and reality—to be owned by the congregations themselves. Such acceptance of some ambiguity, and lack of formal legal ties, exists infrequently in hospital partnerships. In his book, *Deeply Woven Roots*, Gunderson (1997: 57) calls this type of partnership that brings diverse and sometimes contentious partners to the table for shared work in a narrowly defined area, a ‘limited domain collaboration’.

Another critical aspect of the CHN logic model is aligning, leveraging and maximizing the effect of trust. Its grassroots leadership model relies heavily on those that work in already existing structures to activate and mobilise resources and assets. Relationships with *trusted liaisons or intermediaries* (Gunderson & Cochrane, 2011; Cochrane, 2006) are crucial to this alignment, leverage, activation and mobilisation at community level. This is especially true in a community that manifests inherent, and often, historically justified distrust and fear of traditional health care services and organisations. The hope is that the CHN model will continue to exemplify what Cochrane (2008: 69) calls ‘a “just health system” that mediates between the necessary leadership or polity from above, and the experience and wisdom of those “below”, taking into account the asymmetries of power that this equation represents.’

Pivotal to the strategy is that the congregational *navigators work from within* each of the Methodist hospitals to partner with the health ministers or liaisons in the congregations, with a focus on the ‘health journey’ of members. The aim is to make this journey a positive experience in which ‘no-one is left behind’. This is done by leveraging and integrating community based care-giving with traditional clinical care. Navigating this health journey happens mostly outside of a hospital setting. It is predicated on optimal health, including ideal body weight, and regular and appropriate physical activity and nutrition habits, within a preventive medicine community-based strategy.

The current health care language for this phenomenon is ‘patient and family-centred care’. CHN’s is intentionally *not* a clinical model, although non-clinical services are linked explicitly through the CHN navigators into deeply clinical services in the hospital and ambulatory care. The key to extending this system of care lies in aligning, leveraging and supporting already existing assets. The CHN has allocated funding, and created a new organisational structure and new job roles to support ongoing meetings within a three-year timeline for building relationships with trusted neighbourhood and community-based liaisons. Also, inherent in this logic model is making visible, aligning and *leveraging the assets of the ‘love economy’*—those who provide care giving and resources without standard compensation, such as volunteers, health ministers in the churches, parish nurses.

The belief is that the CHN system as a socially-based ‘intervention’ can show evidence of positive benefits to its members compared to matched control non-CHN members, including those areas critical to hospital and other stakeholders. Explicitly, the community-based work seeks to further develop the community domain outlined in the chronic care and collaborative care models for prevention (Wagner et al. 2001; Glasgow et al. 2001). The programme was designed from a faith-driven and congregation-based concept of care or ‘change pathways’, a term that differentiates the model from traditional, often ineffective or harmful tracks that people take to access health care. MLH, via the CHN, thus works synergistically with the faith community to leverage all existing faith and health resources in building a ‘best practice’ care model. This model shows how to integrate already existing social networks and ministries in the community, how to build trust and share generously, and how to engage in clinically appropriate, large scale network-building, community care giving, and research that can make an impact on the health status and health outcomes in the broader community.

Lastly, the CHN logic draws heavily from what is termed ‘*blended intelligences*’. The local pastoral intelligence is constantly being viewed and enhanced by its blending with the diverse intelligence offered by MLH staff, ARHAP, and partners and centres of excellence in faith and health, grounded in global best practice and science. Indeed, the open, creative space of CHN development attracts many

complementary intelligence partners in health care. This includes several key MLH staff and directors of medical services, operations, finances and quality. Further, the ‘visiting scholar’ model offers constant ‘fresh eyes’ with which to view growth and expansion in Memphis through the CHN, with a critical role in the short-loop learning process. This ‘blended intelligence’ authentically honours grassroots wisdom and skills, and allows external academic experts to serve, but not dominate, the CHN work or to change the process. As such, only scholars who manifest a truly humble spirit are chosen to blend with the Network’s grassroots partners.

COVENANT COMMITTEE DESIGN

Starting in 2006, CHN convened the original thought-leaders, a group of twelve pastors, to serve as consultants on bi-weekly design team meetings. Approximately twenty of these meetings have been held to date. With the pastors’ input, CHN developed a Covenant for pastors to sign up their congregations and recruit their members, with a focus on serving ‘neighbours’ living in the same neighbourhood.

Some critical elements of the covenant include the pastors’ help to design and populate the care pathways, starting in the congregations and accompanying the people into the hospital system and back out of into the communities again. Members of the covenant design committee have shared their pastoral intelligence to help craft five models of care for prevention, education, treatment (ambulatory care), intervention (in-patient care) and aftercare efforts. They agree to be exemplary role models for demonstrating faith and health in their personal habits, offer messages from the pulpit to encourage healthy living, and help evaluate the effectiveness of the CHN strategies. Lastly, continued involvement of the pastors’ design steering committee, which serves as an advisory board and ‘community conscience’, should keep the CHN accountable for doing the community and faith-driven work with the integrity needed to enhance the overall health of all in Memphis. In return MLH agrees to offer a 60% discount on out-of-pocket hospital charges to clergy, to offer training at no cost to CHN members and clergy and to share findings transparently.

The ultimate motivation of the hospital for doing this work is to decrease overall length of stay (LOS) of patients, and decrease costs of care for CHN members by directing them to most appropriate levels of care. This is valuable to all stakeholders. From an economic perspective, decreasing average LOS in the Memphis hospital system by even half a day will result in a \$5 million savings annually. From a patient-centred care view, a shorter hospital stay and early discharge to a competent, activated and trusted caring community can greatly improve quality of life and well-being; it decreases the probability of premature return to hospital care or of developing hospital-acquired infections and enhances healing, thereby improving health outcomes (DiGioia, 2010).

If hospital personnel feel that there is a caring community to which a patient can be discharged, they are likely to discharge a patient earlier instead of allowing protracted length of stay for fear of malpractice or medical neglect charges. Given the difficulties that MLH has faced in placing some patients in appropriate post-acute or aftercare settings, developing and nurturing these care pathways outside of the hospital walls per se could be a huge asset for the hospital system, patients, providers and the community at large. On the front end of the care pathway journey, getting patients to the least invasive level of care before a problem is acute or critical can save money for the hospital and suffering for the patient as well.

PROGRAMME EXPANSION AND STRUCTURE

The CHN has run under the directorship of Rev. Bobby Baker since 2007. He had been the lead chaplain for several years, knows the community well, and serves as an active Baptist pastor. Rev. Baker embodies how trusted leadership can be leveraged in Memphis to achieve critical community engagement. MLH dedicated over \$250 000 of new budget money in the 2008--2009 Faith and Health division budget to fund the CHN work going forward, including hiring a new organisational director and four navigator positions.

At the time of writing, over 340 partner congregations in the CHN exist, representing a wide array of denominations, including Baptist (American, Southern, National, Progressive), United Methodist, African Methodist Episcopal, Catholic, Church of God in Christ, Lutheran, Assembly of God, United Congregational Church, Presbyterian and Episcopalian. Recently, a Hispanic specialty navigator was added to work with the Hispanic pastors in a culturally competent fashion and strengthen that unique network. Some twenty Hispanic pastors have been convened and invited to be a part of the CHN. While relationships have not yet been formalised, Muslim representatives have also participated in CHN activities, and there is strong support as well from the Jewish faith community. In total, approximately 40 000 congregational members are directly or indirectly influenced by the CHN programme.

The organisational structure of the CHN includes a Director and five navigators. Supporting that team are the Manager of Volunteers and two specialists who work with both volunteers in the hospital and in the congregations. Many of the other staff in the MLH Faith and Health Division, including chaplains and spiritual care administrative staff, work to support or enhance the work of CHN. The Director of Research and Innovative Practice in the Center of Excellence in Faith and Health aids in designing and evaluating the research efforts of the CHN. The Project Manager provides information technology support and data management for the team, especially with regard to the electronic medical record input and tracking of patients. The Covenant Design team of pastors is critical to the intellectual work, blending the existing ministries with hospital and other health care efforts. Global and national

consultants are invited to think through the CHN and broader hospital strategies for improving overall health, quality of life and access to health care. Community safety-net partners and local academic partners also support this work through research and evaluation projects done by student interns for small stipends. Medical directors, case and disease managers and outreach workers in the two local managed care organisations for the under-served partner with the CHN to ‘reach’ patients who over-utilise or inappropriately utilise health care resources, usually at tertiary levels.

Navigator and Liaison Roles

The navigator role is not a clinical one, but one that literally helps members find their around and through the workings of a complex hospital system, while linking tightly into community resources outside the hospital. The seven navigators have different disciplinary backgrounds—representing chaplaincy, Lutheran clergy, patient advocacy, medical records, laboratory technology, health fair coordination and hospital-wide translation—and varying personalities. But all are adept at connecting resources and building and nurturing relationships, and all are passionate about their work.

This diversity is intentional; the navigators serve as pathfinders, using their diverse and distinctive strengths to define their respective work in a way that fits the different ‘personalities’ of the four hospital systems and the Hispanic and international community. For example, navigator Blanch Thomas, a community organiser by spirit, is a great fit at the community hospital, Methodist South, surrounded as it is by small to moderate size Baptist churches. Navigator Russell Belisle, a chaplain and member of the Lutheran clergy, does well for Methodist Germantown, located in the most affluent part of town, where he interacts with many male pastors heading mega-churches with strong hierarchical structures.

A liaison is a person, assigned by the local pastor or clergy leader, who is respected and trusted by the congregation, understands and abides by rules of confidentiality, and acts as the bridge between their congregation and the MLH system. Liaisons ideally are integrated into the life and culture of the congregations, have good communication and organisational skills, can document well, are comfortable and compassionate with members in distress, are available for training, and can work with the navigators. They also agree to complete a short monthly report outlining their activities.

Clergy are asked to assign at least two liaisons per church, to avoid one person ‘doing it all’ (the ‘Lone Ranger’ syndrome). Liaisons must attend a two hour training, which addresses the issues listed above as well as standards of respecting confidentiality and rules surrounding the HIPAA (health care information portability and access act) laws that protect individual health information.

Lastly, the health liaisons and pastors are vital links in bringing the work of the CHN literally ‘to ground’ and extending its efforts to build care pathways that make the walls of the hospital invisible. Indeed, CHN believes that the liaisons care giving efforts in the congregations are responsible for the early positive outcomes evident in preliminary data analyses described below.

Registering Congregations and Training

Efforts to register congregations begin with securing the buy-in and ownership of the clergy leader. Recruiting and registering small, moderate and large congregations, with the vagaries of engaging different denominational structures, has yielded a wealth of knowledge. For example, engaging partners in small to moderate Baptist denominations with buy-in from senior clergy leader tends to happen quickly and easily. This has not been the case with larger and more complex denominations like the United Methodist Church. The figure below shows the extent of this network at the point when it had reached 280 congregations.

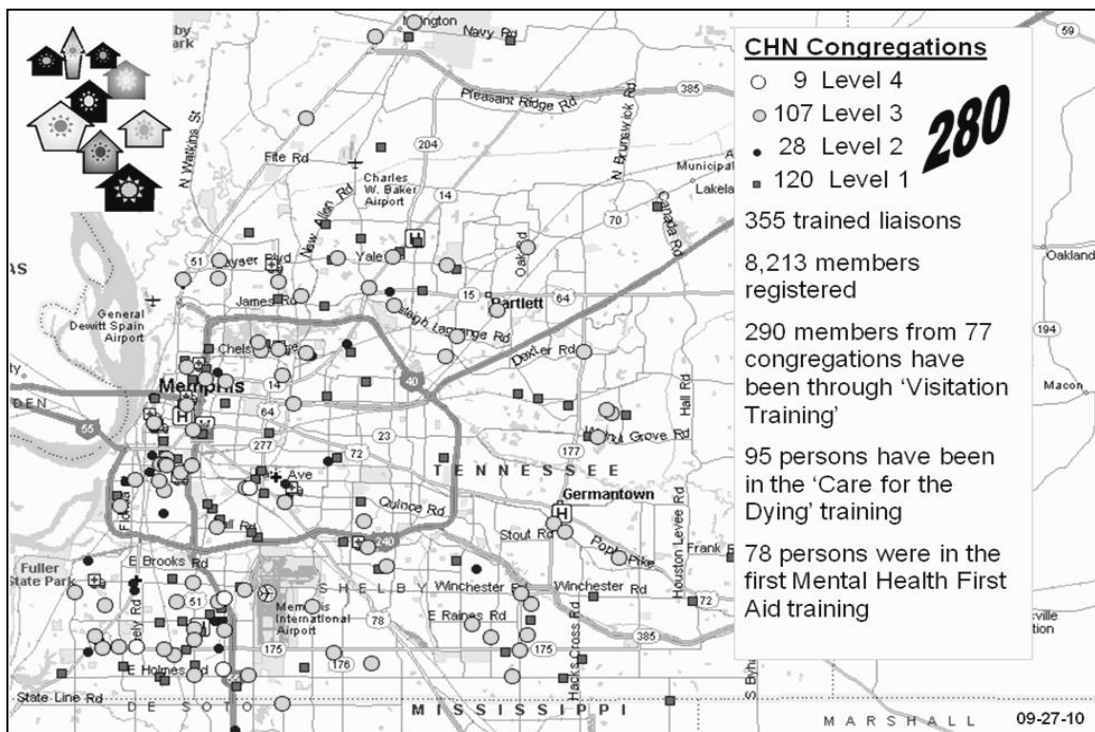


Figure 1. CHN Partner Congregation Map

CHN members are registered in their congregations prior to coming into the hospital, then ‘pre-loaded’ into the CHN electronic medical record (EMR). To date, over 9000 CHN individual members have been registered in the EMR. CHN congregations are ranked according to level of activity and engagement. Clergy leadership of Level 4 (our most engaged) congregations sign a covenant, train liaisons

in basics of CHN and other seven week sessions, participate in data analysis and program development efforts, and share narratives of healing from their members and liaisons. Level 3 congregations match Level 4 in engagement, with the exception that they do not share narratives. Level 2 congregations have signed covenants and liaisons trained in the basic work. Level 1 (least engaged) congregations have signed a covenant only.

Current training includes brief immersion in and demystification of the hospital culture, rules and systems. Seven-week training modules include care for the dying, mental health first aid, and aftercare training to aid patients and care givers subsequent to hospital discharge. Other ad hoc training deals, inter alia, with violence in faith communities and handling suicide.

EVALUATION OF CHN

The CHN design essentially builds care or change pathways that are centred in the congregation, but which extend farther out to the broader community through the hospital and other care entities. The CHN logic model predicts that this community-based intervention model of congregational engagement will decrease overall length of stay in hospital, decrease unnecessary emergency room usage, redirect patients to most appropriate level of care, and decrease unnecessary re-hospitalisations. Ideally, CHN efforts, coupled with community care giving from the Network's unpaid volunteers, will optimise members' health status via promoting regular physical activity, improved nutrition and maintenance of healthy body mass index.

EMR technology has been pivotal in demonstrating the effectiveness of the CHN going forward. This 'back end data capture' undergirds the CHN evaluation processes and supports the measurement of outcomes, in a non-invasive manner. If a registered CHN member 'opts in' for a given hospital visit (necessary to circumvent HIPAA regulations), a consultant in EMR flags navigators to visit the patient, and alerts pastors or health liaisons that a member is in the hospital.

Significantly, the development of the EMR technology for tracking CHN members both inside the hospital and in the congregations or communities has created an easily replicable vehicle for data capture and evaluation that shows how both hospitals and community members benefit from these preventive health activities. This data collection started in October 2007 and generates monthly and quarterly reports to compare overall length of stay, recidivism, diagnoses and zip code residence between CHN members and matched controls who are not.

It has been hypothesised that the simple 'human touch' of navigators working closely with liaisons and clergy will decrease the disconnect, fear and friction that those entering hospitals usually experience. In terms of return on investment, the CHN is already showing that it will ultimately result in savings for MLH, as overall length of stay, total charges, recidivism (measured by re-admission within 30 days), and

levels of non-emergent care presenting in the emergency departments for CHN members versus matched control patients will all decrease. It is also expected that the CHN strategy will improve patient satisfaction scores and increase the percentage of patients with advanced directives or plans for end of life care in place thereby resulting in less futile care, unnecessary high end tertiary care usage and improved quality of life.

EARLY MAPPING EFFORTS AND DATA SNAPSHOTS

Preliminary Hospital Data

CHN member level data at the time of writing (2009) has been promising on many fronts. Although data aggregation of CHN members through hospital flow populates slowly (the average person, happily, comes through a hospital system once every seven years), 473 members have come through one of the seven MLH hospitals since October 2007 when EMR tracking began. The first quarter of 2009 offered some powerful data for driving health outcomes change. For example, approximately 75% of CHN patients had some medical health care coverage; only 3% were indigent. Also, approximately 80% came from the four target zip codes where poverty and health disparity are particularly prevalent; these are the areas in which CHN managed care organisation partners are trying to reach their patients for preventive care *before* they present at the emergency department for care. In addition, 45% of the most active CHN congregations are located in these four zip codes.

Early outcome data (from the first 25 months of CHN operation) is tremendously positive. Through the hospital's EMR, CHN members have been compared with control patients (matched on age, gender and ethnicity) who entered the hospital at the same time as the first 473 CHN members. Comparing CHN and non-CHN members, CHN patients saved \$8 705 per patient per head and accrued an almost \$4 million dollars savings for the MLH. These savings appear to be due to patients accessing the hospital before their conditions are highly acute, such that they require less costly health care resources. Also, when considering the most frequent diagnoses, such as congestive heart failure, other cardiovascular diagnoses, stroke and diabetes, CHN members' charges were significantly lower in 10/12 diagnostic related groups. Lastly, crude mortality rates were double in the non-CHN versus CHN group, the members who entered the hospital at that time, suggesting that the leveraging of trust and connectedness or the social support of the faith communities is a very powerful 'intervention' in itself in terms of enhancing health outcomes and managing multiple chronic conditions.

Mapping CHN and other MLH Hospital Staff Roles

'Mapping' efforts, both inside the hospital and outside, are pivotal to appropriately aligning and leveraging community assets with hospital resources and staff. Mapping

in the hospital has focused on delineating the roles of CHN navigator staff and their integration with church liaisons, as well as partnering with the chief medical officers, case managers, social workers, home health, hospice and admission staff to maximise the community-based resources of partner congregations in discharge planning and placement, particularly with the large frail elderly population.

Community Health Asset Mapping Partnership (CHAMP)

Mapping currently fragmented services and making visible the in-house, external and ‘interfacing’ networks and assets in the community, are key to building a strong system of care across Memphis. As such, the CHN has partnered in Community Health Assets Mapping (CHAMP) work, beginning in August 2007 in Memphis under the leadership of MLH, with colleagues from the universities of Cape Town and Kwa-Zulu Natal in South Africa (see Figure 2 for the areas, variously shaded, mapped in Memphis thus far).

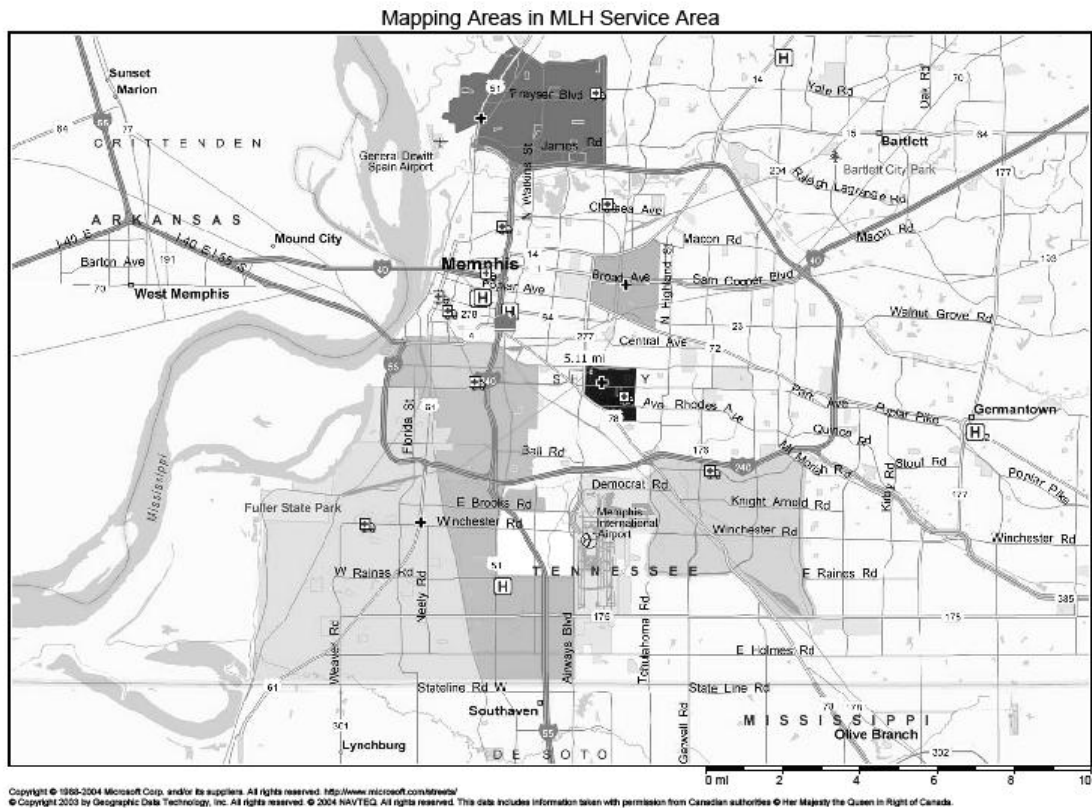


Figure 2. PIRHANA Map Sites

Using the ARHAP model of Participatory Inquiry into Religious Health Assets, Networks and Agency (PIRHANA), described by De Gruchy et al in this volume, CHN mapped both faith and public health assets, starting with geographical information system or GIS efforts, followed by participatory inquiry at the grassroots

and city levels. The ‘output’ from those leadership engagement strategies is compiled electronically and shared with all partners and the broader public. These findings are shared back to the community through the CHAMP website, in hard copy, and in partnership with the local library system data repository for accessing community resources.

Through the PIRHANA workshops (twelve held to date), the people who live on the map ‘validate’ and further enrich and populate the map in five of the lower income neighbourhoods where many of the CHN partner congregations are located (De Gruchy et al, this volume). Participants articulate what next steps can be taken to enhance overall health and well-being in their neighbourhood.

The PIRHANA workshops have proven to be a great strategy for engaging grassroots leadership. Locals in these neighbourhoods are offered hope and become energised to do more when they ‘see’ their assets with fresh eyes through the PIRHANA lens and methodology. The mapping work stresses ‘partnership’ and maximises both community engagement and the ‘found’ assets in the community to build a corps of grassroots teams that can work with the CHN in each of these neighbourhoods. Additionally, transparent sharing of all these findings can strengthen other organisations’ efforts.

These workshops also strengthen the ‘webs of trust’ that can sustain the care delivery system CHN is weaving together in its health care model. For example, community partners are activated and mobilised to work with CHN on initiatives to increase safety and promote early childhood brain development. Lastly, case studies are being undertaken in two of these target neighbourhoods to develop a richer understanding of the variables that impact health and well-being locally.

SUMMARY AND LESSONS LEARNED

MLH and the communities or congregations via CHN are being aligned to create a seamless faith-driven community care system that leverages and integrates existing partners and assets to enhance the health and well-being of all. What are the early lessons learned from this unprecedented venture between a traditional hospital system and a faith-saturated community?

Fluid, organic, turbulent, boundary leadership (Gunderson 2004) that holds open space for creative emergence and growth of each grassroots network, as well as engaging traditional senior leaders in the hospital, are critical. For CHN this was exemplified in Gunderson’s ability to shift the thinking or the imagination of his peers in the hospital leadership concerning their view of community, to engage them in this process, and in his abdication of the front-line leadership role to Director Bobby Baker with his extensive relationships in the city. This stresses the importance that the leadership of such a network must reflect the ‘face’ and ‘intelligence’ of the area or the city to extend a ‘just health system’ (Cochrane, 2008: 69).

Allowing the clergy and congregational leadership and intelligence to define what they want and need and meeting those named training needs is critical to respecting and nurturing the partnership. Building, nurturing, protecting and maintaining trust with congregational and community partners requires tremendous effort, but synergistic networks cannot exist without this key factor. That trust must be advocated for and protected. Many of the CHN staff act as trusted intermediaries to the congregations and CHN partners often have to be vetted and/or protected from well-meaning, but potentially exploitative research or other partnering ventures or opportunities.

Community partnership development and collaborative design take a lot more time than expected. For example, the Covenant Design committee took approximately six months to refine a one page covenant document, much more time than initially anticipated.

Honouring and ‘lifting up’ the intelligence of clergy and other partners on the ground is inherently valuable for building and nurturing trust in collaborative partnerships and revitalizing those in the trenches. Bringing in global faith health partners who see the work with ‘fresh eyes’ greatly maximises this effect and results in enhanced ‘blended intelligence’ as a platform for true community-based participatory research.

Sharing the abundance generously, for example, through micro-grants, technical support and ‘seed money’ can garner much goodwill from partners who often function with limited external resources. This can powerfully leverage and enhance the scope and scale of services offered.

Transparency and truth-telling are key for engaging and nurturing partnerships. Congregational and community leaders are happily surprised by truth-telling and information shared openly from hospital leadership, because prior experience has made them wary of being proffered such partnerships, anticipating little return on their investment. For example, a critical juncture in the early engagement of CHN clergy occurred when Gunderson shared a ‘trade secret’ from the hospital, that is, that the hospitals lose money when patients have extended lengths of stay, amounting to millions of dollars a year.

The roles and foci of navigators’ work change as the network grows and develops. While the early focus was recruitment of congregations, this shifted subsequently to nurturing relationships and signing up individual members within congregations. Identifying the right person for a navigator position depends on the dynamics, CEO leadership and location of each hospital.

Recruiting congregations and getting ‘buy-in’ differs greatly based upon the denomination, size, and structure of the churches, with smaller churches with less complicated structure making for easier and faster sign up.

Non-invasive, back end data capture prevents some of the problems inherent in trying to obtain utilitarian and valid measures from faith-based partners. However, some type of evaluation is crucial to prove return on investment to the operational, financial and senior leaders who may like the idea of mobilizing the faith community, yet secretly doubt that this work will improve outcomes or save money for the hospital. Evidence is the language that these primary stakeholders understand.

Finding healthcare ‘champions’ for the network in the hospital is crucial. For example, the Chief Medical Officer, Dr. Robin Womeodu, at MUH, the teaching hospital in the inner city, has been crucial in helping senior leadership see how CHN can impact care and in engaging the social workers, case managers and other staff to integrate the CHN work with their own disciplines with the hospital.

CHN partner clergy have already begun to ‘raise the bar’ on improving decent and quality inpatient care in the hospital by alerting the CHN staff and network when inappropriate care is delivered. Closing the feedback loop with consumer input elevates the expectations of consumers, but benefits all in terms of enhancing quality efforts or care delivery.

Every market and area where health care is delivered will differ markedly and will need to delineate its own assets core. However, as ARHAP colleague, Paul Germond, has pointed out, conditions favouring the ‘Memphis Model’ are found in many cities in sub-Saharan Africa (and elsewhere) where there is only one major hospital system that provides the majority of care for the under-served.

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