National health care policy has encouraged health systems to develop community partnerships designed to decrease costs and readmissions, particularly for underserved populations. This commentary describes and compares the Congregational Health Network’s Memphis Model to early local efforts at clinical-faith community partnerships in North Carolina, which we call “The North Carolina Way.” Necessary components for building robust health system and congregational partnerships to address social determinants of health and impact health care utilization include partnership growth, allocation of health system resources, community trust, and time.

Many health systems (HSs) are attempting to build robust partnerships with community partners to address social determinants of health as a way to adapt to the Affordable Care Act’s decreasing reimbursement for readmissions and care for indigent persons [1]. While faith community partnerships with HSs are not new, few have shown true return on investment or viable metrics to support their efforts [2]. The impact these partnerships can have on health care utilization are supported by data from 2 large-scale clinical-faith community partnerships: the Congregational Health Network (CHN) in Memphis, TN, which includes over 600 predominantly (86%) African-American churches; and the emerging faith-based partnerships in North Carolina, whose 8 early adopter HSs include Wake Forest Baptist Medical Center (WFBMC).

Background

The Memphis Model

The Memphis Model, or CHN, is a partnership of 604 congregations (who sign formal covenants) and Methodist Le Bonheur Healthcare (a $1.5 billion, 7-hospital system) located in Memphis, TN. The CHN’s 12-month covenant design committee was comprised of 25 local clergy who developed 5 care pathways. In the CHN, clergy and other church representatives play an equal role with hospital staff, promoting better health by serving as role models, helping individuals adopt healthier lifestyles, encouraging use of community-based programs, and serving as links between congregants and the health care system. By “taking the brick off the walls of the hospital,” this partnership decenters the hospital’s power so that the hospital is only one part of the total community health care system [3]. Other key functions of the CHN include authentic community-based design, partnership with community and congregational entities, participatory data analysis, evaluation, and ongoing program development [4]. See Figure 1 for a visual depicting the CHN structure.

As part of the CHN program, whenever enrolled congregants (now over 20,000) are admitted to the hospital, they are flagged in the health system’s electronic medical records. A hospital-employed navigator visits the patient to determine his or her needs and then works with a church liaison to arrange post-discharge services and facilitate transition. Additionally, community caregiving, including transportation, food, social support, and other types of support, are provided by more than 700 congregational and community laypeople, who have participated in at least 1 of 14 different capacity-building, 7-week trainings designed to improve community caregiving skills.

In 2012, WFBMC, North Carolina philanthropies, and the North Carolina Hospital Association sought to bring the Memphis Model to the state, including recruiting this article’s Gary Gunderson to lead what was initially named FaithHealthNC. The statewide process is now known as The North Carolina Way. Drawn by the logic of proactive mercy toward the poor, versus the usual reactive charity strategies of HSs [5], the WFBMC board committed internal foundation funds to achieve these 3 indicators: evidence of wide and growing community partnerships; self pay increases in
2013 for the indigent (due to expanded access) followed by annual decreases; and peer endorsement of the model. Self pay in this model refers only to write off charity care for indigent who have no sponsorship, excluding unpaid co-pays.

The North Carolina Way

The emergence of the North Carolina Way network has been much slower in speed and scale than that of Memphis, and is a more distributed and localized model, especially in certain rural counties. However, since late 2013, the congregational partnerships have grown, particularly around congregational caregiving. Common caregiving services include providing transportation, food, social support, medication assistance (funds for obtaining medications or delivery of medications), and other support such as home repair, light housekeeping, ramp building, and paperwork completion. To date, we have 320 congregational partners spanning 21 North Carolina counties (and 1 in Virginia) and 8 HSs. See Figure 2 for a visual of the umbrella North Carolina Way structure, with WFBMC leading this effort.

The North Carolina Way, which spans the work and agents across the whole state of North Carolina, includes 7 Fellows, 30 Connectors, 3 Liaisons (1 each representing the General Baptist Convention of 2,000 congregations, the North Carolina Baptist State Convention of 3,600 congregations, and the Cooperative Baptist Convention of 400 congregations, totaling roughly 6,000 congregations), 2,024 visiting clergy, and 1,037 trained lay volunteers (348 persons have participated in 1,037 training sessions). These lay volunteers have participated in 4,973 hours of training and have provided 2011 hours in caregiving service to persons in their respective communities.

FaithHealth Fellows are a collaborative learning cohort from across North Carolina, trained as leaders in the theory and practice of integrating HS and community efforts. They serve as paid faculty, training the next cohort of leaders. Connectors, who are locally embedded in given geographical areas and/or other denominational networks, are triage volunteers who provide direct caregiving, train lay persons, and build capacity across networks. Most work 10 hours per week for a monthly stipend of $500. A full-time paid Liaison represents each of the 3 Baptist denominational conventions mentioned above. Liaisons serve to interface directly with regional and local denominational groups, such as the Baptist Aging Ministry in Ashe County, building the connections between local congregations and the North Carolina Way. Lastly, pivotal to our local Wake Forest/Forsyth County model are our 5 full-time staff, the Supporters of Health, who work primarily in our most underserved neighborhoods in Forsyth County.

Included under the North Carolina Way are 7 other partner system efforts: Appalachian Regional Healthcare System (Watauga County); Carolinas Healthcare System, Blue Ridge (Burke County); CaroMont Health (Gaston County); McDowell Hospital (McDowell County); Randolph Hospital (Randolph County); Southeastern Regional Medical Center, now referred to as Southeastern Health (Robeson County); and Wilkes Regional Medical Center (Wilkes County). All sites have at least 1 Connector and Fellow (funded by the WFBMC Kate B. Reynolds grant) and received community engagement and evaluation funds from WFBMC’s Duke Endowment grant. The Northwest Area Health Education Center has also supported this work.

WFBMC. WFBMC in Winston-Salem is a critical tertiary care center with a catchment area of 19 North Carolina counties and 5 counties in Virginia. In addition to hiring Gunderson to lead this effort, the WFBMC Foundation allocated approximately $1M to fund the FaithHealth efforts (estimated to be 5% of the total of self pay charges in FY2012). Starting in 2013, these monies have been used to fund a new Director of Community Engagement, 5 Supporters of Health (former environmental service workers who now work as hybrid

![Figure 1. Congregational Health Network (CHN) or The Memphis Model](image-url)
community health workers and care triagers), percentages of an embedded evaluator/program developer, 10 local Forsyth County Connectors, and our General Baptist Convention liaison. Underserved and populations of color in Forsyth County have low trust levels in WFBMC, given that it ran the decades-long Eugenics program [8] and closed the Kate Bitting Reynolds Memorial Hospital in the underserved section of the county in 1970 [9].

Several Community Health Assets Mapping Partnership Access to Care workshops have been held in Forsyth County, including 4 for Hispanic populations (2014) [10], 2 devoted to food pathways (2015), and 2 focused on behavioral health (2016). The mapping workshops offer a platform for encouraging dialogue about perceived injustices, such as the Eugenics program described above, and signaling to the community that the health system wishes to repair and build trust with the underserved community.

Components of Robust Health System and Congregational Partnerships

The common, necessary components of building robust HS and congregational partnerships include leadership inside the hospital and in the community/congregational settings that individuals trust; funding provided by HSs for the emerging partnership efforts; the ability to align, leverage, and mobilize community assets with fresh eyes through some form of mapping [6]; and hospital and HS leadership in adopting a humble stance with regard to community—what we call being a “teachable hospital” vs just a “teaching hospital” [5]. Also important to note is that each site has a distinct tipping point, or an event—and its timing—that allowed work to spread, grow, and flourish [7].

Results

The Memphis Model

Early findings showed that CHN members cared for by the network had aggregate total charges that were $4M less than those of non-CHN members matched on age, sex, race, and diagnostic-related groups [6]. More rigorous predictive modeling of the data archived in the electronic medical record showed that CHN members’ time to readmission for all diagnoses was significantly longer than that of matched controls, and their gross mortality levels were roughly half that of non-CHN patients [11]. The Memphis Model findings have captured the attention of many high level groups including the US Department of Health and Human Services [12], the Agency for Healthcare Research and Quality [4], and the National Academies of Sciences, Engineering, and Medicine. Stine and colleagues [1] promoted the CHN as best practice in an underserved urban setting with a majority African-American population for its leveraging of the strength of faith-based community networks and resources. The tipping point for growth occurred at 33 months from start when female lay leaders in the churches self-organized an advisory council, moving top leadership away from the predominantly male clergy.

The North Carolina Way

WFBMC’s 2012 budget was $1.9B and its estimated aggregate charity care spending was $60,073,940, with roughly 30% of self pay patients accounting for those costs being concentrated in 5 underserved ZIP codes in Forsyth County. From a baseline in FY2012, self pay figures increased 9% in FY2013 due to expanded access, then manifested a down-
ward trend in FY2014 (16% decrease from baseline FY2012) and FY2015 (4% decrease from baseline), representing a decrease of $2,508,460. See Figure 3 for exact aggregate self-pay dollars for the 4 year timeline.

Since 2012, congregational partnership growth in Forsyth County has been steady, with 89 partner congregations representing 20% penetration of the total congregations (our target for each county) and 39 volunteers. Partner congregations promote health and well-being by providing nonclinical caregiving to persons identified as having needs by WFBMC staff, such as transportation to medical appointments, assistance with obtaining food or needed medications, social support and/or home repairs or form completion.

The tipping point of the overall North Carolina Way happened when the nonclinical partners began to adapt and localize the process to reflect their particular assets, intelligence, and priorities at county and catchment levels. For example, WFBMC stopped their efforts to triage and supervise all out of county requests. Instead, they appointed local Fellows to supervise Connectors and posted contact information on the website to encourage persons to send those requests directly to the Connectors and Fellows in any given county. The North Carolina Way has achieved the 3 process metrics promised by Gunderson at the beginning of the project in 2012: self-pay costs decreased, partnerships grew, and the model has attained national attention [13]. We believe that the work of the congregational partners, Connectors, and Fellows have contributed to a decrease in hospital charges for self-pay patients by meeting the social determinant needs of those persons and by navigating them to more appropriate—usually lower acuity—levels of care.

**Other Health System Findings**

Examining the growth of the 7 HSs through the criteria named above, Table 1 offers the duration of partnerships in months, estimated allocation of resources (both in dollar values and number of dedicated staff), trust rating, total extramural funding that has been obtained as the networks emerged, and time in months from start to “tipping point” when work flourished.

As expected, those systems that have worked longer in the community appear to have built larger networks, reflecting longer duration in developing skills and credibility. In terms of rural/urban distinctions, McDowell, the most rural of all counties, engaged the highest percentage of congregations. Additionally, caregiving encounters in the more rural communities tend to be higher in number, perhaps out of sheer necessity in diverse and geographically large counties such as McDowell. Across all sites, caregiving needs are consistent, with transportation as the top community need, followed by food, social support, medication assistance (funds for obtaining medications or delivery of medications), and other (e.g., home repair, light housekeeping, ramp building, paperwork completion).

Timing from start date to tipping points at each site ranged from a low of 10 months (Southeastern Health) to a high of 34 months (WFBMC), with a mean of 17.5 months and median of 11 months. HSs with the shortest duration in terms of tipping point had sent representatives to Memphis and WFBMC educational offerings. All systems also conducted some type of community asset mapping. In terms of community trust in the HSs, 4 were rated “average,” 2 were rated “low,” and only 1 (McDowell) was rated “high.”

**Lessons Learned and Discussion**

Lessons learned from adapting the Memphis Model to North Carolina include these tenets: North Carolina churches are reluctant to sign covenants, which we believe reflects wariness of “company town” entanglement, as hospitals are often perceived as similar to very large companies [14]; training caregivers in churches before there is a structure to engage them can quickly suppress congrega-
tional mobilization efforts; a focus on locally responsive heterogeneous caregiving models works more effectively than WFBMC staff providing centralized coordination oversight; Underserved and minority populations’ community distrust of academic medical centers remains strong, given past historical trauma such as the Eugenics program in North Carolina [8] and renders community engagement efforts in marginalized communities difficult and slow.

Another clear lesson learned is that allowing grassroots leaders (even within the hierarchy of local churches) to have more control over work and processes allows for a more robust partnership and accelerated growth. In both the seminal Memphis and WFBMC sites, this occurred at slightly under 3 years of operation. For Memphis, this occurred at approximately 33 months post-start date when the predominantly male clergy relinquished control to a self-organizing group of female lay persons. Likewise, growth of North Carolina Way partnerships flourished at 34 months post-start date after the partnerships released the need for covenant signings, adopted a more distributed, less top-down model of partnering, and set partnership criteria as bi-directional community care pathways to meet needs. That is, a congregation was considered a partner if it referred a person with a need to health system staff and that need was met, or if our health system staff made a patient need referred to a congregation and that need was met.

Other HSs outlined above continue to work toward maturation of their local networks, and evaluation is ongoing. It appears that having other dedicated staff besides the designated HS leader was crucial to reaching the tipping point for the growth of each network. Attending the Memphis Adaptation workshop and the WFBMC Learning Forum, both outlining operational and theoretical principles driving the 2 networks, suggests that learning curves can be escalated via these educational offerings. This was evidenced anecdotally in that 4 of our current Fellows in participating HSs attended these events, and reported faster program development in the HS and quicker partnership growth. Having an expert in this field keynote local conferences marked the starting point for FaithHealth effort’s work in at least 3 sites, and accelerated their progress.

In terms of community trust in the HSs, McDowell County, which has engaged the most congregations, is rated as “high” by the community they serve, which supports our assumption that higher levels of trust correspond to stronger partnership growth. Interestingly, though, the systems who rated community trust levels as “low” engaged both the lowest number of congregations (Southeastern Health) and a relatively high number of HSs (WFBMC), possibly reflecting a rural-urban difference. Thus, our view that community trust in a HS is necessary for a faith-based partnership to thrive may reflect a more complex vs linear relationship, meriting further study.

**Conclusion**

Religion, faith, and local community culture have a long history in the social and organizational fabric of North Carolina, even in the creation and staffing of health care
The North Carolina Way reflects both working relationships with clinical relevance to the social drivers of health and healing, and partnerships credible to local social religious realities, whether urban or rural. Given that the partnership is embedded in naturally occurring social structures, it may demonstrate more cost effectiveness and sustainability than the current professional case management models adopted by many HSs. We expect that the North Carolina Way will, in the long run, improve community level health. As such, this commentary might be useful to other HSs and both community and congregational partners working to improve community health. Clearly, this innovative work merits further systematic and long-term study.

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