

# Stakeholder Health

Insights from New Systems of Health

## Leader's Guide For the Faith Community

By Gary Gunderson



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for

Stakeholder Health: Insights from New  
Systems of Health

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## Stakeholder Health

Insights from New Systems of Health

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# Leader's Guide

## For the Faith Community

### HOW TO USE THE LEADER'S GUIDE

This guide is designed for use with groups working on complex issues. It's leaders in the faith community and for hospital health systems that see in the current policy environment the opportunity to address the underlying causes of poor health in their communities by strategically shifting existing resources and partnering with diverse stakeholders.

You can order the [book through Amazon](#) or download a pdf of each chapter at: [www.stakeholderhealth.org/the-book/](http://www.stakeholderhealth.org/the-book/) and make copies for people to read ahead of time.

## Introduction

### New Systems of Health and Spirit

*By Gary Gunderson, MDiv, DMin.*

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What is a hospital?

What is church, mosque, synagogue or temple?

What does it mean to be an agent—or agency—of healing?

The last half century of both faith and health organizations has been marked by profound and sometimes disturbing change, as both adapted to fundamental shifts in science, technology, finance and culture. The largest number of hospitals in the United States were started by religious groups, often a small gathering in the basement of a church convened, as in Memphis, by a layperson who wondered why their members didn't have the chance to go to their own hospital. Or it might have been led by a small group of physicians, perhaps Black or Jewish, who were denied the right to practice in the local hospital. Often the hospital was the next logical step of ministry

that began as home-based nursing or diaconal care, the usual, and in every case, astonishing Catholic and Lutheran story.

Today the word “hospital” describes vast technical institutions that dwarf the religious networks that conceived them. However, those religious networks raised the thousands of dollars for the institutions’ first bricks, sewed the sheets on their first beds and wiped the sweat and tears from the first patients hoping that the early science would help their struggle for life. While a few systems, such as Wake Forest Baptist Medical Center, receive significant financial support from their birth parent, most hospitals are overwhelmingly dependent—and responsive—to the government and private payers and the calculus of those in far-away financial centers who lend them the money to buy extraordinarily expensive technology.

The churches, mosques and temples have changed, too. For one thing, it is not just “church” any more, especially inside the radical diversity inside a hospital and the unpredictably diverse places where vulnerability is concentrated. New language may help us see the new reality, so let us speak of “communities of spirit” to bring to focus the 300,000 institutions that continue to exist for the purpose of forming and expressing faith. Although many of their buildings are similar—and in some cases the very same ones—most all the other functions, processes, and relationships have adapted to the wild flows of the 21st century culture. No physician would want to practice within the limits of a 1908 hospital; neither would a modern leader of a community of spirit.

This modest piece is an invitation for those of influence within the new systems of health to enter into dialogue with their peers in the new systems of spirit. The invitation is prompted by some years of intense collaborative learning by people working within health organizations, both hospitals, public health and varieties of academic fields. Forty-four of these individuals came together under the convening of Stakeholder Health to describe what we’ve seen emerging, not from the struggles of the past, but let us say the struggles where the future is breaking through. We write of the “insights from new systems of health.” The new is already present on the toughest streets, bearing witness of what is possible everywhere. These new systems are emerging from within and around the old systems, of course, so it is easy to miss the significance of what has already happened and what it tells us about what is possible next.

Ironically, many of the participating health organizations that have contributed to this collaborative learning process were born of faith, but have lost meaningful relationship with those seminal faith networks. The faith that provided the imagination that created us is now nearly out of dialogue range. We want the dialogue very badly, not out of nostalgia, but because of what we’ve learned about the new and the next. Science and technology will continue to accelerate. But the really new part of the “new systems of health” is the profound integration with the full array of community partnerships. A hundred years or so ago, the community invented hospitals. Now we together need to reinvent community, something that demands

deep, sustained, faithful dialogue—especially between those most immersed in the networks of health and those of the spirit. This invitation is born of humility, but is marked by confidence that the dialogue will help all of us who care for the future of the neighborhoods we love be deeply accountable for what is possible.

This piece is written for two audiences. The first and most immediate are those faith leaders coming to a meeting at Howard University in September of 2017, a meeting explicitly built around the findings of the Stakeholder Health collaborative learning process, hoping to set off a serious dialogue with our faith partners. But we do not expect the two days at Howard to do anything but start that dialogue. So this piece may be useful for other people in or near faith institutions or networks that want to be partners in the spreading dialogue likely to follow the Howard event. The Stakeholder Health learning is a lot to take in and respond to. This piece hopes to make it more clear why it may be worth the trouble to do so.

It's fair to ask "Why do you want to talk now?" And, frankly, "Why should we care?" After all, it's much harder to run a faith organization these days than a hospital. The demographic and financial ecology on which a congregation depends has changed more fundamentally than healthcare economics. The next few pages are intended to answer the question, "Who cares about the relationship between faith and health?" The framework will be to explore the book Stakeholder Health: Insights from New Systems of Health by looking at how each of the 11 chapters suggests some ways in

which that relationship is filled with new possibilities that could help both sides thrive in sustained service to the communities we love.

But before we even get to the logic, let us be clear about the fact that the authors of the book live on both sides of the relationship, as do the people of faith. We are not secular health professionals speaking to faith members who are not deeply familiar with the journey of health themselves. We are members, parents, children, neighbors, employees and, in short, grown-ups trying to do the best we can to live with integrity in all those roles. What we learned about the new systems of health piqued our imagination about living with integrity, about how becoming deeply accountable to how our lives could contribute to the health and wellbeing of those we love. Rather than standing passively before changes that seem to tear apart and undermine what we love the most, we have learned that we can act with purpose to build a future for those we love.

The key is finding the deep common ground between those within faith and health networks. Let us take a few pages to explain why we are committed to doing that by walking chapter by chapter through the book. Please understand this as doing you the respect of explaining carefully why we value the dialogue so much, the exact opposite of thinking we have learned so much we can tell you what to do. In fact, we have learned enough to know we need the dialogue with one of the other sectors who love the same community.

You'll see that this approach toward partnership on the very first pages of the book. The chapters—all ten of them—seek to address these critical questions:

- How should we think differently about and help improve the social conditions in which our most vulnerable neighbors live?
- How do we move toward establishing essential healthcare as a basic human right—something that simply comes with being created by a loving God born into a human community designed to express shalom or wholeness?
- How do we help achieve health and other types of fairness in our communities?
- How do we use our leadership roles and work in health systems—and faith systems—to engage the heart and spirit of our local communities, including those who work within the organizations of health and faith?
- How do we answer these four questions by moving upstream, earlier in the development of negative conditions by working earlier on the positive drivers of health?

It should be obvious that all of these questions point toward deep partnership born of deep dialogue with those in the community focused on faithful imagination—you.

## Chapter 2

### Systems Thinking Approach to the Social Determinants of Health

#### Community as a System

This chapter offers an invitation to see the whole system that creates health as dynamic, open and social. Health at community scale is not just the inevitable result of anonymous diseases spreading like a rising flood. If you read the founding documents of most faith-based hospitals or other ministries, like children's homes, you'll see that we've always known the most health conditions—even those for which we prescribe pills and surgery—began and are exacerbated by social drivers. The health professions call those conditions “social determinants” but they are actually variables and certainly not all negative. Congregations—communities of spirit—are social drivers that are mostly powerfully positive. This chapter unpacks a way of seeing the process of health as malleable, changeable, anything but determined. It does this by looking through the lens of systems thinking.

A system is not just a pile of bricks like a building. A System focuses on the network of relationships of factors and humans that shape what happens. Systems have many moving parts, including intangibles such as hope, fear, imagination... and faith. Systems are marked by a) dynamism, b) complexity, c)

interdependency and d) difficulty in communicating how the first three function in a sustained manner over time. This sounds like every congregation I've ever belonged to and every church committee I've ever been doomed to serve upon. Thinking of the community as a system is very different from thinking of it as a passive patient just waiting on some group of experts to make their problems go away so they can be well. The hospital or public health agency can't make the neighborhood well; the whole system of interrelating components produces its health.

What does this mean for “communities of spirit?” First, you can see why we need more flexible and dynamic language to even talk about “churches, synagogues, mosques, etc.” You can't talk about the new systems of health using 1919 mental models and words. All of these are themselves components of a new system of spirit in the community. And we've already said that each of your individual congregations is marked by dynamism, complexity and interdependency that is hard to explain to anyone trying to understand it standing outside. What difference does it make for your congregation, denomination or interfaith network to see itself as a system playing a role in a complex community system?

The chapter focuses on the way that health emerges not just from a system of germs and medicine, but as the fruit of a social process. Clergy know that the neighborhood largely shapes the nature and vitality of the congregation. Hospitals are gradually learning this, too. Life expectancy is best predicted by zip code, not genetic code (p. 7). It's now widely un-

derstood by health professionals that clinical care accounts for only about 20 percent of long-term health. The physical environment (10 percent), social and economic factors (40 percent) and health behaviors (30 percent) are four times more powerful. It is especially important to see these factors as a system—dynamic and interdependent—that includes the powerful role of the institutions of spirit, hope, faith and compassion.

People tuned to the spirit will appreciate that hospitals are finally coming to realize that health happens only when the whole community of people are well, just and merciful. This dawning awareness is called “population health” among health professionals, but is really old news in all the ancient traditions of spirit. The Hebrew prophets always spoke to the whole people, not just a collection of individuals who happened to be living in the same place. “The people” is the same as a population, so it is important that the New Systems of Health are aimed at the health of the people, not just trying to build clever techniques to benefit one individual at a time. It is always right to be merciful to every single human, but even more right to create new systems of health and spirit so that the people experience mercy and even justice.

You can look at the case studies in the chapter, but probably can easily look out the window of your congregation and experience how different the dialogue moves when you think of negative social factors that can only be turned by a positive social process. How is your community of spirit already doing

that in ways you may have been underestimating? How do you see yourselves as part of the whole system?

## Chapter 3

### Accountable Lives: Leading Complex Health Structures

#### Leading the New Systems of Health

If communities are dynamic systems driven by the energy of multiple interdependent factors... who is in charge? What is a leader? Heck, what is a grown-up? This chapter, written with those who think they are leading health organizations in mind turns out to be just as relevant to those who think they are leading communities of spirit. Clergy and those playing roles of influence within religious structures know that the vast majority of people in their group are there voluntarily, and nothing is harder to order or even fire than a volunteer. Hospitals are actually much like that; not as many volunteers, but huge networks of individuals with credentials designated by external guilds and layers of rules and protocols that date from earlier ideas. Like faith organizations, hospitals use other peoples' money who often give with expectations, if not strings. Most communities of spirit have distinctive hierarchies of privilege and power, often not very clear to those on the outside but painfully clear within. And all of this is changing as everything around the organization is changing. Words that once held power, now are regarded as recommendations. Extrinsic factors are examples of this—as superficial as dress codes to such fundamental commitments as the rules of open

admission to care or what gender identity gets to offer the sacraments.

There is much in this chapter to provoke a long discussion about how the role of the leader is changing. But listen carefully to the tone of the discussion. Does it reflect lament over what is lost, or is it tuned to the new possibilities of how your organization can find its life as part of the complex life of the whole system. What is new about the leaders of the new systems of health and spirit?

One part to read most carefully is how the role of leader—new or old—is embodied in those playing the role of influence in the systems. The stresses, positive and negative, literally enter in and take home in the bodies of those living with the expectations of leadership. This is obvious in the lives of those leading the health organizations and is often used to justify pay and privileges that seem quite comfortable. Those in faith systems carry the same embodied stresses, but rarely with anything like the pay or privileges. The new systems are never stable or predictable; healthy systems are by definition dynamic for ever and ever. Only unhealthy systems are predictable, guaranteed to remain behind while all else changes. How do your leaders embody the hopes and stresses of sustained dynamic change? How do you? What does this mean for how we treat each other and support each other in times when the energy wanes and clarity fades?

One clue to influencing the new systems is the role of showing up, literally putting our bodies and eyeballs in places where

new parts of the overall system can have an influence on us. Leaders in this model of health (and spirit) lead by learning; and learn by showing up where the edges of emerging reality have a chance to be taken into account to change our minds and actions. When leaders do this without anxiety in a spirit of faithful hopefulness, the whole system bends just a bit in the direction of the future. This may sound way too abstract when it is the daily bread and butter of pastoral leadership inside and all around a community of spirit. Clergy show up in people's homes and at times of transition in their lives. They show up and make eyeball contact when the mom comes to the church for food or shoot a few hoops with the lonely kid playing on the basketball court behind the sanctuary. They show up at the high school football game and greet some kids by name who thought that nobody remembers them at all. And of course they show up in the hospital even—especially—when the limits of medicine are reached and passed, making the passing with ancient words that people are still surprised to find needed to assuage their pain in their family.

As health finds its way into the new systems, we often find ourselves moving into relationships and parts of the community where clergy and communities of spirit already are (and have been!).

- What would you want the leaders of the new health systems to understand about what faith understands in these places?

- How could you invite one of your health friends into a place or experience that would help them see the overall community system in a new way?

The chapter is about accountability of those expected to lead, but we know that the hallmark of systems is interdependence. Some ministerial associations are adopting the staff on especially stressed hospital wards. Volunteer chaplain groups are expanding and finding new voice and new welcome. A community hospital in Point Pleasant, West Virginia is not “faith-based” but as volunteer clergy record prayers that are played over the hallway speakers at 8 am and 8 pm every day, bringing a moment of pause and peace to the busy environment. The sensitivity of their prayers has expanded the credibility of the partnership between the hospital and the community of spirit nearby.

Can you imagine lending the strengths from your ritual toolbox to heal and nurture those who work in the health systems? Not just the leaders but all those who work there?

## Chapter 4

### Optimizing the Patient Encounter: Relational Technology that Integrates Social and Spiritual Domains into the Electronic Health Record

#### Relational Technology

This chapter may look like one you can leave out of the “deep dialogue” category as discussions about the electronic medical record would seem to be the ultimate in inside hospital baseball; the least appropriate for engagement with communities of spirit that run on the power of the narrative and parable. No religion ever started with a database. But every faith tradition is marked by a distinct language about what matters most and a way of keeping track of key landmarks in the journey through life (and beyond).

Nowhere in the whole apparatus of healthcare is the individualistic and transactional nature of modern system of disease care more vivid than in the substance and methodology of how we manage the data. Many data systems within healthcare began as billing systems that make sure that everyone gets what they deserve. Public health data is not much better. Although public health maintains “vital statistics” nearly all of the data is about what is trying to kill us. That’s a pretty limited way to think of health, but it is hard not to point out that some see religious systems the same way. And before the

religious folks get too self-righteous about how much better stories are than numbers, listen carefully to the pattern of the stories and the implicit narrative of helplessness or magical thinking.

The key insight driving the Stakeholder Health way of seeing technology is that it’s not just information. Data is a kind of energy that enables and drives relationships.

This chapter builds on the first two chapters;

- What kind of knowledge helps a dynamic interdependent community system thrive?
- What kind of information do the leaders of communities of health and spirit need in order to be deeply accountable for where they lend their influence?

The Stakeholder Health group burrowing into the subject of data and relational technology realized the potential power of building new systems of information that would make more visible the role of community assets in the healing journey of patients and to make that power visible to all of those providing care—not just those getting paid for taking care of this or that organ and something else tomorrow. Just imagine if everyone who loved and cared about a person could be confident that everyone else involved in that life could see in the data that person’s

- clinical needs
- social needs

- fundamental needs being met
- potential threats or hazards in the person’s physical environment or where they work or play

Maybe the community could see clearly the relationship of the various types of caregivers to each other, not just to one person who they may think of as “their” client.

The power of data—and its association with privilege—makes this chapter important for dialogue about trust at social scale. Many communities of spirit are associated with groups that may have good historical reason to be skeptical of the intentions of government and healthcare organizations. These groups may find it disconcerting to think of even more data becoming visible to those powers.

- What is the possible role of faith leaders in protecting the stigmatized, undocumented or easily exploited from inappropriate use of health data?

People outside of healthcare and public health may not be entirely encouraged to learn how primitive the data systems actually are and how far from the leading edge of science they are. Perhaps a deeper dialogue among the community systems, such as those of faith, could provide positive pressure for the data systems to be more holistic, so as to serve the interests of the new systems of health.

A simple step is to make sure that the hospitals include basic and accurate information about the geographic reality of their patients. It is now obvious that the zip code tells us more than the genetic code about the journey of health and even what pharmaceuticals and follow-up medical may be available and trusted. Most hospitals are at the dawn of the era of taking this kind of information seriously enough to be inside the computer systems their doctors rely on for help in diagnosing and following patients. Very few health records include a place to even note the name of the congregation a person worships with. There is usually room for a note about “religious preference” but that is mainly to make sure the right flavor of spiritual succor is provided near death. Everything in the Stakeholder Health perspective rests on the relationality of health. Far more important to that journey is the name of the people one journeys with—the community of spirit.

- Can you imagine what you’d consider the most important for a hospital to know about the healing role of your congregation?
- Most electrical medical records send reminders to the physicians and nurses to make sure the right things happen on time. What would you want the system to say about someone of your congregation to be sure that you—the caring congregation—was involved at the right time?

# Chapter 5

## Navigating for Health

### Helping People Find their Way Among Systems Still Under Construction

Anyone who has experienced any health event more serious than a common cold knows that the actual nature of our current non-system of health is defined by perverse disconnections and bizarrely expensive inconvenience. That's true even if one is insured and speaks English and blessed with enough anal characteristics to keep one's records in perfect order. Being sick can be a full time job. How can one possibly navigate all the sharp and broken edges when one is sick, depressed, anxious or simply unfamiliar? Many, many people in that situation turn to a faith community for help even if it is not one attended. The appearance of faith at least suggests the promise of non-hostile relationship, the first step to finding a way through a crisis or new reality.

What about the next step? That's what chapter four is all about—the array of emerging roles all built around the need to help people navigate on their journey of health.

All you need is one glance at page 54 to see the variety of roles that are like colors of the rainbow amid a storm:

- Care Coordinator

- Health Navigator
- Community Health worker
- Promotora
- Faith Community Nurse
- Peer Support Specialist
- Navigator
- Doula

All of these are stable, credentialed roles with widespread training program and associations which meet regularly sharpening the skills of that type of work and often working hard at integrating the role into the broader system of health locally. Most of these roles are reimbursed in some parts of the country while others are usually volunteer (but still credentialed such as Faith Community Nurse). One way to look at this feast of competencies is to think about which one(s) might be helpful in your particular neighborhood.

Another way is to look at the actual work they do and think about how the roles existing in your congregation or community of spirit might learn from that role definition.

- How is a youth minister like a navigator or peer support specialist? A lot, that's what!
  - How could that youth minister's role be enhanced by seeing them through the lens of a new role?
  - Perhaps they could get additional training and certification.

- How is a church secretary like a care coordinator or health navigator? A lot!
  - What if the local hospitals offered training and certificate to these critical nodes with such high trust?
  - What would the new system of health look like, if it was organized by all the church secretaries? (This is a really, really good question)

This chapter is organized around a day in the life of a community health worker, Nada Dickinson associated with the Women-Inspired Neighborhood Network (WINN) which is supported by four competing Detroit health organizations. Your first thought on reading of her day is that we need Nada in my town! This will be followed quickly by “I’m glad I’m not Nada! After the positive shock wears off, consider how Nada’s daily walk through the lives of the people she serves turns the lights on about the possible daily work of our community of spirit. Nothing she does is out of reach of even the smallest congregation if they worked together, built their skills and wrapped themselves in a relationship with people who need them.

- What kind of relationship with what other part of the new system of health would you need to become like that?
- Who would want to help you become that kind of healing agent in your town?
- How are you already doing many of these things?

The end of the chapter is an invitation to go deeply into the heart of compassion: “Tools cannot replace the value of walking with someone on their journey. Hope never happens on the internet along, or in a medical record. It happens at the intersections where people come together with the care that is right for them—accessible, patient-focused, health literate, culturally competent, high-quality and equitable. And its eminently more likely to happen when people—especially, but not exclusively vulnerable populations—can see, embrace and embark on a clear road forward, connecting to other people and existing resources that empower them to achieve the healthiest, best life possible for themselves and their families.”

That invitation to the future might remind you of the best moments in the life of your congregation when it fulfilled its highest spirit of compassion and the love of God. Does it remind you of yourself?

## Chapter 6

### Community Asset Mapping: Integrating and Engaging Community and Health Systems

#### Seeing All with which We Have to Work

Communities of Spirit may wonder how their colleagues in the health organizations came to notice them after many decades of considering them nearly irrelevant to real medicine. We touched on the key reasons in chapter one; health care folks noticed that the thing called health is only about 20 percent dependent on all that health professionals offer in the way of clinical care. The other 70 percent reflects community systems. But what are the specific components of those community systems? The answer in the *Stakeholder Health* book is the curious phrase, “community health assets” and the other curious phrase about “mapping” those assets. Religious people tend to stumble over what seems to be an inappropriate financial bit of language. Communities of spirit should not be (de)valued in monetary terms. We agree on the dumbing down effect of valuing everything into mere money; but the term assets sharpens the mind by forcing the issue: in what way are what things in the community assets to be held accountable for providing their promised role—valued in health, not money. An asset is simply something that has the capacity to do something valuable. Does it do that? A community

health asset should be accountable for contributing to the health of the community.

The original language was—faith people will be surprised to learn—religious health assets, and was then broadened as the chapter explains because faith folks in Memphis considered nearly everything of faith to be relevant to most everything in community, so took the “religious” word to mean only the things pertaining directly to operations of the house of worship. Community assets included all the religious tangible and intangible things, so nothing religious was left out.

This chapter is the real key to the whole book because it offers up such a rich toolbox for making visible—and thus accountable—the stuff a community has to work with. This is what makes the new systems of health and spirit come to life; what makes them possible upon which to work. As long as health is just a long list of needs and spirit an ephemeral abstraction, nobody is really accountable to themselves, their kind or to others in the community. But if there is a way to get concrete about what we have to work with, we are now in a real dialogue about real possibilities. It has been common for some years now for hospitals, public health and other agencies—even banks!—to do a systematic survey of community needs. The list of needs rarely changes very much and almost never surprises any clergy who are in ministry anywhere near an actual vulnerable neighborhood. But flipping the process to focus on assets changes the subject entirely. Now the possibilities are the subject, not just what’s wrong.

This is one chapter that you simply have to read all the way through, constantly asking:

- Does this way of describing assets accurately get my community of spirit on the map?
- Does this or that methodology give us new insight about our current and possible role in the dynamic community system?
- Does this model of mapping clarify the most powerful interdependencies in which our community of faith play its role?

It may be surprising to some that many of models for mapping health assets are highly sensitivity to the intangible qualities of the community assets. The most important thing to know about is the quality of trust, which seems obvious once you understand the relational nature of the community systems. Trust is more important than money in affecting where people go when they or their loved ones is in pain. But it also affects who comes to what coalition meetings and who shows up to protest or protect a key policy important to a group with little voice.

Trust is important, but can you get it on a map? Can trust become visible and thus accountable? Yes, the right person with the right attitude and the right goals has to use the right technique. The front cover of the *Stakeholder Health* book is a picture of an ID drive for mostly undocumented Hispanics that

came directly as a result of a process that got all those things right, so while in a book, this is not “book learning.” It is more like a witness. When you see your own faith group as an asset for fulfilling the promise God created it for and it becomes visible on the map as part of a complex community system, it becomes possible to be deeply accountable and to be held accountable. The dialogue between the systems of health and systems of faith moves toward sacred ground.

## Chapter 7

### Integrating Care to Improve Health Outcomes: Trauma, Resilience and Mental Health

#### Integrating Trauma, Resilience and Mental Health

Hospitals are great—and getting greater—at the biomedical parts of health, the painful things that can be fixed with knives and pills. They are poorly designed to deal with the emotional damages of trauma, the slow-moving conditions that steal decades and building the positive qualities of resilience that we all need to find our way through difficult parts of our journey of life. Communities of spirit have the exact opposite balance of strengths and weaknesses. At least they are reputed to do so. As the new systems of health have begun to emerge, the value is dramatically increasing for resilience and the power of navigating long cycles of chronic conditions that are often defined by high emotional demands. Much of the hopefulness of the Stakeholder Health perspective rests in the confidence that the interdependent array of community health assets can be brought into alignment and fulfill the promise of what can only be called shalom.

This is the other chapter that people of faith simply have to read all the way through to understand why we do not think we are delusional to be so hopeful. The key to our hope is the rapidly emergent science and array of functional models that

are proving shockingly effective at exactly the places that previously seemed intractable. It turns out that the new systems of health—and spirit—can advance resilience and recovery even from severe trauma and do so at community scale. Old models could never be done at the scale of real communities depended on individualistic therapy with highly educated professionals to help people recover their strength over a long period of time often including expensive prescription medicine. Viewing the community as a dynamic interdependent system demands a whole different way of working.

That whole different way turns out to... work. It just takes a complex set of generous partners who are willing to have their own particular form of individualism be decentered. The traditional professionals are needed, but not at the center of the process doing individualistic therapy. What works is carefully aligned community systems pouring intelligence and hopeful practices into non-traditional (but obvious) community networks, such as the schools and even more obvious, the communities of spirit.

It's impossible to overstate the opportunity—and accountability—this view of community poses to communities of spirit. The challenge, of course, is that this is real work linked to real science. It is not something that you can ask the preacher to do in the pulpit; it requires the whole community of spirit to lend its strengths to the the whole community.

This is one chapter that most clearly describes a hole in the community fabric that the communities of spirit can obviously

rise and fill. The good news is that the tools to learn how to play this key role are plentiful and tested and well-suited to the way communities of spirit already think. In effect, you just have to become more yourself. You already have the muscles and DNA; you just have to take them more seriously.

## Chapter 8

### Financial Accounting that Produces Health

#### Money Matters

About one-in-every-five dollars spent on anything at all in the United States is spent on healthcare. That makes healthcare very, very big business, which is more than a little ironic as we do not have very good health as a nation. A visiting Norwegian said, “it is hard to understand how you accomplish so little with so much.”

This chapter may seem to be most relevant to somebody other than faith leaders, but it is worth pausing to ask of yourselves as it does of hospitals, about the social return on investment. Our faith partners should be careful of self-righteousness here, as the same could be said of philanthropy of which such a large share goes through local congregations, and rarely managing to make it 30 feet from the congregational office, much less altar. This is a chapter that cuts both ways, asking sharply critical questions about the effectiveness of the investments in healthcare that could equally be applied to faith. Most congregations do not face the problem of managing a large investment portfolio and justifying their decisions to a cold-blooded table of New York bond holders. Hospitals do just that. But people of faith will be surprised by the positive

creative witness emerging from some of the new systems of health at exactly this point.

The positive perspective of the chapter rests in the fact that a significant body of real-life learning is emerging that point to shockingly effective investment strategies that invest directly in the things that make for health. Again, the perspective on community as a complex system opens the eyes for where to find higher return for investment. The key is to seek investments in... health... not just the machines for treating disease. It turns out that you can invest in health by investing in the 80 percent of non-clinical things that produce health, such as housing. That’s big news all by itself. The witness from the streets is that thoughtfully constructed portfolio of investments compete well with traditional investments in terms of both return and security. The idea that generosity is frivolous while real finance is likely to be mean-spirited simply contradicts the evidence. You can look it up.

The chapter also offers a view of some of the new ways money is moving toward mission—and being accountable in the process. In olden days there was a sharp distinction between the world of profit-making business and non-profit altruistic organizations. Today among the most interesting developments in community health are the lighter shades of gray that are coming to define a middle zone. The definitive “pay for success” models that chapter unpacks is an encouraging hybrid that brings together government, philanthropy and private investment to projects with adequately encouraging science and best practice to justify investment in projects that offer reward

if and only if the project produces the promised outcomes. To relate to the phenomenon ask yourself what your congregation promises that it is so sure of accomplishing that it would ask for an offering only after the project had succeeded. Many of these projects—deals, really—are being built around the criminal justice rehabilitation field or maternal and child development in which the outcomes depend on carefully orchestrated complex interventions sustained over time. That sounds like a youth group to me.

- But what church is so confident of its youth ministry that it would only ask the parents to donate funds when their child successfully graduated from college drug free?

We note this only to underline the seriousness with which some health systems are building community scale partnerships.

- What are the faith partners willing to risk for what goals in what kind of sustained partnership?

# Chapter 9

## Philanthropy

### Giving It away with Intelligent Decency

The role of private philanthropy in the new systems of health is unusual in the United States. This chapter explores the way in which the same dynamics driving a whole new way of seeing community are changing some of the seemingly most privileged and powerful organizations in the large array of partners, those with flexible money to donate.

The largest portion of all money voluntarily donated in the United States goes to local religious organizations, the local community of spirit. The vast portion of that money goes to pay the clergy and other staff as well as to keep the building open, heated, cooled and dry. A bit goes to mission, mostly local and a bit goes to the umbrella organization such as the United Methodist national or global mission budget. Congregations do not think of themselves as philanthropies defined by what they donate their money to. Rather the whole thing is a ministry, one small part of which involves giving money to do something beyond the operation of the local entity.

In most communities, philanthropy plays a role in raising some issues and projects as priorities that appeal to the rich and powerful, but often with the expressed purpose of helping

the poor and powerless. That ironic tension lies at the heart of philanthropy everywhere but is more sharply being called to account in how these instruments of privilege contribute over time to the thriving of the new systems of health.

Most congregations will not think of themselves as rich and powerful; but they may find themselves a bit uncomfortable with the sharp questions concerning power and privilege play out in how foundations—and religious networks—keep control of vital community dialogue so as to protect the existing patterns. Congregations have different powers—usually not financial. They do have distinctive legal privileges designed to protect them from government influence. This chapter explores foundations in a way that may shed light on the opportunities for deep—or at least deeper—accountability by faith organizations.

- What if our congregations were accountable publicly for where we put our time and money?
- What if our congregation leadership reviewed the results of our ministries with the same transparency and annual reporting as do foundations?
- What could foundations learn from highly effective congregations about stewardship?

# Chapter 10

## Global Dynamics at Home

### Being Part of the World

The new systems of health emerging in the United States are marked by high levels of professional leadership from people who have come from every part of the world. Even the most rural hospital could not stay open a single day without its medical providers from Pakistan, India, Nigeria or the Philippines. No Christian hospital could operate without Muslim or Bahá'í or Sikh staff. Likewise, the ideas under the wings of the new systems of health originate across many boundaries and languages. This chapter, which should be a whole book, only hints at the rich flow of ideas and practices that are making the new systems of health and spirit truly global, powered by more than any one national perspective could possibly offer.

Stakeholder Health is distinctive, but not unique in its global debts. What of our hospitals emerged out of purely local soil? Advocate Health Care traces to the German Lutherans as surely as the vast Catholic systems testify to the century-spanning influence of small groups of sisters. The hundreds of Adventist hospitals see themselves as part of a lively interdependent global phenomenon with constant evocative surprises (including joint ventures in the Middle East and with the Chinese Communist Party—who knew?). The learning col-

laborations of Stakeholder Health are deeply influenced by more recent intellectual debts, especially to Africa. The technique and theory underlying the community health assets mapping phenomenon and its capacity to make trust visible is African. The notion of the Leading Causes of Life that is quietly simmering under many parts of the new systems logic was deeply shaped and now led by African scholars. Many of the seminal models for community health workers unpacked with such promise in Chapter Four are welcome immigrants, notably the *promotores* and faith community nurses (a direct import from the European diaconal movement).

This chapter bears witness to the promise of how much remains to be learned when we drop our parochial lens and see the world of health and spirit whole. We can also see more clearly how much of our local community includes people from so many other places on the globe. Few things are more powerful than dropping our foggy and inaccurate vision of who lives in our local community so we can see the full dynamic and interdependent system already alive inside our institutions and on our streets. It is a very rare U.S. community that does not have people within range of having coffee and conversation that have come from every continent, with family still in places of great stress with much to share to create a common vision of health and wholeness for all. The two most powerful lens for seeing this vision are health and spirit. But both need to be liberated from the old ways of seeing and tuned intentionally to the opportunity to see the new systems of health emerging in surprising ways.

# Chapter 11

## Mission and the Heart of Healthy Communities

### Deeply Accountable for What Matters Most

Faith people should probably read this chapter first as a way of approaching all the others. This one is about mission, purpose, power and the desire to be of use for things greater than any one of our lives: indeed, even the lives of the institutions we have built. Some of you will find the appendix even more convicting than the flow the chapter, as we have included some of the official positions of various faith groups' view of health. You'll see the deep resonance with the Stakeholder Health perspective, which makes sense given that most of our members were invented by these very faith networks. The blood should run true. What is a bit surprising is how the different accents of spirit resonate so naturally with the perspective of the new systems of health. Faith is not surprised by dynamism or interdependence; indeed, faith is not surprised by new opportunities for health and healing that lie beyond the old imagination which was limited by the reach of this or that treatment technique or technology.

The chapter is so short and powerful that you might consider reading it aloud, ideally rotating the voice among all of those present in your small group. You know, the group seeking for the spirit of deep accountability for the mystery beating in our

heart that tells us that we are not passive before the causes of death that hold so many in fear. No, we are of life and spirit; we have helped each other know that in our bones that are arising for this very moment. We are alive and made so that our interdependent lives can be in service of life. That all a grown up could hope for. And it is true.

Please accept this invitation to deep dialogue in person at Howard University September 5th and 6th, or in any one of the many small groups likely to happen afterward.