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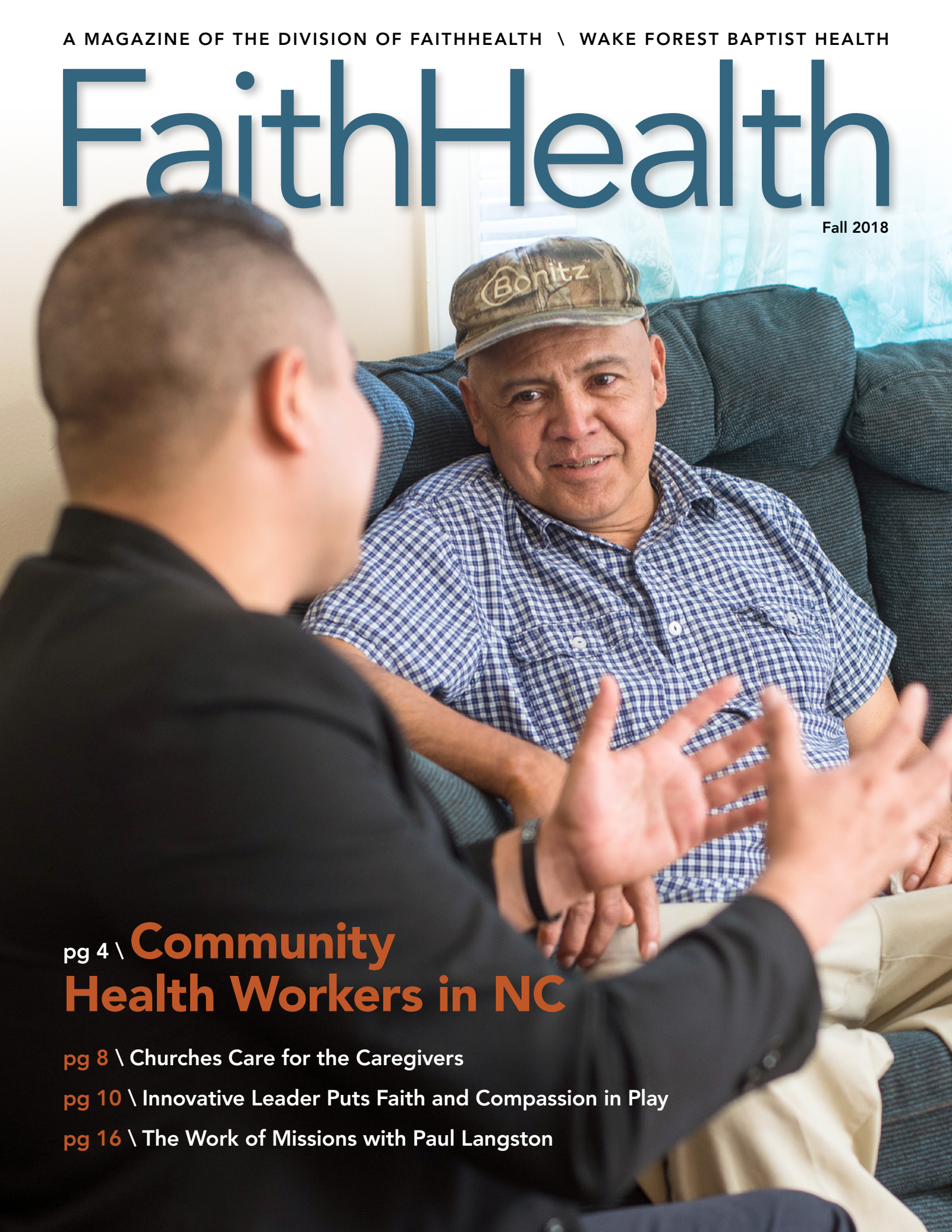
FaithHealth

Fall 2018



pg 4 \ **Community Health Workers in NC**

pg 8 \ Churches Care for the Caregivers

pg 10 \ Innovative Leader Puts Faith and Compassion in Play

pg 16 \ The Work of Missions with Paul Langston

'Living Dangerously' in the Spirit of Community Health Workers

Friends,

Rev. Gary R. Gunderson

This issue of FaithHealth is about how we are all healers of the communities that God so loves. Some of the stories appear to be about extraordinary people doing amazing things. But when you look more closely, you realize they are more tenacious than brilliant—just doing one right thing and then another, never looking away from those in need. Any of us can do that. The surprise is that when we do, we find ourselves not depleted but more alive. Jesus said that would be so and not as some mysterious paradox. That's how life works.

This is most obvious in times of great conflict or disaster. As this is written, a massive storm is approaching. By the time you read this, winds will be past, but not the suffering and the loss. And not the joy of being part of the healing.

The FaithHealth division declared this year as our year of "living dangerously," to lean in where others lean back, to stand steady where others move away. We don't have to look for the vulnerable; we are already connected to those who are most exposed with the most reasons to fear. On the stormiest nights, our chaplains will, of course, be among the patients and staff in our hospitals who are under enormous stress. But every single day our supporters and connectors are in the neighborhoods most likely to bear the brunt of all kinds of storms. Our CareNet counselors are in the lives of those still living with grief and anxiety over past storms and most likely to be in the greatest stress next. We know our health care staff are themselves most vulnerable and are grateful for our faith partners who come alongside to care for them. We know the names of friends living under bridges. Our first responder partners are already on the way into harm's way. Our varieties of faith partners are at the ends of every low-lying road.

Living dangerously means not waiting for the call. Before the next storm hits, take a few minutes and reach out to the ones within range of your love to let them know that you—and by connection, we—are on alert for them. Listen carefully. And then reach out to the rest of us, if there's something we can do. Think vine and branches, not solitary heroes.

We all know that the greatest challenge is after the crisis when the news cycle rolls onto the next thing. So we pray to be living tenaciously, not just urgently. That's why we have built all the roles you live in every day that extend and connect deeply. These are dangerous roles in which to live. But that's where the fresh air is. Blessed are the merciful—not just those who feel sorry for others.

Gary Gunderson, MDiv, DMin, DDiv
Vice President, FaithHealth

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Contents \ Fall 2018

4
Community Health Workers in North Carolina:
Their Evolving Role in a Changing Health Care System

READ MORE: A Day in the Life of a Community Health Worker

Community Health Workers Right FIT for Program Serving Formerly Incarcerated

8
Churches Care for the Caregivers

10
Innovative Leader Puts Faith and Compassion in Play

12
The Science of Faith-based Assets

13
FaithHealth Learning Forum Spreads Ideas, Practices

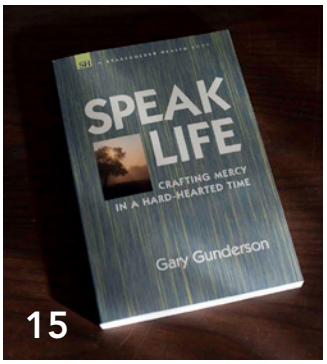
14
Q&A with Paul Langston

15
People and Events

New Hires

Hatch Lecture Series

New Book: *Speak Life*



Cover photo: Supporter of Health Enrique Catana (left) visits with patient Santos Matias Argueta.

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Community Health Workers in North Carolina:

Their Evolving Role in a Changing Health Care System

BY MELANIE RASKIN

From left, community health workers Pecola Blackburn, Mary Dendy, Enrique Catana, Vernita Frazier and Annika Archie

Now, more than ever, states are feeling the call to close the gap between the health care workforce they have and the health care workforce they need.

That gap is deep and wide, as it is across the nation. With neighborhoods representing hundreds of countries, cultures and ethnicities dotting the nation, it is clear that a broader, more diverse and culturally competent health care workforce is needed to provide crucial services.

Bridging that gap are community health workers (CHWs), trusted and treasured public health professionals who are a part of and solidly invested in their service community, CHWs connect people to social and health services. Sometimes paid, sometimes volunteers, CHWs are local people working part- or full-time with clinics, health centers, nonprofits, public health departments, medical practices, faith organizations and other agencies. They are committed to improving health knowledge and self-sufficiency in the neighborhoods they know and care about through outreach, education, informal counseling, social support and advocacy ... which also improves health outcomes.

Now, North Carolina is exploring a commitment of its own: to create a standardized system for training, delineating skills, paying and better integrating CHWs into the current, corporate health system of hospitals, medical centers and insurance carriers. The goal? Officially connect the dots between traditional health systems and boots-on-the-ground health care workers — in a word, empowerment, not just for CHWs, but also for patients.

The Case for Community Health Workers

Changes to health care law have created a new paradigm: the need to combine value pricing with more integrated team-based care. But to do that, first you have to understand the factors affecting how people receive care.

Studies show that the biggest boosts to health are not from traditional health care, such as the doctor's office or a hospital. The ability to thrive is actually based on where people live, work, pray and learn. The Robert Wood Johnson Foundation found that a person's health is 20 percent related to clinical care and 80 percent based on social and economic factors, health behaviors and the physical environment. The problems come when communities lack quality (or any)

STUDIES SHOW THAT THE BIGGEST BOOSTS TO HEALTH ARE NOT FROM TRADITIONAL HEALTH CARE, SUCH AS THE DOCTOR'S OFFICE OR A HOSPITAL. THE ABILITY TO THRIVE IS ACTUALLY BASED ON WHERE PEOPLE LIVE, WORK, PRAY AND LEARN.

resources or face barriers. People quickly go from thriving to barely surviving.

"We already experience immensely expensive downstream impacts associated with a lack of access to early childhood education, quality housing, child care, and affordable, healthy food," says Kevin Barnett, senior investigator for the Public Health Institute in Oakland, California. "All play a critical role in producing higher school dropout rates, delinquency, substance abuse, homelessness and unprecedented rates of chronic disease."

Barnett is part of the California Future Health Workforce Commission, a team tasked with defining credentials, training and deployment strategies for CHWs to better serve California's ever-expanding health needs with increased diversity and a solid plan to address health inequities by the year 2030.

"All of this costs a lot of money — and the cost is only going to go up," Barnett says. "Hospitals are looking down the road and seeing many people in communities without access to the basics, which means they are much more likely to be sick and in our ERs. Plus, providers are now being told care is about value and every time a sick person comes in — and has to come back — they lose money.

"That has the potential to push these health care system leaders, who are among the biggest employers in communities across the nation, to seek more robust engagement in the civic arena about better grocery stores, housing, schools, job opportunities and child care. It is so much bigger and with vaster impacts — and it should be. Now, it's going to be about investing in communities, which is very exciting."

Enter community health workers, and just in time.

The Case for Community Health Workers in North Carolina

As North Carolina's population grows and ages, so will the need for CHWs. A July 2017 Census Bureau report concluded that of the 10.3 million people in the state, 16 percent were age 65 and older. That percentage is only going to increase. By 2030, one in five North Carolinians will be 65 or older; by 2035, this population will outnumber children under age 18.

This is especially relevant, based on a North Carolina CHW Stakeholder Initiative survey last summer. Surveyed CHWs (168 in 42 counties) reported their largest client base was seniors over the age of 65 (47 percent) with multiple chronic diseases including diabetes (55 percent), heart disease (45 percent) and mental health issues (47 percent).

AS NORTH CAROLINA'S POPULATION GROWS AND AGES, SO WILL THE NEED FOR CHWs.

CHW activities included connecting clients to health care (80 percent), food assistance (54 percent) and transportation (46 percent). Clients included the uninsured (52 percent), those living with a disability (46 percent) and rural residents (42 percent). Based on the forecasts, the role of the CHWs in the health care delivery process is only going to increase.

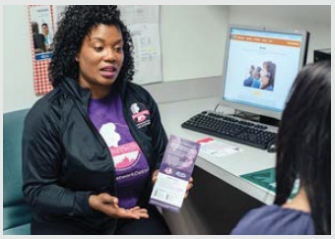
According to Tish Singletary, Community Health Worker program coordinator in the N.C. Department of Health and Human Services' Office of Rural Health, CHWs are the trusted, contextual experts of the communities they serve. They are both the outward- and inward-facing professional partners to health care systems and other organizations that want to practice whole-person health.

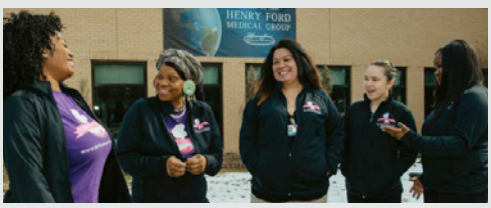
"Team-based care is a combination of whole-person care and accountable care communities," she explains. "That means there is no stopping of the health care community and beginning of CHWs. We need to include CHWs in the conversation about the care of the client/patient. The health outcomes for that client/patient are dependent upon the entire team. The health care community (a.k.a. team) all need to value the expertise of each other and create a level of service that is client/patient-centered.

READ MORE: A Day in the Life of a Community Health Worker

Wonder what a typical day is like for a community health worker?

Nada Dickinson works on a team within the Women-Inspired Neighborhood Network, a collaboration among four Detroit health systems, public health agencies, universities and more than 40 community partners to reduce the city's high infant mortality rate. She is also a health insurance navigator with Henry Ford Health Medical Center.





Read about how she serves as a "bridge of support" for those clients who need her at **stakeholderhealth.org/chw.**

Community Health Workers … *continued*

In turn, the client/patient should feel valued in the process.

"Time and again, I have heard feedback from CHWs who have clients that have reported negative experiences with the health care community, including cultural barriers, lack of time, and perceived disrespect and mistrust of the health care community. CHWs can empower and build the confidence of clients to address their needs with health care providers. CHWs can also assist the health care providers in building their confidence working with those patients."

It makes sense that the community should be an active participant in the healing of the community.

"One of our CHWs working through FaithHealthNC had a referral from the ER who needed help in something socially driven," says Jeremy Moseley, Director of Community Engagement for FaithHealth NC and a team member in the NC CHW Stakeholder Initiative.

"When the CHW and client got together, they realized they not only knew each other but were actually related. You can't train or design that kind of connection. If you have people from the community, with an ingrained sense of community, serving the community, they provide avenues of support the traditional health care system can't. There's faster trust and a sense of connection.

"CHWs have a social intelligence that is really just as smart as medical strategies and techniques. You need that to navigate these complex communities. It's a lot like surgery: You have to know the body to do surgery. The same goes for communities."

How Credentialing NC CHWs Will Look

The credentialing process is all about building an infrastructure for sustainability for CHWs in North Carolina. But how do you accomplish that when you have thousands of people working to connect people to wholeness with more than 150 job descriptions, such as HIV peer advocate, asthma outreach worker, wellness ambassador, diabetes navigator, addiction treatment specialist, care coordinator, mental health worker, bilingual family advocate, parent aide and more?

You do it carefully and slowly. The state aims to implement a standardized core competency training, create a certification process, develop a NC CHW Network, ensure CHWs are being paid a family-supporting wage and develop a process that includes a potential for specialized training.

The plan is to phase in some elements, such as CHWs supporting the Medicaid system in 2020. And it will be a rolling process. Current CHWs will be grandfathered in — some will go the employment route, and some will go the certification route. It's a plan built for success, for CHWs and for communities.

A World with CHWs Makes a World of Difference to Patients

More and more in this constantly changing health care world, we're discovering that it takes a village to care for the village. CHWs are a vital part of that village. North Carolina is working to formalize the status of CHWs and ensure their meaningful contributions for years to come.

"I envision that CHWs will become integral health care team members, as valued as they are in the communities they serve," Singletary concludes. "In a perfect world, there will be a coordinated network of CHWs which allows them a platform to coalesce around their professional needs and advocate for themselves and the needs of their communities beyond health. This future will include intentional multi-sector partnerships that work to eliminate those environmental and social factors that negatively impact health outcomes and value the efforts of CHWs as part of an equation to eliminate those factors."

Moseley agrees that the future of NC CHWs is bright with promise, as is the health of North Carolinians.

"I am excited about credentialing

CHWs, giving them the respect they deserve, fixing the social determinants and creating workforce opportunities in — and for — the neighborhoods that need them the most," he says. "I expect a more understanding world that realizes there are assets and resources that are positive in communities that we have not tapped into yet, like CHWs.

"These are pieces that can give us life and more wellness instead of focusing on disease, sickness and death. The goal is to leverage those pieces and change the way we think about health care and public health."

Community Health Workers Right FIT for Program Serving Formerly Incarcerated

BY MELANIE RASKIN

Imagine serving your time and, at last, being released from prison. Second chances can be tough if you don't have housing, a job or a medical home. It's even worse if you have a chronic disease, such as diabetes, kidney disease or mental illness.

To keep former prisoners from falling through the health care cracks, the North Carolina Formerly Incarcerated Transition Program (NC FIT) is working to pull them out with the help of community health workers—public health professionals who work with populations they know well to improve health knowledge and empower people.

NC FIT, a partnership of Lincoln Community Health Center, Durham Criminal Justice Resource Center, Durham County Department of Public Health and the N.C. Department of Public Safety, launched in 2017 to reconnect former offenders to "the real world."

Community health workers (CHWs) are vital to the process, says Program Director and Professor of Family Medicine at UNC-Chapel Hill Dr. Evan Ashkin. They use outreach, education, social support and advocacy to help clients re-enter successfully with a direct link to health care and a physician champion willing to show caring support, as well as essential information on transitional housing, vocational rehabilitation and community college education programs.

But FIT CHWs are different from their public health peers in 25 similar clinics across the country. FIT's CHWs are former prisoners.

"Our program is working because our CHWs have walked in our clients' shoes," Ashkin points out. "They have been there themselves and faced the same struggles and barriers, so there's a unique trust and rapport. They are true peer navigators for a population that is highly marginalized and often forgotten."

So far, two CHWs serving Durham and Orange counties have arranged for 50 clients to receive primary care services, providing support in the form of transportation to medical appointments, vouchers for clinic co-pays and help with driver's licenses. A third CHW was added for Wake County, and two more are joining the program in Mecklenburg County this fall.

FIT's unique approach is paying off: It has reduced use of emergency rooms by program participants and improved health and other outcomes. And there's the added bonus of providing formerly incarcerated individuals good jobs with benefits as CHWs, and a way to take care of their families and contribute to a community they know well.

"We worked with one client who was a diabetic," Ashkin explains. "When he was released, he may have had one month of meds and was housing insecure. He ended up in a diabetic coma for four days. We got him and now he's doing great. That one hospitalization cost more than a CHW's entire salary. If we had gotten the client sooner, we could have saved him pain and suffering, and saved the health care system a lot of money."

Ashkin emphasized his belief that everyone has a right to health care.

"Incarceration is the only time a person has a constitutional right to health care," he says. "That ends after release. These people leave prison with chronic disease and are not eligible for insurance. They can't even apply for ACA insurance. This is not rocket science.

"FIT is a completely sound financial argument. There are people who think we are expending public resources on folks who chose to commit a crime. But economically, it makes sense to provide basic primary care services, instead of having someone with kidney failure or diabetes end up at the hospital for long-term, expensive care."

Churches Care for the Caregivers

Rehabilitation Unit Receives Dedicated Support from Local Congregation

BY ERIC WHITTINGTON

Having witnessed life-altering care provided to one of their own, a local congregation is using the FaithHealth Unit Adoption Program to care for the caregivers.

Members of Center Grove Baptist Church in Clemmons are partnering with the Division of FaithHealth to provide care to the nurses, therapists and caregivers on the third-floor rehabilitation unit at Wake Forest Baptist Medical Center's Sticht Center on Aging.

The program, now entering its sixth year, is managed through the Department of Chaplaincy and Clinical Ministries at the Medical Center. It allows local faith communities to forge relationships that support the staff.

Center Grove Baptist Church members Mike and Robin Lancaster

"To care and be cared for requires the whole beloved community to participate," says Rev. Maria Teresa Jones, chaplaincy program manager for staff support. "Faith communities can and do make an incredible difference in the lives of professional caregivers and can create an ever-evolving healthy community for all."

Jones says the program can address such concerns as compassion fatigue, burnout and moral distress among caregivers. Faith communities provide prayer, support, care and comfort to everyone who works on a specific unit. Those caregivers can then give more fully compassionate care, along with nursing and medical skill.

"It's about building the relationships and letting them know that we care for them," says Gretchen Bayne, a Center Grove member and manager of wellness programs for BestHealth For Us at Wake Forest Baptist. "We're here to provide support and encouragement — whatever that looks like for them.

"Our church Life Group class thought it was a great opportunity to care for the people who cared for someone we love so much."

The Lancasters' Experience

That "someone" is a couple — Center Grove members Mike and Robin Lancaster. In February 2013, Mike awoke with what he thought was a migraine. When Robin heard Mike slur his speech, she realized her husband was having a stroke.

Mike, who was 44 and on the Medical Center's information technology staff, got the care he needed at Wake Forest Baptist and eventually moved to the Sticht Center's Acquired Brain Injury (ABI) unit for post-stroke rehab. He spent 10 weeks there over two years. The care was excellent throughout, and "I can't say enough about the nurses," Robin Lancaster says.

Rev. Maria T. Jones

Their friends from Center Grove visited regularly and saw the difference that the dedicated nurses and therapists made in Mike's recovery. When the Life Group learned about the unit adoption program in early 2018, they knew what they wanted to do.

"Children's floors usually get adopted first, and they were tickled that we were taking a different unit," Robin Lancaster says. "They took such good care of us, and we wanted to repay that."

Connections with Ripple Effects

Center Grove member Melinda Rice serves as a liaison between the group and the unit. She works directly with Jamie Brown, RN, unit nurse manager on the third-floor unit.

"We're just a small group of people," Rice says. "But when we come together, we can make a big difference in the life of one, which would be enough, or many if we're allowed to."

Members of Center Grove Baptist Church visit with nurses and staff on the third-floor Rehabilitation and Acquired Brain Injury unit at the Sticht Center

BROWN SAYS THE CENTER GROVE MEMBERS HAVE HELPED THE STAFF IN THE REHAB/BRAIN INJURY UNIT SEE THE LASTING IMPACT THEIR WORK HAS ON PATIENTS AND FAMILIES.

Brown says the Center Grove members have helped the staff in the rehab/brain injury unit see the lasting impact their work has on patients and families.

"Center Grove Baptist Church has been overly generous and inclusive to be sure that all members of the team are cared for, including those that work night shift and members of all interdisciplinary teams, including nursing and therapy staff," Brown says. "They have provided snacks, support and meals, along with a positive and uplifting spirit to the unit."

Ellen Thompson, chaplain for the unit who coordinates monthly visits with the group, says the support of faith communities can uplift staff and spread beyond.

"The circle of shared spiritual and physical well-being travels through the employees to the Medical Center's patients and families, developing into healthy community relationships," she says.

"The Sticht Center's Rehab and the ABI Unit is the perfect place for relationship building because it is often an area of the hospital where connections and bonds are finding hope and new beginnings."

A Consistent Way to Serve

The Center Grove group includes about 30 people, according to Life Group leader Ray McDowell. He says the goal is to fulfill the church's mission to love, grow, serve and share.

"Our church does a lot of outreach, but as a group, we were looking for something we could do on a regular basis to complete that," McDowell says.

"Right now, we're bringing food and that's a good thing, but we're also looking for other things, to relate more, to really care about these staff and caregivers, and to find opportunities to do things that are more personal for them."

In September, the group made its third visit to the floor and set up a prayer box for the staff. Ultimately, every act is designed with the caregivers in mind.

"I hope the nurses and staff realize how much they're loved and appreciated," Robin Lancaster says. "As a patient, it can be hard to convey that when you're overwhelmed by this major life event that's just happened. It can be easy for the nurses and staff to get overlooked and overshadowed. We want them to know that they are noticed and hopefully just share the love of Jesus with them."

Innovative Leader Puts Faith and Compassion in Play

Downtown Health Plaza and Director Robert Jones Always Find a Way

BY LES GURA

Robert Jones, PhD, speaks softly, in the gentle Southern accent of his native Scotland County, North Carolina. Behind that quiet voice, though, lies a powerful life purpose.

And a mighty pen.

Jones is director of the Downtown Health Plaza (DHP), a center that serves the underinsured and uninsured in Winston-Salem. Beyond the 11 years at DHP, Jones has spent four decades fighting for people who often don't have or can't access proper health care.

"Robert is a very unassuming individual," says Karen Gerancher, MD, residency program director of Obstetrics and Gynecology at Wake Forest Baptist Medical Center, which operates the DHP. "He does not walk around saying, 'Look at what I've done.'

"You obtain knowledge of what he's done by experiencing it. All of a sudden one day, there's access to something for our patients that has not been here before. Well, Robert wrote a grant."

An Early Calling

When Jones was 10, a pharmacy sent a delivery boy who was African-American to his home to bring medication for his grandmother. The delivery boy was hot and tired after a long bicycle ride and so Jones grabbed some allowance money, ran up the street after him and told the youth his grandmother had forgotten to give him a proper tip.

Over the years, he accepted this social justice component of his personality and its influence on his life.

- While attending the University of North Carolina – Wilmington, he traveled to Ecuador with 11 fellow students to collect vampire bats for a Smithsonian Institution project on food insecurity.

- After graduation, he joined the Journeyman program through the Southern Baptist church he'd grown up in, working with a physician in Honduras — where he became fluent in Spanish — to provide clinics in remote locations.
- He came home to obtain a PhD in nutrition from Mississippi State University, and then took a job to address hunger and malnutrition in poverty-stricken Senegal.

Jones returned to the U.S. in 1992, eventually becoming assistant health director for preventive health for Forsyth County. In 2000, he was recruited to join the county-run Reynolds Health Center in Winston-Salem, the predecessor to the DHP. Center Director Michael Clements says Jones "understood how to deal with human beings and folks in a way that would get the best outcome."

And so Jones got to work writing grant applications and running day-to-day operations. Soon after, Reynolds Health Center came under full control of Wake Forest Baptist, which built the Downtown Health Plaza to replace Reynolds. When Clements left in 2007, Jones succeeded him.

Pursuing Innovative Programs

Despite operating $1 million in the red annually, the DHP under Jones' leadership has enacted many innovative programs, including:

- Centering Pregnancy, which provides prenatal education and care to expectant moms and encourages breastfeeding as a way to reduce post-partum issues for mother and child.
- The introduction of a behavioral health specialist in many DHP clinics so that patients with anxiety, depression or other mental health issues can be seen by a professional at the same time they have their medical appointment.
- A community garden that has vastly grown over the past 10 years and offers free fresh vegetables to patients and their families.

> "THE COMMUNITY WE SERVE HAS A VERY FAITH-CENTRIC APPROACH TO LIFE. SO IF YOU'RE SERVING PEOPLE WHO HAVE THAT VIEW OF THE WORLD, YOU HAVE TO MEET PEOPLE WHERE THEY ARE."
>
> ROBERT JONES, PHD
> DIRECTOR, DOWNTOWN HEALTH PLAZA

- Free or reduced-cost transportation to the DHP through a variety of sources for any patient who needs a ride.

Gerancher says the behavioral health program has been a godsend for physicians and patients.

"I don't know what word to use to say how important it is. The patients probably didn't see themselves as having access to those resources," she says. "The fact that they didn't have to ask and it was there — especially for those who don't have English as a native language — is huge."

Community and Dignity

Jones says one of the more difficult parts of his job is persuading financial administrators of the hidden value behind the emphasis of nearly every program at DHP, which is preventive care.

He is most successful when administrators who might not be aware of the challenges facing the underserved population take the time to visit — seeing how patients are treated by the entire staff.

"What we do is we are very in touch with the population we serve, and we look for a way to improve their outcomes. We can say that we prevent some more serious problems," Jones says.

He gives examples to back it up. There was a man living in an apartment complex who Jones noticed on a Medicaid report had gone to the emergency department six times in three months by ambulance — a very expensive proposition. It turns out the man had a leg problem and didn't feel he could walk to the DHP. Jones spoke with him about the expense of going to the ED and soon the man was using bus passes the DHP provided to get to his appointments. "He loved that; he said he'd much rather come here."

There was a woman who burst into tears at her medical appointment because her son had been killed in a drive-by shooting. It turns out she had borrowed money to pay for his funeral and because of that had not paid her rent and was being evicted. After being calmed by her behavioral health provider at DHP, the entire care team, which included a patient navigator, helped get the eviction stopped to give the patient more time to figure out what to do.

"We're not just saying, 'Well, here's your prescription I hope it all goes well,'" Jones says. "We're going to listen to your story, and we've got ways to assure that your needs are met so that you can take care of yourself better."

In the end, Jones says his work is about faith and spirituality.

"The community we serve has a very faith-centric approach to life," he says. "So if you're serving people who have that view of the world, you have to meet people where they are."

Clements knows his former colleague and longtime friend has the faith and sense of community necessary of effective leaders.

"The attitude he brings, a belief in the human condition — and what to do and how to react to that — is outstanding," Clements says. "We need a lot more Robert Joneses in the world."

The Science of Faith-based Assets

BY REV. GARY GUNDERSON

NATIONAL ACADEMY OF SCIENCES

You appreciate facts when the fog of conflict is greatest. So it's not entirely surprising that, just as Robert E. Lee was preparing to launch north into Pennsylvania in hopes of surrounding Washington, D.C., Abraham Lincoln created the National Academies of Science (NAS).

Lincoln created this trustworthy structure that could be used by any department to investigate, examine, experiment and report upon any subject of science or art. Once Lee was turned back at Gettysburg, this new body addressed coinage, weights and measures, iron ship hulls and the purity of whiskey.

Today, in a time of polarization second only perhaps to the Civil War, the NAS remains a well-oiled engine of inquiry, conducting an extraordinary array of blue-chip reports on the most technical, practical and controversial subjects. The NAS has two basic forms of study, one to conclude a subject by reaching an expert consensus and a second to open a subject up, through a broad and curious Roundtable. I serve on the open-it-up body, representing both Wake Forest Baptist Medical Center and Stakeholder Health.

Last March, the NAS Roundtable on Population Health Improvement held a public workshop on the campus of Shaw University in Raleigh, N.C. It opened up the subject of how the networks and social structures of faith are assets for public health.

Shaw, the educational jewel of the General Baptist State Convention, was established by an ordained Union soldier to educate former slaves, and it knows about conflict and facts. Seminary students crafted the bricks for the nation's first four-year medical school (months before Harvard), and it was later closed in the Flexner reforms that standardized medical training — with no small racial bias that lingers today.

The March workshop opened up the subject at the center of two moving fields: What are the assets of the broad and diverse "communities of spirit" in the 21st century? And what do those assets have to do with the rapidly evolving bodies of science and technique of population health?

These are brave questions at a conflicted time. It's easier to simply say they are separate, and the more separate the better, but that would be looking away from exactly where the most interesting opportunities lie.

The workshop brought together a range of examples of boundary-spanning collaboration beginning with an opening presentation by Dr. Prabhjot Singh of the Icahn School of Medicine at Mount Sinai. He noted that 350,000 U.S. congregations overlap with 250,000 neighborhoods, together forming the "connective tissue" that must be understood to improve population health.

THE WORKSHOP OFFERED BRAVE QUESTIONS AT A CONFLICTED TIME.

"At a time when public health and health care institutions are both trying to work more concertedly to improve population health, they are finding common ground in neighborhoods," Singh said.

The sheer spread and scale of these neighborhood-level assets was further opened up by the simple, but profound, matrix that came from the work of the Africa Religious Health Assets Program. All of these assets can be understood as having tangible, intangible, immediate and long-term kinds of effects on health over a lifespan. The 350,000 congregations — communities of spirit, since they are not all Christian — are themselves complex social entities.

The key question is how these many complex assets can be woven into collaborations that advance the health of the whole community. The workshop raised up examples of this work in Chicago, Alabama, California, Mississippi, Memphis and North Carolina, including large-scale outcome data.

Each of these examples could easily have absorbed an entire day, and the workshop opened up a subject that will take years to unpack. Many of the most interesting large-scale collaborations are quite young — Memphis, the largest, just marked its 10th anniversary. Many share work at smaller scale. Few have a full and robust evaluation process that allow for real comparison across different social-economic settings.

A full monograph from the meeting will be published by the NAS this fall, along with supporting papers about the underlying theory of Communities of Spirit and working with these complex collaborations. Links to brief workshop proceedings, videos and other resources are available online at faithhealthnc.org/nas.

FaithHealth Learning Forum Spreads Ideas, Practices

The FaithHealth division staff got enough calls from people from around the country asking for help in developing programs similar to those at Wake Forest Baptist Health that they decided to offer a day-long workshop twice a year.

"It's low-tech and highly relational," says Emily Viverette, director of FaithHealth Education, who manages the Learning Forum. "There aren't a lot of PowerPoints or how-to's. It's really conversations with folks doing the on-the-ground work here."

Participants hear the theory and funding of the initiatives. This is followed by an interview session where FaithHealth staff describe their various roles. Then, in an exercise called "Shift and Share," small groups move around the room for interactive briefings on various topics such as community engagement, research and evaluation, and working with targeted populations.

The forums are open to anyone and usually include an interesting mix of participants: clergy, senior-level hospital leaders and people from community agencies. "The broader and more diverse, the better the conversation," says Viverette. "And we always see this as collaborative learning. We learn as much from the people who come as those who share."

While most participants come from North Carolina, others come from across the country. Viverette reports that the last Forum included people from West Virginia, Texas and New Jersey. Many spend an extra night to come back the next morning for an open session that's smaller and more tailored to dialog on specific issues.

"So, if I were working in a hospital and had been hearing about this "FaithHealth" thing, this is the kind of program I should come to," says Viverette. "Sometimes, we have people who have been tasked by their administrators who tell them, 'We want to do this work. Go figure out how to do it.' They send people to the Learning Forum for that purpose."

Their backgrounds vary widely, she says. "Some are chaplains, some are nurses and others work with community benefit."

Over time, the forum is building a learning community of people that stretches across the state and the nation. Donna Stauber of Texas-based Baylor Scott & White Health says she was able to learn what the various speakers did in their day-to-day work.

"I saw how they referred the patients, how they worked with the CPE [chaplaincy training] programs, how those chaplains were interacting and placed around the city at the different homeless shelters and domestic violence shelters," she says. "I saw how they connected with the community. It was a short day-and-a-half conference, but it had pretty much all of the things you need to get an idea of what Faith Health is like."

The October Learning Forum attracted clergy, senior-level hospital leaders and people from community agencies.

Participants like Stauber take what they learn and adapt them to fit the work in their own communities and situations.

"We have taken Wake Forest's model of the 'connector,' a retired nurse or other professional who is willing to spend, say, eight hours a week maybe working with 20 or 25 churches to connect that area," she says. "That is working really well."

"There's a lot of energy and lots of fun at the Learning Forums," says Viverette. "And we learn something every time we do it."

– TOM PETERSON

Q&A

The Work of Missions

With Paul Langston

Paul Langston, missions mobilization consultant for the North Carolina Baptists, helps churches involve their members in missions through local, state, national and international projects. He discussed his work with the Rev. Leland Kerr, a FaithHealth NC liaison with the Baptist State Convention of North Carolina.

Paul Langston, MDiv, DMin

Leland Kerr: You all have a lot of different projects at any point in time, including some ramp building that particularly impacts some people's ability to receive health care.

Paul Langston: Yes, Dennis Holloway in Richmond County has a team that builds a ramp every week, 50 or 60 a year. They just built a ramp for a young man who has cancer in his legs. The family didn't have a ramp so they were having to carry him out of the house to receive treatment. They were going as rarely as they could, and when they did, it put his mom and dad at risk of injuring themselves. This team built the ramp, and now the young man has easy access in and out of the house. There were projects in about 200 different churches that we know of, and probably two or three times that many that didn't report back.

Kerr: I know a project you've been working on just in the last week — tell me about the Bethel Colony of Mercy.

Langston: This is a treatment center for men facing addiction that's been a men's campus in downtown Lenoir for 70 years. They recently felt led to begin a women's campus, a rehabilitation program for drug addiction, and purchased a camp that had been unused for several years. The camp isn't in horrendous condition, but it wasn't really usable. The first step was renovating two cabins and making them habitable for women. We've put some floors in, did some painting and replaced toilets, sinks and vanities with functioning ones.

Next we'll repair the director's house. They're praying to open up Oct. 15 and already have a waiting list of women. This is through an Impact NC project. I've been told there are 30-some odd centers in North and South Carolina for men, and only five for women. It's a tremendous area of need. Most of the women's centers are small, and this one will begin with 13 women. A third cabin they're renovating will allow them to take eight more. Then they've got other buildings on the property so in the coming years they'll expand further.

Kerr: I understand this will be fairly affordable.

Langston: It's almost free. They ask the students — that's what they call them — to pay $250. It's a 65-day residential program. Everything other than that is through donations.

We're working with another ministry in Oxford, the Greater Joy Baptist Church, an African-American church, that's planning to build a transitional house for men who have gone through addictions and are getting their feet back on the ground. Later they'll add housing for women.

Kerr: These projects, often well-kept secrets, are happening all over North Carolina. Relief from hurricanes and other disasters has been around a long time with North Carolina Baptist Men and Baptist Home Missions. People don't often realize what continues after the initial wave we see on television.

Langston: Hurricane Matthew is a good example. It hit North Carolina about two years ago. In the early part, we provided a half-million meals and tore out several hundred homes. Ongoing, we've had rebuilds in five sites: Lumberton, Goldsboro, Windsor, Black River and Warsaw. We've been able to see 260 families and counting move back into their houses after volunteers have worked.

Following this interview, Hurricane Florence hit North Carolina, and N.C. Baptists on Mission are currently engaged in disaster relief and recovery efforts that will continue for quite some time. To learn more about N.C. Baptists on Mission or to donate, go to **baptistsonmission.org.**

People *and* Events

New Hires

- **Nathaniel Lenny Burrison III** is staff chaplain.
- **Andrew James Finkler, Taylor Brooke Pisel Miller** and **Samantha Renee Fields** are associate behavioral health clinicians at CareNet.
- **Tracy Lynne Herrin** is CareNet accounts specialist.
- **Jeanne McNeill Butler** is senior secretary at CareNet.
- **Christina Lynn Stakely** is marriage and family therapist at CareNet.
- **Paula Elaine Briedis** is Carenet staff counselor.

Hatch Lecture Series

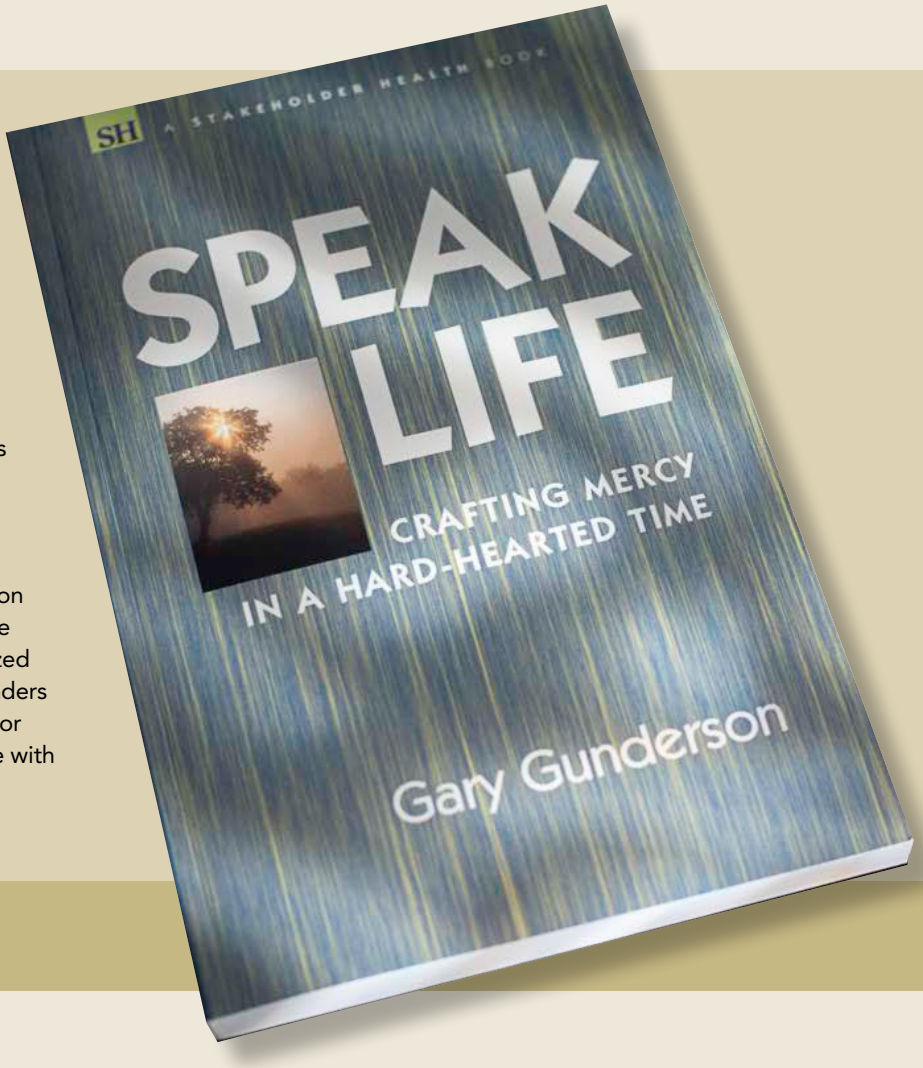
The Third Annual John W. Hatch FaithHealth Lectures will take place at Shaw University in Raleigh, Tuesday, Nov. 27, 2018. The keynote lecturer will be **Rev. Dr. William Barber II.** The event is free and open to the public. For questions, please contact Dawn Hall at dmhall@wakehealth.edu.

New Book: *Speak Life*

Speak Life: Crafting Mercy in a Hard-hearted Time
By Gary Gunderson

Speak Life represents another step in the journey of stakeholder health, a network of mission-focused, charitable and faith-based health care organizations that shares ideas and inspiration to foster health of communities.

The movement believes that together we can build communities in which every person counts, where no one is left out and no one suffers needlessly because of institutionalized unfairness. *Speak Life* offers thoughtful readers opportunities to explore their own hopes for abundant life, for themselves and for those with whom they share life in community.



Available through Amazon or online at **stakeholderhealth.org.**

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RESOURCES

CareNet Counseling,
a professional, community-based counseling organization, helps clients restore and maintain mental wellness.
carenetcounseling.org

Center for Congregational Health
provides ministry and training for hundreds of churches, clergy and lay leaders each year.
healthychurch.org

Chaplaincy and Pastoral Education
provides spiritual care for hospitalized patients and their loved ones, and offers accredited programs in Clinical Pastoral Education. For information, or to contact a chaplain, call **336-716-4745.**
WakeHealth.edu/Chaplaincy-and-Pastoral-Education

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