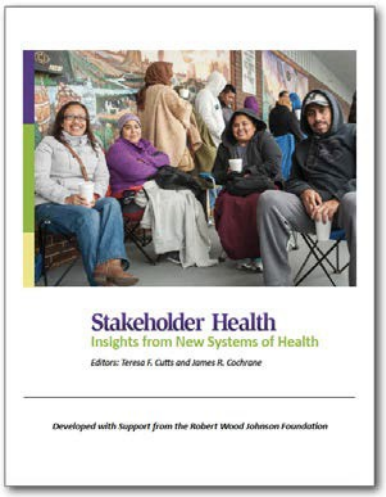
Stakeholder Health

Chapter 11

Mission and the Heart of Healthy Communities



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CHAPTER 11

Mission and the Heart of Healthy Communities

Gerald Winslow with Fred Smith, Don Stiger, Dora Barilla and Cynthia Carter Perrilliat

Introduction

In our previous monograph, we gave brief expression to the core convictions that have empowered the mission of faith-based and charitable health systems in their work for community health development. We reflected on the essential values and beliefs that have led health systems to work for the health of whole communities, and to create what we called "the beloved community of health." We wrote that "we accept our responsibility to lead organizations that will pioneer new ways of achieving truly healthy communities. We know we have a significant role in helping to create and sustain communities that invite the engagement of all members—communities that sense both their shared heritage and their shared future" (Health Systems Learning Group, 2013, p. 82).

The exploration of our founding principles, and the sense of calling they represent, renewed our appreciation of what gives heart to our work in communities of great need. This, we believe, is what furnishes durability to efforts that are often gritty and difficult. It is also what makes this work joyous, even when it is hard. In the present chapter, we give further attention to the mission, purpose, and power of the organizations that have chosen to be generative nodes in the growing network of Stakeholder Health.

By generative nodes we mean those organizations where differing streams of thought, innovations, and relationships come together to form a hub capable of generating fresh approaches to community health development. Such nodes create new connections and facilitate the exchange of creative ideas and new energy. Thus they add life to the growing Faith and Health Movement. The goal of this network is to learn from each other not only how to do the work of building more whole communities, but also to learn more about why this work is essential to our mission.

In the time since writing the earlier monograph, the importance of creating a network of health systems that share a commitment to the development of healthy communities has become even more evident. The energy generated in recent years by healthcare reform or, perhaps more accurately, the reform of healthcare reimbursement, has led to increased attention on the part of healthcare systems to "population health."

Often this expression refers to little more than hospitals' attempts to improve traditional case management. But the transformational work of creating a culture of health for whole communities will require far more fundamental changes—particularly, more effective and efficient coordination of care. Collaborative networks of organizations, including communities of faith, can help us move toward the goal in demonstrably effective ways. While we celebrate the fact that millions of fellow citizens have received health insurance coverage for the first time, we know that more health care does not always lead to healthier communities. For this, we need the collaboration of all segments and supporting systems of the community. Communities of faith and charitable health care will continue to play a critical role in this transformational and fundamental change, if we are to create a beloved community of health.

During this same time period, some formidable challenges and risks for charitable health care have also become more apparent. The rapid strides toward mergers and acquisitions, leading to ever larger, bureaucratized and more commoditized systems, threaten to undermine the identity of health care institutions with long traditions of faith-inspired, benevolent missions (Panicola & Hamel, 2015). It is thus important to reconsider the basic commitments to human wholeness, compassion and social justice that fuel our willingness to become integrally united with the communities we serve, for the sake of strengthening health, hope, and healing.

Heritage of Faith and Health

From its beginnings in our culture, health care has had strong, organic links to religious faith. Early examples include Egyptian and Greek temples where people sought cures for their diseases. Notable among these were the temples dedicated to Asclepius, the god of healing in Greek mythology (Rosen, 1999; Edelstein & Edelstein, 1998). To this day, the snake-entwined rod of Asclepius remains one of medicine's most recognized symbols. And the time-honored Oath of Hippocrates, still adapted for use in some medical schools (Orr, Pang, Pellegrion, & Siegler, 1997), begins by swearing allegiance to Asclepius and his daughters, Hygeia and Panacea. Some of the initial steps to systematize the healing arts also arose in the context of Greek temples of healing, where attempted remedies, including the therapeutic energies of music, were carefully observed and documented (Risse, 1990).

Throughout Jewish history, as evidenced in sacred writings, health and healing have been understood as direct manifestations of what it means to be created "in the image of God" (Hebrew *b'tzelem Elo-him*). In the tradition of inclusive Abrahamic hospitality, health care is not a privilege for a few, but should be equitably available to all. Judaism continues to hold wholeness and completeness (*shalom bayit*) at the center of its teaching and practice. Shalom is realized through faithful, loving-kindness (*chesed*). Important dimensions of contemporary Jewish life include the concepts of repairing what is broken in the world (*tikkun olam*) and whole-person care for the sick (*bikkur holim*), remaining mindful of the abiding promise: "For I am the LORD who heals you" (Exodus 15:26, *New Revised Standard Version*).

With the rise of Christianity, the story of organized health care often involved members of the faith community creating institutions in which ministry to the sick could be provided. By the fourth century, hospitals were being established in the larger cities where there was also a cathedral. The most prominent of these came to be known as "Basilicas" founded by St. Basil in Cappadocia in 369 (Walsh, 1910). This institution was eventually organized as a small city with homes for physicians and nurses, and a variety of buildings for persons with differing needs, including those with leprosy. The name given to such institutions came from the Latin root *hospes* that referred both to guests and to hosts, and appears in other words today such as hostel and hospitality.

Established in mercy to care for those who were in need, early hospitals provided shelter not only for the sick but also traveling pilgrims, the homeless, and the destitute. The religious impulse to provide hospitality to those in need continued with the development of monastic orders throughout the Middle Ages. Monasteries and convents often included facilities that were designed to give both physical and spiritual care to the needy. For example, the Alexian Brothers risked their own lives in order to provide care for victims of the Black Plague in Europe (Alexian Brothers, 2016). Another of these religious orders, San Spirito (the Order of the Holy Ghost) founded hospitals first in Rome and then in many other European cities (Moeller, 1910). These facilities provided food, clothing, and shelter for the poor and typically gave some medical and nursing care.

Within Islamic history, there has also been a very close relationship between religion and medicine. In the Qur'an and other teachings, Muhammad includes instructions for sick persons to take medicine, as he did himself through expert physicians. Muslims have traditionally placed strong emphasis on charitable care, as well as the disciplined practice of preventative measures in healthcare. Islam has particularly been known for a refreshing openness to accept, use, and improve upon non-Muslim, as well as pre-Islamic, health and healing practices.

The religious impulses of Western health care have been prominent in the development of health care in America, which was predominantly built on the commitments of religious faith to offer charitable care. The tradition of religious almshouses, or "poor houses," which had begun in Europe, was continued in the U.S. Eventually, these institutions began adding wards in which the sick could receive care. In the Nineteenth Century, both Catholics and Protestants established hospitals intended primarily to care for the poor. During this time period, wealthy people who became ill were typically treated in their own homes by physicians and nurses who were paid to engage in home care, including surgery (Wall, n.d.) Today, many of the health care systems in the U.S. bear the names of their founding Roman Catholic religious orders, such as the Congregation of the Sisters of Bon Secours, or Sisters of Providence, or their parent Protestant denominations such as Lutheran, Methodist, Presbyterian, Baptist, or Adventist. Several of the organizations affiliated with Stakeholder Health have their roots in this tradition of faith-based and charitable health care. care (see Appendix 3 for full vision and mission statements from select faith traditions).

MOTHER JOSEPH OF THE SACRED HEART

Mother Joseph arrived at Fort Vancouver in the Washington Territory on December 8, 1856. Following her profound belief in Divine Providence and faith in the Sacred Heart of Jesus Christ, she began her work to serve those suffering the misfortunes of life. When she first arrived she discovered a land with no hospitals, and insignificant schools and charitable organizations for those suffering hardships on the frontier. With an attic as home for herself and her fellow sisters, she immediately embarked upon her purpose. Their mandate and their desire was to care for the poor and the sick, to educate the children, and to bring the light of Christ into the lives of all they met.

Born and raised in Quebec Canada, Mother Joseph only spoke French upon her arrival in Vancouver; this issue was only the smallest of stumbling blocks as she traversed the territory and petitioned for funding. Until she learned the language, two bilingual sisters facilitated communication and taught her English. Her first project, after hearing the desires of the people of Vancouver, was to found and construct a boarding school, most recently known as Providence Academy. The citizens were now also clamoring for a hospital; with the assurance the women of Vancouver would pay for poor patients to receive treatment, Mother Joseph converted a building into the first permanent hospital in the Northwest, St. Joseph Hospital. The corporation Mother Joseph established in 1859 is acknowledged as a "Pioneer Corporation in Washington State," and is one of the oldest in the Northwest.

As the more people moved into the territory, Mother Joseph was tireless in her efforts, traveling by horse to communities across what is now Washington, Oregon, Idaho, Montana, and British Columbia.

As a child, she was instructed in design and the industrial arts by her father, an expert coach builder. These skills and knowledge would serve her repeatedly in her mission of service. She was an exacting supervisor and took personal interest in all of the projects she oversaw; people would recount seeing her climbing and inspecting construction quality, or working long into the night herself to repair poor build quality. The design and quality of her buildings led the American Institute of Architects to declare Mother Joseph "The First Architect of the Pacific Northwest".

She worked tirelessly for over 45 years and is responsible for opening over 30 hospitals, schools, and homes for orphans. Even as her strength failed and she was treated for breast cancer she considered it only "inconveniences" and continued her work traveling to support the work of the Sisters of Providence. She was known for her political acumen, intelligence, and compassion; these traits paled in comparison to her faith and devotion to the Sacred Heart of Jesus. With her final breath she spoke these words, "My dear sisters, allow me to recommend to you the care of the poor in our houses, as well as those without. Take good care of them; have no fear of them; assist them and receive them. Then, you will have no regrets. Do not say: ah! This does not concern me, let others see to them. My sisters, whatever concerns the poor is always our affair."

The Language of Mission

Among the gifts bequeathed by the heritage of faith-inspired and charitable health care is language that shapes our moral imagination. The words we use to express the meaning of health care are not mere linguistic decorations. The words have a powerful capacity to support or to undermine commitments to provide charitable care. The philosopher, Jeffrey Stout, observes this about the moral power of the language we choose: "The idea that there are distinct moral languages, disparate conceptualities within which to understand and appraise conduct, character, and community, has become a commonplace in recent humanistic scholarship" (Stout, 1988, p. x). This means that faith-based and charitable healthcare organizations would do well to attend to the dominant language used to describe their work (Winslow, 1996). Some healthcare systems, such as that of Providence Health & Services, whose founder, Mother Joseph, in described in the sidebar above, have been careful to retain that language of service and caring.

As we have seen, one of the oldest ways to frame health care in Western culture (and perhaps in most human societies) is as sacred service. Consider, for example, the prayer attributed to the legendary medieval Jewish physician, Maimonides, which ends with these words: "Thou, All-Bountiful One, has chosen me to watch over the life and death of Thy creatures. I prepare myself now for my calling. Stand Thou by me in this great task, so that it may prosper" (Lyons & Petrucelli, 1978, p. 315). Similarly, in Christianity the connection between faith and the ministry of healing has remained strong. In the Christian testament, for example, one word (Greek *sozo*) means both "to heal" and "to save." Jesus commissioned his followers to teach the news about salvation and to heal the sick (Luke 9:1-2).

The evidence of health care's roots in religious faith remains, even if sometimes muted, in the languages of today's Western cultures. In Germany, for instance, nurses are still referred to as *Krankenschwestern*, or "sisters for the sick." In England, nurse managers are still called "ward sisters." Hospitals named for saints, or called Good Samaritan, Deaconess, or Sacred Heart are still common. Air ambulances in some areas fly through the sky with the name "Mercy" emblazoned on them. Multitudes of healthcare professionals in our society still understand their work as a vocational calling that is first and foremost a sacred ministry to those in need (Chapman, 2006). A prime example of this was the founder of NYU Brooklyn Lutheran Hospital, Sister Betty, a Lutheran visionary (see sidebar below).

I WAS A STRANGER AND YOU WELCOMED ME. (MATTHEW 25)

As waves of new immigrants struggled to survive in America's largest cities during the latter half of the 19th century, several faith groups were among the charitable organizations that stepped forward to create much-needed safety nets of health and human services. The depth and breadth of social ministries sponsored by the Catholic Church soon became an inspiring model for many other denominations. Norwegian American Lutherans alone sponsored 28 hospitals, 20 hospices, 20 "homes for the aged," 14 children's homes, and a home-placement service for orphaned children.

A predominant number of these health and social ministry services were founded and operated through the Protestant Deaconess movement, with scores of women trained in "motherhouses" to serve as nurses and healthcare providers. The Norwegian churches in America established 3 such motherhouses in Brooklyn (1883), Minneapolis (1889) and Chicago (1897). These faith-grounded communities, centered in nurturing vocation and practical training, served as "nodes" for a widespread array of healthcare ministries, reaching inestimable numbers of unserved and underserved persons. For them, mission, meaning, and motivation were all grounded in faith, core values, and a deeply felt commitment to religious vocation.

A Norwegian Deaconess Nurse, Sister Elisabeth Fedde, stands prominently among those who literally immersed themselves—body, mind, and spirit—in providing medical care not only to their own particular ethnic group, but who also actively addressed the underlying "social determinants" of health/well-being encountered throughout the multi-cultural communities they served. In Fedde's case, The Norwegian Relief Society—the fledgling mission she founded with local congregations in 1883 in a 3-room boardinghouse—soon became known not only for providing medical care to Scandinavian seafarers, but also as a wider mission marked by whole person care throughout south Brooklyn—particularly benefitting the disenfranchised and impoverished. That included spiritual care, work in homes, prisons and congregations, financial relief, and placement services for orphans and the unemployed. The mission quickly evolved into a 50-bed hospital with both an ambulance service and nursing school. Now incorporated as "NYU Lutheran," its mission to the underserved immigrants of south Brooklyn *has virtually not changed*. Today it comprises one to the busiest Level I Trauma Centers in New York City, serving all 5 boroughs through one of the oldest and largest Federally Qualified Health Centers in the United States.

There are, of course, alternative ways to describe the work of health care. During the second half of the 19th Century, for example, a novel way of talking about health care arose—it became *war* against disease. One author suggests that this language coincided with the arrival of germ theory, the bacterial enemies viewed as threatening invaders capable of overwhelming the body's defenses (Sontag, 1978). It is also the case that much of what medicine came to know about trauma surgery, triage, and the control of infections during this time was being learned on the battlefields of Europe. In the military manner of speaking, health care's mission was to combat diseases with batteries of tests and arsenals of drugs, sometime referred to as the physicians' armamentarium. Doctors write "orders," and younger staff physicians are still called house "officers." It is also telltale that patients who leave hospitals are discharged. Nurses, who work at stations, take orders when they are on duty. Sometimes they refer to the injections they give as "shots." Today the military language is so pervasive that what was once novel has become common.

The widespread adoption of military language in the provision of health care has had powerful effects in creating a shared understanding of the work's meaning. Its use helps to ensure the expectation of loyal obedience to authority along with courageous, self-sacrificial service against a common enemy. Such language supports a willingness to take risks, work long hours, and create a tightly knit team in the noble battle against illness.

Today, the languages of the ministry and of the military have largely yielded center stage to the language of the market. The 1980s witnessed the appearance of the "health care industry." One of the first persons to notice such language and complain about it in print was Rashi Fein who wrote: "A new language is infecting the culture of American medicine. It is the language of the marketplace … and the cost accountant" (Fein, 1982, p. 863). At the heart of his complaint was the belief that such language "depersonalizes both patients and physicians" (Fein, 1982, p. 863). Now, more than 30 years later, the idioms of business tend to dominate much of our talk about health care. In this business-like way of speaking, health care professionals became providers and patients became customers or, especially in the language of some nurses, clients. Discussions among health care executives are filled with references to market share, productivity measures, and product lines. Such language is borrowed substantially from economics and marketing. Those who cannot or choose not to speak this way are likely to be written off as lacking necessary, hard-edged economic realism. In sum, today's health care increasingly runs the danger of losing its charitable soul, devolving into yet another commoditized industry.

The distance from the ministry of healing to the health care industry is great. It is not measured in years or miles but in the way people understand the essence and meaning of what they are doing when they care for the health of another person, and *why* such care is offered. Each of the three ways of characterizing health care's purpose as described above discloses some important truths about caring for the health of whole communities and for their members who become ill. No one can deny, for example, that medicine today is big business, and growing bigger all the time. The financial resources required to keep such efforts going are enormous. No one who cares about the viability of today's health care can ignore the pervasive financial realities. And whether it is a battle against an outbreak of the Ebola virus or a fight against cancer, there are certainly analogies to marshalling the troops to win the war. Physicians will still give orders, and patients will still hope to be discharged, as opposed to "checking out."

What about health care as the response of faith, hope, and charity to people's often inconvenient pleas for mercy? One of the critically important roles for Stakeholder Health is strengthening the self-understanding of faith-inspired and charitable health systems as they develop more effective ways to care for the health of whole communities. This requires more than the preservation of nostalgic language or storied past. Together, the participants in this learning collaborative can find new language

that powerfully expresses our commitments to charitable service in the 21st Century with all its cultural and religious diversity. Finding fresh ways to explain the core value of health care understood as spiritually meaningful service is a welcome opportunity. There is good reason to hope that creative communities of spirit will find those fresh ways to grow their centuries-old legacy of health care as the service of mercy, such as that emerging in Alameda County, California (see Alameda County Care Alliance Advanced Illness Care Program™ sidebar).

THE ALAMEDA COUNTY CARE ALLIANCE ADVANCED ILLNESS CARE PROGRAM™: A FAITH LED COMMUNITY-FAITH-HEALTH SYSTEM PARTNERSHIP

The Alameda County Care Alliance (ACCA) is a coalition of five churches representing over 35,000 people in Alameda County. Together, the Pastors and congregation members with experience in healthcare and healthcare administration have designed The Advanced Illness Care Program™. This program provides persons needing advanced illness care and their caregivers with navigation assistance to local resources and information to manage spiritual, social, health, and planning for advanced care needs. With support from Kaiser Permanente, the Advanced Illness Care Program™ has been developed as a partnership of the ACCA with local clinical, academic, and public health institutions.

ACCA utilizes a three-pronged approach to improving care management for persons with advanced illness and their caregivers by training 1) church-based community care navigators, 2) pastors and faith leaders, and 3) family caregivers. Through a series of 10 in-person and telephone interactions, ACCA care navigators and faith leaders link persons needing advanced illness care and family caregivers to needed resources, including transportation and meal preparation, support for advanced care planning, and to address identified physical, psychological, and spiritual needs. The Advanced Illness Care Program™ will enroll 500 persons needing care and caregivers, tracking program feasibility, process implementation measures, and satisfaction, quality of life, and experiences of care for persons with advanced illness, their caregivers, pastors and faith leaders, and navigators. ACCA will serve as a national resource and knowledge base for a faith led community-faith-health system partnership to improve advanced illness care management.

Building off the community health worker model of community health clinics, the ACCA has developed the community care navigator role from a faith-based perspective within all Hub churches. Community care navigators are not medical professionals, but are trusted, well-respected individuals in their ACCA church. Having undergone extensive training with a curriculum developed by the ACCA and the Allen Temple Leadership Institute, community care navigators work closely with their churches, ministries, and community organizations to align advanced illness care resources and associated information to the needs of persons needing care and caregivers. The ACCA has also developed a Care Ministry of dedicated volunteer congregants who work with the ACCA and care navigators to support programmatic needs. Seven care navigators have been trained and are working with over 300 persons needing care and caregivers through the 5 ACCA Hub Churches in Alameda County. Additionally, 61 volunteers are assisting with the program. Over 98 individuals participated in a 2-day care ministry volunteer training at the end of July 2015 on advanced illness care, interviewing skills, and roles and responsibilities of volunteers in the ACCA AIC Program™.

The ACCA program has comprehensive outreach efforts in place for recruitment of participants, communications with local media and partner organizations, and is building partnerships with health systems and hospitals, hospices, and community organizations. On August 30, 2015, the ACCA and its partners hosted a Caregiver Recognition Celebration and Health Expo bringing together 1100 people across Alameda County to honor the dedication and support that caregivers provide to loved ones. Over 25 local, regional, and national organizations attended this event.

The ACCA is part of a national movement to transform care for those with advanced illness, and is a member of the Coalition to Transform Advanced Care (C-TAC), a national, non-partisan, non-profit coalition of 120+ organizations. ACCA shares the C-TAC vision that all Americans with advanced illness, especially the sickest and most vulnerable, should receive comprehensive, high-quality, person-centered and family- centered care that is consistent with their personal goals and values and honors their dignity. ACCA looks to expand the program within the Hub churches and beyond, partnering with community organizations and health systems to support advanced care planning. For more information on the ACCA Advanced Illness Care Program™, Hub churches and Partners, sponsorship opportunities, and the Caregiver Recognition Celebration and Health Expo, please visit www.accarealliance.org or contact Rev. Cynthia Carter Perrilliat, Executive Director, 510-427-4624.

Moral Vision

The moral vision of Stakeholder Health continues to be best expressed in the expectation of creating the beloved community of life, health, and hope. Both the heritage and language of faith-based and charitable healthcare institutions grow out of the compelling moral vision of grace, sacrifice, compassion, and abundant life. This is a vision of life over death—a vision of health continually coming to life within communities of spirit. The vision of the beloved community of health is the yearning expression of faithful people to create better health outcomes for all.

We believe the current period of America's story represents what may be called a *Kairos* moment—the right time for renewing the moral vision of faith-shaped and charitable healthcare. Alternatives to the complete commodification of healthcare are needed now more than ever. Health care envisioned as the business of waging war against death, in the most cost-efficient manner, will not provide the transformative power that will lead to the beloved community of health. What is needed, instead, is an abiding commitment to social justice and a firm unwillingness to accept health disparities as inevitable. This is the vision that has enlivened the participants in Stakeholder Health at their best.

Such vision is exemplified beyond the normal boundaries of healthcare in the growing movement called "Black Lives Matter" which challenges the notion that the lives of African American are in any way less valuable than other lives in our society (Day, 2015). The movement seeks to address the issues of violence and discrimination in the administration of criminal "justice." The need for such a movement is a reminder of the depth of social injustice that is still pervasive in our social institutions, including health care. As Dr. Martin Luther King, Jr. (1966) once said, "Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane." Inexplicable and inexcusable unfairness in healthcare is now so much a part of the fabric of our society that it may cease to shock our collective conscience.

Part of the prophetic core mission of Stakeholder Health is to remind society that the social determinants contributing to poor health are the products of intentional behaviors and policies. These policies are often rooted in soil that includes white supremacy, male dominance, and pervasive xenophobia. This is the soil of death and destruction. The moral vision of Stakeholder Health emboldens us to stand against such injustice and take the side of life.

Choosing Life

In this chapter, we have set forth some of the central values that can guide the work of creating and sustaining the beloved community of health. We have also attended to the ways in which our language is shaped by a moral vision of mercy and justice and, in turn, how our choice of language may extend or diminish the moral vision. We conclude this chapter with a renewed expression of commitment to this vision. As leaders of organizations that participate in Stakeholder Health, we are devoted to investing our creative energy to *build a future in which whole communities choose life over death*.

As we wrote in our previous monograph, "We have the audacity to believe in a future in which a healthy, beloved community is an achievable reality" (Health Systems Learning Group, 2013, p. 82). We will continually refresh our covenant to learn from each other how we can best accomplish this goal.

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