

FaithHealth

Spring 2019

pg 4 \ **All Hands on Deck:
Roles in FaithHealth**

pg 8 \ The Activated Congregation

pg 10 \ The Perfect Storm of Care

pg 14 \ Why Should We Care about Medicaid?

Healing through a Tenacious Blend of Mercy, Justice and Compassion

The town was mostly long gone, the factories and downtown stores with more ghosts than workers or customers. Hard-working people with hardly any work to do. Everything struggled—the restaurants, roads, post office, clinics and churches. Disease and addiction followed the path of least resistance, shattered families and allowed despair to reach epidemic levels.



Rev. Gary R. Gunderson

This was Zambia in 2005, but it could be Mount Airy where yet another factory recently closed. It's time for all hands on deck, which is what this issue of the magazine describes—roles for all of us.

The World Health Organization wanted to know if the faith networks actually had any relevance to the vast health problems. Leaders of health policy in North Carolina are asking the same thing.

The answer is to focus on what we do have, not what is missing. We were in Zambia to pilot a new way of seeing the community as a place of assets, not just needs. We've used the same technique in Wilkes and looking out the back door of the Winston-Salem jail. Some of the same conditions show up: HIV/AIDS was the driving issue in Zambia, and it still is one of the highest cost challenges in downtown Winston-Salem.

We'll be looking for assets all over the state of North Carolina as the fundamental architecture of the relationships between government, church, hospitals and community organizations shifts quite dramatically as \$6 billion of care for the poor is invested in whole new ways.

In a tough neighborhood in Ndola, I noted a sign above a corner store: General Dealers, Shalom. Faithful folks no matter how tough the streets. That's the answer, really—there then, and here now. What the bleeding-edge health experts call "integrated health" and "population health" driven by the "social determinants of health" are nothing more than a screaming call for the most ancient of all ideas: shalom in Hebrew, salaam in Arabic, Bophelo in Lesotho.

What heals is a tenacious blend of mercy, justice and compassion. This only comes to life on the tough streets and lives when communities of spirit train themselves to be general dealers of shalom. This is not the same as picking one or two issues to delegate to a committee of gullible do-gooders.

This issue is for grown-ups who do not yearn for the quick and slick answers. This is about the complex and comprehensive work of being a community of healing, of seeing the long path of becoming a fit instrument for God's expansive love for the world God so loves.

You can see the stages of development that take years, even decades to mature and bear the fruit of mercy at community scale. You can see what has grown strong when the wind blows hard and water rises high. Last fall, that happened in Wilmington, and the community saw that it had grown the kind of strong bonds no wind could match and that would remain long after the TV cameras left.

Shalom. We're open for healing.



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



FaithHealth

Contents \ Spring 2019

4
FaithHealth: All Hands
on Deck

6
The Activated
Congregation: Five Levels
of Engagement

8
Community Engagement

9
Chaplaincy and
Spiritual Care

10
Special Communities

11
Integrated Behavioral
Health

12
Data, Evaluation and
Mapping

14
First Responder
Chaplaincy

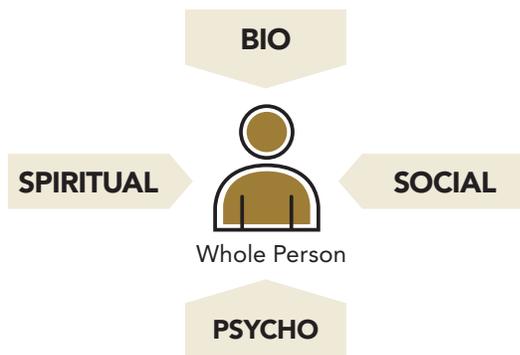
16
The Perfect Storm of Care
Serving Eastern North
Carolina Clergy During
Hurricane Florence

18
Q&A with
Richard Lord, MD

19
FaithHealth is Now a
Podcast
.....
Mother's Day Offering
Thank You



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FaithHealth is a set of dynamic partnerships among faith communities, health systems and other providers focused on improving health. The partnerships combine the caring strengths of congregations, the clinical expertise of health providers and a network of community resources, with partners linked in a shared mission of healing.

[Learn more at FaithHealthNC.org.](http://FaithHealthNC.org)



All Hands on Deck: The Roles in FaithHealth

BY EMILY VIVERETTE

FaithHealth roles are ever-evolving, fluid and grounded in trust. They work together with community partners, clergy and congregations to create a coordinated web of care to get people to the right door at the right time, ready to be treated and not alone.

Congregations provide volunteers to extend compassionate care beyond the walls of the medical center and agencies. Each FaithHealth role offers a strengths-based approach and serves as a bridge between human beings and resources for health. The roles typically involve some combination of caregiving and capacity building.

Connectors, a part-time, lightly funded role, provide hands-on caregiving, such as delivering meals, while also recruiting and training volunteers. Most are recruited as connectors because they are already deeply trusted in the community or in a specific social network, such as a denomination or in an agency, like the Hispanic League. Many were doing FaithHealth work before FaithHealth existed.

Supporters of health are full-time staff who are a nuanced mix between a community health worker and peer support specialist. As individuals with similar lived experiences to their clients, supporters work within specific ZIP codes, which they know well, to navigate complex referrals and provide sensitive care. Supporters can connect clients with primary care appointments and medication, complete insurance paperwork, deliver food and much more.

Chaplains are clinically trained full-time employees of the health system who work both inside and outside the walls. Inside the medical center, they offer spiritual care and triage

and make FaithHealth referrals. Outside the walls, they share the FaithHealth message in the community and seek to collaborate with faith communities and agencies to build capacity for FaithHealth work. Chaplain managers provide hospitality and some education to visiting clergy, whom they recognize as partners in community health and well-being.

FaithHealth fellows are full-time employees in agencies or systems committed to improving health in their communities. They commit to an 18-month educational program that is primarily a collaborative partnership. Many fellows have been chaplains, though previous fellows have also included a faith community nurse, a care coordinator, a counselor and a program manager at a public health department. They serve to develop FaithHealth capacity at a system level.

CareNet counselors are licensed mental health professionals who provide education and support for clients and families. These counselors are located in CareNet Centers across the state and specialize in spiritually integrated counseling. They recognize the value of faith in supporting the mental health and wellness of their clients.

FaithHealth roles work across the bio-psycho-social-spiritual spectrum to improve access and seek systemic solutions to gaps in care. Ultimately, no matter the specific role, FaithHealth is about neighbors helping neighbors and building a community of health that embraces the significance of faith.

The Activated Congregation:

FIVE LEVELS OF ENGAGEMENT

In many languages of the world (except English), it is simply not possible to say “faith” and not mean “health,” or to ask about one’s “health” and not include the state of their spirit. This is why this magazine is named *FaithHealth*, without so much as an empty space in between. We are complex and wonderfully made, says the Psalmist, not bolted together of separate parts, but seamlessly woven.



All this can also be true of the social structure of faith, the congregation, which Paul spoke of as the very body of Christ. There is no congregation that is not also a ragged gaggle of humans of all ages and sorts that comes together to worship but also to drink coffee, and catch up with neighbors, sports and local politics. We tend to each other’s development and, inevitably, healing when we are wounded and just as inevitably, caring when we enter into our time of dependence even unto death.

This is how it works among humans on this little planet—not faith over there in the little box called church and not health over there in the big box called hospital. Every moving part of both (and all the institutions in between) has implications that are biological, psychological, social and spiritual. There was a time in the last century when it looked like we could build a society in which all the organizational bits and parts could be separate and specialized. But 21st century science calls us back toward integration at community scale, especially over time.

So it is critical that leaders within the congregations give thought to how their congregation might be organized to live into this more integrated, whole, seamlessly-woven human fabric that includes the hospital and public health. For some this may be a new thought that begins with simply meeting the local hospital people. It may be a new thought for the hospital, too! But you can probably be introduced by some of your own members or a neighbor who works there! There are many other steps along the way as the relationship grows naturally toward greater collaboration built on appreciation of the complementary strengths.

– GARY GUNDERSON

SO IT IS CRITICAL THAT LEADERS WITHIN THE CONGREGATIONS GIVE THOUGHT TO HOW THEIR CONGREGATION MIGHT BE ORGANIZED TO LIVE INTO THIS MORE INTEGRATED, WHOLE, SEAMLESSLY-WOVEN HUMAN FABRIC THAT INCLUDES THE HOSPITAL AND PUBLIC HEALTH.

LEVELS

5

STRENGTHEN COMMUNITY STRUCTURES

4

OWN THE HEALING STORY

3

BUILD CAPACITY

2

SHARE & CARE

1

CONNECT



■ Connects to local public health and social services, both governmental and private.

■ Might have recognition day for its members who work in these settings.

■ May attend public meetings to offer words of support.

■ May have education days and materials to help people enroll in programs such as Medicaid, the exchange, financial help from hospitals, etc.

■ Claims the work as their own by telling their story in which they are their own heroes.

■ Not somebody else's story (the hospital) but their own strengths, capacity, structures.

■ The hospital (and others) play enabling and supporting roles, sometimes quite important.

■ Secretary, youth director, choir leader, assistant women's prayer group leader and others find key roles—along with members with medical training whether employed or retired.

■ The clergy or care team trains, learns and adds capacity.

■ For example: Clinical Pastoral Education, Center for Congregational Health, Community Nursing, Area Health Education Centers, FaithHealth, etc.

■ Key: this is congregational capacity, not just individual credentialing.

■ Best if congregation and hospital somehow jointly honor this.

■ A complete cycle of care for at least one person jointly cared for by the hospital and congregation.

■ Care goes beyond members to include neighbors.

■ Currently about 500 congregations at this level.

■ Congregation makes itself known. Hospital has contact information for clergy or care team partners of congregation with some acknowledged roles. This could be developed around free parking.



Community Engagement

JEREMY MOSELEY is director of FaithHealth Community Engagement. He formerly worked with the North Carolina Division of Public Health.

Supporters and connectors. I oversee a group of “supporters of health.” Traditionally, they’re called community health workers. These former environmental services staff are our hands, eyes and feet out in the community. They perform a lot of the home visitation that our patients need or request. These are often individuals who do not have family members or social networks involved in their care. We provide a sort of extended family through our supporters. I also oversee a group of “connectors” who provide similar support but who also build the social networks around the patients.

Supporters are medical center employees, part of our operations, while connectors are more of a contracted role, paid a stipend a day or two per week. The supporters are more directly involved. If you think of community case management, of what social work would look like in the community, they provide a similar function. Their skill set allows them to enter into complex neighborhoods and communities.

Connectors can do some of the same but are often individuals who work full time or are bi-vocational, so they may not have the time or ability to do some of the hands-on work our supporters would do. But they have relationships that extend beyond our supporters’ network. They bring new partners to the table such as civic organizations, faith communities, sororities and fraternities. They have direct relationships with those entities.

Angela Brown, our patient or client referral coordinator, handles the influx of referrals we receive over the phone,

through email, through our electronic medical records system, through our website and through walk-ins. She speaks with the individual or provider, assesses the referral to see if it’s appropriate for FaithHealth to get involved, and makes sure we get permission to get involved. Then, she assesses what type of network or staff member should get involved.

It takes a village. Most of our success stories involve multiple components of our health system, such as our discharge planners or care coordinators. Or we may make a referral to CareNet for more counseling. These successes involve the entire health system inside the walls and the team outside in the community. It takes a village.

One individual had been in-patient for about a month. The care coordination team was unable to figure out how to discharge this individual because they had come into the hospital walking but would be discharged with the use of a wheelchair.

That person’s total life had just changed. Who else to call but FaithHealth? We identified the need for a wheelchair ramp in order for the patient to gain entry into their home. We had a Baptist connector who knew the ministries within the Baptist network involved with building ramps. He immediately contacted one of our local



congregations, and the lead member of that ministry reached out to the patient’s family.

He arrived at the patient’s house to assess the situation and look at coding situations, so they get very detailed about their methods. That build took no longer than a week or two. The materials were paid for in part by that congregation but also with involvement with Care Coordination and FaithHealth. As soon as that ramp was built, the patient was discharged.

Beloved community. FaithHealth is about creating a beloved community. You can’t put a timeframe on that. And not putting a time frame on that has allowed us to move at the speed of trust. That requires us to not only meet short-term metrics but also plan for long-term goals and solutions.

FAITHHEALTH IS ABOUT CREATING A BELOVED COMMUNITY. YOU CAN’T PUT A TIMEFRAME ON THAT.

Chaplaincy and Spiritual Care

JAY FOSTER served as director of FaithHealth Chaplaincy and Clinical Ministries. He is a board-certified chaplain and educator. He was recently recruited to the position of vice president of spiritual care chaplaincy and congregational partnerships with Indiana University Health System.

Traditional and evolving roles. What a chaplain does really is attend to issues of meaning and purpose in people's lives. A chaplain is specially trained to work with people of all faiths or of no faith, to be with them and listen to them as they work with issues of faith, concerns and questions they have. In the hospital, that also looks like some very specific things: We're there when someone is dying. We are there when there's a crisis. We're there to help with things like living wills and advance directives.

I'd been a hospital chaplain for 25 years, and I thought I knew something about it. With the advent of FaithHealth about five years ago, Gary Gunderson said something wonderfully challenging to me: People come to the hospital for treatment, but they go home to get well. To build relationships with congregations and community resources ahead of discharge and give an actual name to somebody who goes out the door, that's effective.

Bridging to the community. The idea developed of a chaplain who has one foot firmly in a clinic and a bridge to

community resources outside that clinic. We began placing some of our chaplaincy residents in clinics, starting with the Downtown Health Plaza (DHP). DHP sees anybody who wants basic medical care, folks who are in need. So, we placed a resident there who works with a team of physicians, social workers and sociologists to meet the spiritual needs of patients and make connections.

In the last four years, the institution has acquired or built four community hospitals. And from the beginning, the division decided that it would be good for chaplains to be, in some ways, the face of FaithHealth in that community. If chaplaincy is going to thrive in the next century, it's going to be because we are able to really do this well: provide spiritual care in the clinic and for those who are really vulnerable help provide that resource in the community. So our chaplains in the smaller community hospitals divide their time between spiritual care and community engagement, finding those congregations and community resources that meet needs, and building referral networks and relationships that connect.



A CHAPLAIN IS SPECIALLY TRAINED TO WORK WITH PEOPLE OF ALL FAITHS OR OF NO FAITH, TO BE WITH THEM AND LISTEN TO THEM AS THEY WORK WITH ISSUES OF FAITH, CONCERNS AND QUESTIONS THEY HAVE.

Boundaries. Efforts are being made within FaithHealth to figure out where do we set a boundary and when do we say no to someone. A major gift of the chaplain is to provide spiritual care. If we say no too early to a referral, does that impinge upon that spiritual care conversation? Or is it our job to take all the referrals that come, provide spiritual care, try to meet that referral and if we are not able to meet it, be able to say, "I'm praying for you, I care for you, even though I can't meet these social determining needs?" So that's at least one way that I'm struggling with that boundary.

Special Communities

The FaithHealth model includes staff who focus on specific populations, such as homeless people, first responders or those who live in a certain area. **FRANCIS RIVERS MEZA** is a certified educator who supervises chaplain students in the Clinical Pastoral Education (CPE) program. He also serves as FaithHealth liaison with the Hispanic/Latino community. Here, he discusses how an ID card program helped unify disparate groups in the community.

Born from dialog. The FaithAction ID card program started in Greensboro and emerged from a dialog between the faith community, primarily the Hispanic/Latino faith community, and the Greensboro Police Department. The police had realized they weren't receiving reports of crimes or domestic violence because undocumented people were afraid to interact with law enforcement. So, after some difficult conversations in which trust needed to be built, the idea of an ID card emerged. Greensboro police worked with FaithAction to establish a process that allowed for stringent vetting of the applicants.

My involvement in the ID program began in 2014 through the asset mapping events we held in predominantly Hispanic/Latino neighborhoods in Winston-Salem. We learned of the tremendous need for an ID for undocumented people. We partnered with the Greensboro group to begin a program in Forsyth County that provides people with an ID that's recognized by the sheriff's office and the police department. Both Novant Health Forsyth Medical Center and Wake Forest Baptist Health agreed to accept the ID as a way to identify patients — from the emergency departments to the clinics.

From this effort emerged a network — of local clergy, primarily, but also some nonprofits — that carried out



the ID drives. Members of this network also respond to requests for help from Hispanic/Latino individuals.

Being better neighbors. One of the biggest challenges we're facing is that undocumented immigrants now are seen as potential terrorists. We're seeing a racialization of immigration. So people have been driven further and further into the shadows. There's tremendous fear and suspicion. If you want to be a better neighbor to the Hispanic/Latino community, find some people willing to enter into what would probably be a difficult dialogue with you. If they are willing to extend to you the credibility and trust that they have in the

community, then a broader conversation can begin. Just listen to the community, see what emerges and be willing to hang on for the ride.

Other things can emerge. In Greensboro, for example, the arts community used the ID card to invite people who have never been to a concert to come to one, and kids who have never been to a music or art class to take classes. So the ID card can help build interaction and trust with groups other than law enforcement.

A real contribution. I'm learning to overcome my own bias that the immigrant only has needs. On the contrary, immigrants have much to offer. Drive along Sprague and Waughtown streets in the South Side neighborhood of Winston-Salem. Largely abandoned 10 years ago, these streets are now being renewed thanks to small businesses and restaurants. The Hispanic/Latino community is making a real contribution, especially in areas of the city that would be falling by the wayside were it not for the energy and entrepreneurship of migrants.

Building trust. I'm most grateful for the friendships I've made with other clergy and community partners. I don't know that the Hispanic/Latino churches are different than any other churches, but they tend to be pretty siloed: the Catholics don't talk to the Protestants, who don't talk to the Pentecostals, who don't talk to the evangelicals. The ID card drive brought together this unique blend of people across faith backgrounds. We began to trust each other. We now go to one another's churches and visit one another's homes.

Integrated Behavioral Health

BRIAN HATCHER is president of CareNet Counseling. A part of FaithHealth, CareNet is a professional counseling organization with 37 locations across North Carolina. Hatcher is an ordained minister and licensed clinical social worker who is pursuing a PhD in public health. Here, he discusses CareNet and how it addresses various issues.

What is CareNet? CareNet participates in FaithHealth through our counseling ministry. We consider ourselves an extension of local faith communities. With people hurting everywhere, pastors and others can't do all the work that's needed, so we partner with them to provide counseling services. All of our clinicians are licensed mental health professionals who demonstrate their ability to integrate the faith and spirituality of our clients.

Integrated care. On integrated behavioral health or integrated care, we try to get our counselors in the same space as the primary care physicians to integrate the two services. When people go to see their physician, they can also see someone for their depression or other mental health scenario, and our counselors and the physicians begin to consult with each other. When we can address a person's mental health, spiritual health, and physical health as one, people tend to get better faster and stay healthier longer.

Leaving the office. Many of our counselors are beginning to shift from just one person at a time to thinking about whole communities. What can we do today to help this community do better? Historically, counselors like ours have comfortably sat in their office waiting for people to walk in, and we still do lots of that. But more and more our counselors are getting outside, going where the people are. We are integrating not only in primary care offices but also in places like homeless shelters and the children's home to serve them right where they are.

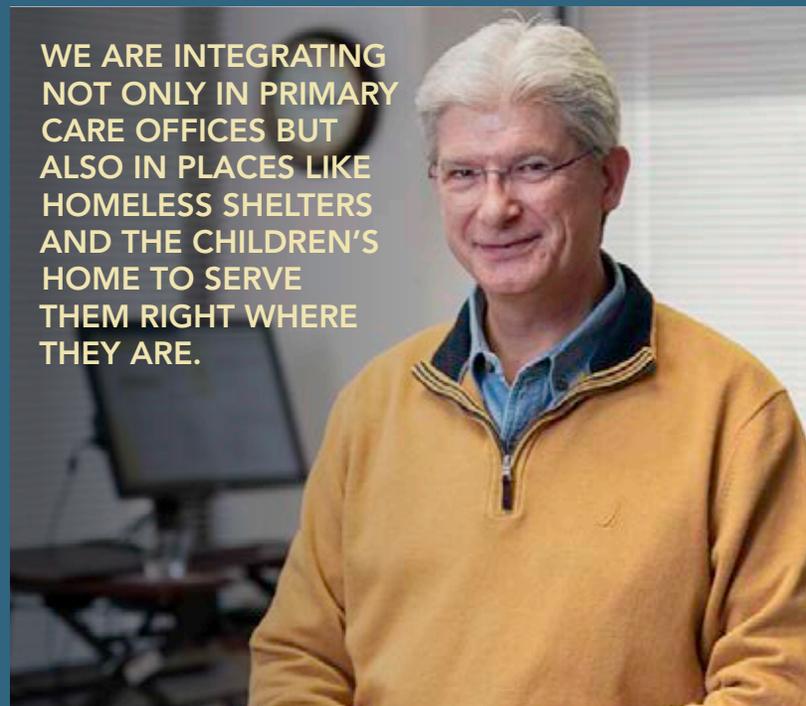
Trauma. The primary issues we dealt with 15 years ago were depression and anxiety. We still do a good amount of that work. But in the last five to 10 years, we have seen more and more trauma being presented in our offices. When we think of trauma, often we think of being in a major car accident or what military veterans may have seen in conflict. But trauma can also be just the little chinks in life, and enough of those can impact a body and a soul, not unlike one major explosion. I don't

know if there is more trauma in the world, but we are certainly more aware of it. Our staff are becoming more focused on understanding how the impact of trauma shifts a person's ability to participate in the world, and then helping them refocus that in a way that is healthy and productive.

Partnerships. Across the state, we are connected to local faith communities, businesses, schools and others. I recently visited two residential programs—one for people with severe and chronic mental health issues, the other for people dealing with addiction issues. CareNet partners with groups like this so we can offer a whole continuum of care. A person can walk in and we can discover multiple needs—such as housing, food or transportation—that are beyond our scope. But with the development of FaithHealth, we can now pick up the phone and call for a number of resources and usually have what they need within a matter of hours.

Congregations and connections. What a great opportunity that congregations have to make a real impact in the world. People who have good relational connections—family and/or social connections, which can come through congregations—tend to do much better than others. If I am isolated and the wave of life knocks me down, it is much harder to get up and be about life again. But if I get hit by that wave and there is a community to help lift me up and hold me, then moving forward is easier. Congregations can be that support system.

WE ARE INTEGRATING NOT ONLY IN PRIMARY CARE OFFICES BUT ALSO IN PLACES LIKE HOMELESS SHELTERS AND THE CHILDREN'S HOME TO SERVE THEM RIGHT WHERE THEY ARE.



Data, Evaluation and Mapping



TERESA CUTTS, PHD, is a clinical health psychologist and a research assistant professor in the Division of Public Health Sciences at Wake Forest Baptist Health. Her skills and research, evaluation and writing are a vital role in the Division of FaithHealth Ministries.

Connected journey of health.

Health systems often see people as “If you touch our system, you’re a patient. Otherwise, you’re invisible to us.” We’re trying to expand that way of thinking to say that a person has a journey of health. Once every seven years for most people, they touch the hospital. They shouldn’t just be visible to us or important to us when they become a patient. Hospitals are beginning to get into the world of looking at social determinants but they’re still rudimentary when they think about how we live within a broader context and that we’re all connected to one another.

On research and evaluation. I think about measurement the way I think of evaluation. Our work, of course, is based on trying to figure out ways to show proof of concept in a very complex system. Because the work we do extends outside the walls and is in community, which is highly complex and messy, it doesn’t lend itself to the traditional medical paradigm of “A causes B.” In our work, we have to think very holistically and broadly in what we measure.

A lot of times, the work I do is more along the lines of what is called applied health services research, where you take data that’s already out there — whether

it’s financial data or what we know about diagnosis or where people live and why they come into the emergency department — and try to show proof of concept for small-scale studies that we do or cohorts we follow like the “supporters of health,” our community health workers.

On mapping workshops. Mapping workshops are an important starting place for people who are beginning to do the work of FaithHealth in a new area. The model we were trained on came out of an African program and evolved to become Community Health Assets Mapping Partnership, or CHAMP. We’ve done around 25 different mappings across North Carolina and in other states. We’ve held mapping workshops with people in the Hispanic community, and we’ve held them on behavioral health. One on cycles of incarceration focused on the people who hit our jail system. Many of them have substance abuse problems. Often people go in and out of halfway houses when they’re coming out of jail or back into jail or back into treatment. We did this workshop in conjunction with the health department.

You have one workshop with health providers. We broadly define health, and

we broadly define providers. A health provider can be a clergy or can be somebody who runs a soup kitchen or it can be



MAPPING WORKSHOPS ARE AN IMPORTANT STARTING PLACE FOR PEOPLE WHO ARE BEGINNING TO DO THE WORK OF FAITHHEALTH IN A NEW AREA.

The FaithHealth team is growing its skills to align, leverage and mobilize community assets through mapping.

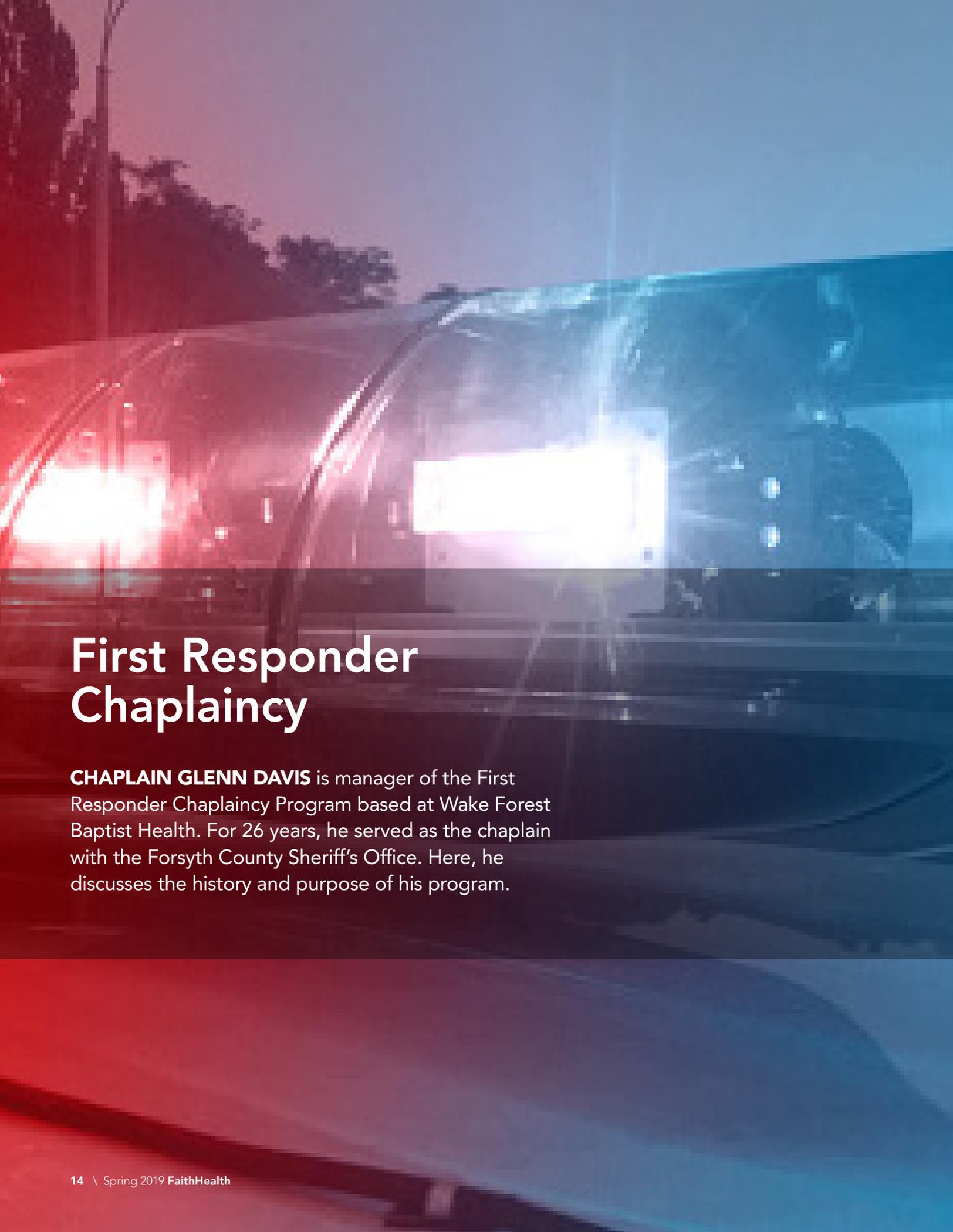
a business owner. Interestingly, we found that people who run funeral homes are great health providers. They actually provide grief counseling groups, and they often help provide people who don't have means a way to bury their loved ones.

So these health providers come one day, and then the health seeker workshop is for people who seek those services. You get to the intangible assets. It's not just the clinic on the corner. The clinic may be on the corner and I may have a card to go there, but maybe they don't do a

quick turnaround on my blood work. The intangibles of how that care is delivered are probably the most important data that comes out of a mapping.

Then after about six weeks, you come back with a detailed report from both the providers and seekers and invite more people into the process, so it's a springboard for future collaboration and/or engagement.





First Responder Chaplaincy

CHAPLAIN GLENN DAVIS is manager of the First Responder Chaplaincy Program based at Wake Forest Baptist Health. For 26 years, he served as the chaplain with the Forsyth County Sheriff's Office. Here, he discusses the history and purpose of his program.

WE GO TO CHURCHES, WORKPLACES, FIRST-RESPONDER GROUPS AND NEW-HIRE ORIENTATIONS TO HELP PEOPLE BOLSTER THEIR CRISIS RESPONSE AND SELF-CARE SKILLS AND THEIR IMMUNITY TO CRISIS AND TRAUMA.

Beginnings of a program. I was a chaplain with the sheriff's office for 26 years, and my role expanded to other first responders: EMS, public health, the fire service. I then had an opportunity to start a program here at the hospital. For me, it made sense because over that long tenure with law enforcement, I was coming in and out of the emergency department every week, if not daily, often after hours when trauma would occur either to a victim of crime or to a first responder. This is where they sought treatment. The hospital was like the nerve center. It also was a neutral place to interact with people.

What do you think a chaplain does? Now put wheels under that person, because this is mobile chaplaincy, and we're responding to a variety of contexts outside the hospital

walls. We may deploy to some location in the hospital to deal with a crisis, but just as easily could be called out to the community to do a death notification or to assist a responder who has been exposed to trauma. I'm the leader of this brave team. Dana Patrick is our first full-time staff chaplain to come onboard. Aaron Eaton has also come onboard full time. Jesus Dominguez is our new chaplain resident, so we have three full-time chaplains and a resident. We are landing in different places during the course of a week.

Challenges and opportunities. One thing that's been unique in the last few years is the increase in opioid-related deaths. We respond to a heroin overdose and address the chaos of that scene in terms of not just the bereaved

family members but neighbors, or if it's a workplace, co-workers and then law enforcement, fire service, EMS. The event creates an environment where the opportunities to help are immense, so we do a lot of triaging to see who needs help first, with lot of referrals afterward.

Another consideration is the level of sensory exposure, just the raw nature of what you actually see when you're at the location where the death has occurred. You see the grief of the family, the reactions of the young responders who perhaps could be on their first call of that nature given its violence or outcome. All these are different variables that make this more difficult to handle.

their immunity to crisis and trauma. That creates a more empathetic workplace so that peers begin to care more for themselves and one another. Supervisors start to demonstrate that same empathy, and it changes the nature of the workplace.

Follow-up. One unique opportunity my team has is the ability to follow up with families. What we might think of as hit-and-run care where we show up at a scene or we're there at the worst moment of their lives, we can now revisit a family. One case that comes to mind is a young man who died of an overdose. We were at his home in the immediate aftermath of that. We were able to go back and visit with the parents on a second visit.



Chaplains Aaron Eaton (center) and Glenn Davis (right) work with Forsyth County's first responders.

We also have many opportunities to do proactive, pre-incident education. We go to churches, workplaces, first-responder groups and new-hire orientations to help people bolster their crisis response and self-care skills and

And then I went back with the detective who was assigned that case to go over the medical examiner's report with that family. So, three different encounters that all, I think, enhanced that bond with that family.



The Perfect Storm of Care

Serving Eastern North Carolina Clergy During Hurricane Florence

BY MELANIE RASKIN

When you think of hurricane relief, you envision truckloads of bottled water and canned foods, clothing and diapers, medical supplies and money. You don't often think of spiritual care — the kind of counseling that convinces you that all things are possible, even in the aftermath of a destructive hurricane.

That's what happened following Hurricane Florence, the wettest tropical cyclone to ever hit eastern North Carolina. From Sept. 12-15, 2018, Florence pounded the state with wind speeds of more than 100 mph. Water proved even more deadly and damaging, as storm surges of nine to 13 feet were topped by devastating rainfall of up to 30 inches. Many towns were completely under water — in every way, including spiritually.

The clergy in Wilmington and the small towns surrounding it, as well as those at New Hanover Medical Center, worked round-the-clock with their communities. Like the people they were serving, many clergy were living without

power, food and water, their homes badly damaged. One exhausted pastor expressed the bright and shining ray of hope: "I knew before it quit raining that the Baptist Men of North Carolina and CareNet would show up to work alongside us."

They did. The story of working alongside church clergy in the trenches began right after the storm, said Terry Tackett, regional director of Coastal Region CareNet, a community-based, counseling ministry offering pastoral care and psychotherapy services to people of all ages, regardless of denomination. An affiliate of CareNet Inc., which is a subsidiary of Wake Forest Baptist Health, the center has clinics across the state, including in Wilmington, Jacksonville, Shallotte and Bolivia in southeastern North Carolina.

The local missionary in charge of the Cape Fear network of Baptist churches set up a meeting with area pastors and CareNet in Burgaw, ground zero for Florence, two weeks into the recovery effort. To Tackett, it was a pivotal



ONE EXHAUSTED PASTOR EXPRESSED THE BRIGHT AND SHINING RAY OF HOPE: "I KNEW BEFORE IT QUIT RAINING THAT THE BAPTIST MEN OF NORTH CAROLINA AND CARENET WOULD SHOW UP TO WORK ALONGSIDE US."

gathering designed to support and renew the strength of the local clergy.

"Fifteen pastors from that hard-hit area came together with us and the Baptist Men Disaster Relief Team for dinner and to share their stories of stress and being overwhelmed," Tackett said. "There were a lot of tears and hugs. It was a powerful time, connecting these pastors and telling them about our resources for

their congregations, their communities and themselves. We made sure they knew they were not alone.”

It was exactly what the ravaged towns around Wilmington needed to know. That included Wilmington’s New Hanover Medical Center, the 769-bed hospital where the chaplaincy department and its student chaplain residents were serving the pastoral needs of more than 200 hospital staff as well as patients. Some chaplains had sheltered in place for as long as 10 days, with no chance to reconnect with family at home. All were eager to serve, despite having lost homes and family members.

The hospital chaplaincy program had been in the midst of a rejuvenation, and the baptism by fire wrought by Hurricane Florence tempered their steel, according to Glenn Davis, supervisor of the First Responder Chaplaincy Program at Wake Forest Baptist Health. His job? To help police, firefighters, EMTs and others do their jobs and make sure first responders feel supported, while they support others.

Davis extended his mission to include the chaplains at New Hanover Medical Center. He counseled the chaplaincy team by phone. Following the storm, he heard stories of trying to juggle chaplains living at the hospital for days, unable to leave and check in with family because of road conditions; of a lack of food and medicine; and of having to figure out how to increase capacity so helicopters could land with supplies, since flooding had closed many roads.

Davis continues to support via phone and visits to talk about post-traumatic growth — how to revitalize and adapt to what the hurricane taught them, ways to better integrate with the community, especially local churches, and methods to improve communication.

“There’s a new-found sense of purpose when people unite around a common goal to help,” Davis said. “I rediscover all the time that compassion is having proximity to someone’s pain, giving them hope and returning them to baseline functioning. Our attitude is, we won’t abandon you in this time of need.

“Most of us find that we didn’t go into ministry to be lost in minutia. We want to help people. Being out there — whether it’s a full-blown disaster affecting an entire community or simply showing up and making a difference in someone’s life on

the worst day of their life — is powerful, life-altering.”

Powerful Hurricane Florence altered lives

in eastern North Carolina and the teams who helped. All of the institutions had to perform their jobs seamlessly with each other, and it worked. It was the perfect storm of care and cooperation at a tough time in a hard-hit place, supporting the people on the front lines who were supporting others spiritually.

Months later, the support continues. Coastal Region CareNet operates a

satellite office in Burgaw one day a week. Wake Forest Baptist is providing scholarship funds via its foundation to people affected by the hurricane who need counseling services. Davis continues partnering with New Hanover

Medical Center to help put processes in place for disaster preparedness and to keep staff refreshed and focused. The Baptist Men are still helping with disaster relief.

“We believe actions speak louder than words,” said CareNet President Bryan Hatcher. “This is an instance of making the word ‘prayer’ an active verb. When we allow ourselves to be part of God’s response to prayer, it makes a difference in a more impactful way. Prayer does miracles, but when prayer becomes someone knocking on your door to help after a hurricane, it changes lives. We are

always looking for the opportunity to do good, to demonstrate God’s love by caring for others, including the clergy who care for us. That’s what this experience was all about.”

Clergy and volunteers package emergency supplies for those in eastern North Carolina who were affected by Hurricane Florence.

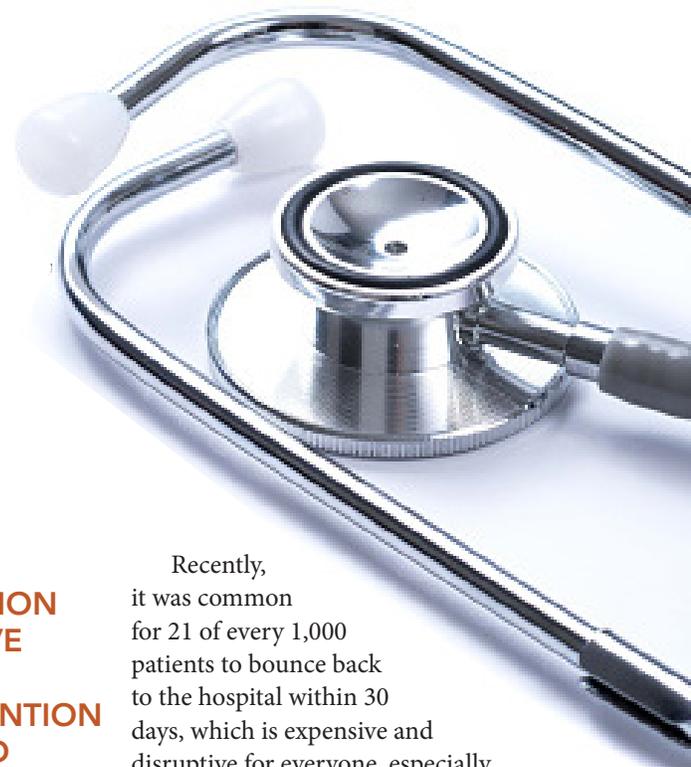
WAKE FOREST BAPTIST IS PROVIDING SCHOLARSHIP FUNDS VIA ITS FOUNDATION TO PEOPLE AFFECTED BY THE HURRICANE WHO NEED COUNSELING SERVICES.



Why Should We Care about Medicaid?

With Richard Lord, MD

One of FaithHealth's closest partners is the Family Medicine Department of Wake Forest Baptist Health and its Population Health team working across the region. Richard Lord, MD, leads both, undergirded by his medical training and a degree in economics. But the driving force goes back further into his youth.



I was drawn to family medicine because of long-term relationships with families and being involved in the community. I learned that in church when I lost my dad at age 12. Four in our small youth group lost a parent, another kid had open-heart surgery, another died of a brain tumor. I could see that medicine mattered, but so did community.



Richard Lord, MD

Community work takes time, as any pastor knows. I worked with a volunteer board for five years to get the first federally qualified clinic open. It took another three years to become United Healthcare Center, now caring for thousands. Almost everything meaningful takes years.

Now we are trying to fix Medicaid, changing the basic structure of the relationship between government and the health of the very poor. For most in the faith community, this is still an abstraction. Some congregations may have no one who's on Medicaid, some have a lot of folks on it. You might not even know. You have to be really poor to qualify, but now everyone on Medicaid in North Carolina has the same coverage. The new process is more complicated.

EVERY CONGREGATION SHOULD HAVE SOMEBODY PAYING ATTENTION TO MEDICAID AS A TRUSTED COMMUNICATOR TO THE REST.

One group qualifies you, and then have to choose

between five plans which aren't identical. In rural areas, physicians could say, "I'm not taking any more Medicaid." So, you could have a Medicaid card but not have access. Some hospitals will be more restrictive (not Wake Forest Baptist!).

Every congregation should have somebody paying attention to Medicaid as a trusted communicator to the rest. If a congregation knows individuals who might qualify, they need to help them make choices rather than sitting back and hoping it all works out.

This is ministry. Churches should feel that this is an important piece of what they're doing. We have a ministry to the poor, but we can also have a ministry to the sick. We have to resist what I call the business-ification of medicine. It's mostly about relationships, not technology. But when we get both right, we've seen amazing things.

Recently, it was common for 21 of every 1,000 patients to bounce back to the hospital within 30 days, which is expensive and disruptive for everyone, especially the patient and family. We focused on navigation with a nurse called Carla. She calls to make sure you understand and have your medicines. She connects things. And now our readmission rates are less than half, all because of the relationship.

We're rediscovering the roots of family medicine. FaithHealth talks about proactive mercy, which means not waiting for people to show up at our doors. Of course, when we're really sick or having a heart attack, getting to a physician is extremely important. But over the long term, so many other things that the church knows a lot about have impact: where we live, our income, what type of food we can afford and access to it, our education. And all this is connected by human relationships. Not everyone in 2019 has a faith community. But as a doctor I can tell a difference when I walk in a patient's room if the pastor has been by to say "We're praying for you. We're here for you. We're going to be here for you when you leave." It makes a huge difference.



FaithHealth is now a Podcast!

Learn more about the FaithHealth movement. How it works, why it matters, and how you can be more involved.

Look for "FaithHealth" wherever you get your podcasts. You can also find all of the episodes at faithhealthnc.org/podcast.

And look for our sister podcast, Stakeholder Health, too!

WAKE FOREST BAPTIST HEALTH

Giving Thanks

MOTHER'S DAY OFFERING



Eddie Barr

Thank You for Supporting the 2019 Mother's Day Offering

To learn more visit:

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About the Mother's Day Offering

Since 1924, North Carolina Baptists have given to the Mother's Day Offering to "extend the healing ministry of Jesus Christ, especially to the needy." Today your gifts to the Mother's Day Offering continue that work to assist patients in financial need at Wake Forest Baptist Health.

faithhealthnc.org \ 336-716-3027

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 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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