

A MAGAZINE OF THE DIVISION OF FAITHHEALTH \ WAKE FOREST BAPTIST HEALTH

# FaithHealth

Fall 2020



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## The Blending of Science and Faith

This issue of *FaithHealth* magazine is about the ancient, modern and future phenomenon of blending science and faith. We think of it as a movement like other ones that have changed our social, political and institutional life. I was once asked by a board member: Who started this movement? I said, hoping for common ground, “Jesus?” And then pointed out that he got it from Isaiah and Micah who clearly pulled from deep in the story of the Jewish people’s long journey with YHWH. Every time science moves forward, it illuminates new ways for people of faith to care for the world God so loves. A hundred years ago, hospitals were possible, so Baptists invented one in Winston-Salem. In a few months, science is likely to give us a vaccine for COVID-19, so faith networks will be crucial to gaining rapid and widespread protection of the people.



Rev. Gary R. Gunderson

When institutions and politics change, new things become possible in new places. As this is written, a new partnership between Wake Forest Baptist Health and Atrium Health opens the possibilities that FaithHealth will spread and morph across 366 miles between the hospital on Hawthorne Hill and the one in Macon, Georgia. This opens a greatly expanded toolkit of ideas, experience and people. The partnership will be one of the 10 largest academic health systems in the nation and the only one with faith in its DNA, driving the learning about how to care for people across three states and hundreds of towns. What is possible to hope for as the Spirit and science move us?

Technically, Atrium is not faith-based, but it traces to an Episcopal woman who started two hospitals in Charlotte to bring science into the lives of people previously out of its range. Over the years, those hospitals became part of the community systems of Charlotte and, eventually, blossomed as Atrium. The values moving the people who made that happen resonate deeply with those of us on the convergent journey of “the Baptist” (Hospital): Gentleness, Justice, Generosity, Humility, Prudence, Wisdom, Kindness, Loyalty, Courage. In these most amazing of days, I (so this couldn’t be misinterpreted as an official Wake Forest Baptist request) would only add curiosity.

There are so many kinds of brokenness in our world that move us to lament. As Jesus wept over the city, so clearly, we do not know the way to shalom, health for all. But maybe together, we can find the next right steps.

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



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**NOTE:**  
*Some photos were shot prior to the COVID-19 pandemic. Since that time, all patients, faculty and staff are required to wear masks at Wake Forest Baptist Health facilities.*



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# The Growing FaithHealth Movement

By Gary Gunderson

These United States are always becoming something new, always moving. And if you want to see and understand this dynamic, it helps to get close enough to see it move. Over the past two years, some colleagues and I have driven the long highways — one road trip in a Winnebago, one in a Mini Cooper. Absent were the lectures, microphones, PowerPoints or ticking clocks you would experience at a big-deal national conference in a fancy hotel. It was just us listening for — and finding — the movement of FaithHealth.

The FaithHealth movement is alive in every community — from San Diego, California, to Wilmington, North Carolina; from El Paso, Texas, to Big Timber, Montana — where small groups organize themselves at the intersection of their most mature faith and some stream of relevant science. Mature means generous and generative — partnering with the Creator for the community that God so loves.

Relevant science is the body of thought and practice validated, tested, vetted by no-kidding scientists — the tools tuned to the challenge and opportunity at hand. If God calls you into the lives of vulnerable moms and their young kids, don't go without the relevant science. If you find yourselves ministering in a pandemic, ditto. Fortunately, this movement, the joining of faith and health, is growing. In every community we visited we found robust relationships between the local public health department or college or hospital and the emerging networks of faith.

Of course, this has been happening a long time, as you can see in our iconic stories of faith. What moved the Good Samaritan as he helped the traveler who had been robbed and beaten? And it is what you see happening in hundreds,

The root curiosity of FaithHealth is about *life*, not death or what's trying to kill us.

no, thousands, of stories almost too common to notice happening in the movement.

Some places FaithHealth shows up are where you would expect to see integration of faith and science — in medical centers established long ago by people of faith, such as Wake Forest Baptist Medical Center. Most of the stories are not in halls of medicine, but on the streets where modern Samaritans walk as neighbors and first responders, public health nurses coming alongside single moms and their kids, people showing inexplicable compassion for others they have no reason to notice under the bridge except that God makes us recognizable to each other.

The root curiosity of FaithHealth is about life, not death or what's trying to kill us. The medical field is way too much about germs and death. You can't afford to be anything but clear-eyed about death rates in a pandemic. But over the course of a life, one needs to understand the causes of life, too.

## Healthy Individuals and Social Webs

The most significant finding in the health sciences in the past quarter century has not been in genetics or pharmaceuticals but the recognition of the nonmedical "determinants of health." In 1998, the World Health Organization convened a panel of experts who announced that actually health is mostly shaped over a lifespan by nonmedical processes that they lumped in the category of "social." In their categorization, pretty much everything useful the Samaritan did was social. But the word by itself doesn't imply the radical power of the fuller phenomenon.

This oversimplification of the social hides the muscular tenacity of how we humans care for each other in complex and nuanced ways over time to not just heal after a wound, but to generate strengths that turn out to be relevant to the broad array of life. The communities that worship together are, of course, social, but they are much more. They work over time along all of the complex stages of life to form us as humans who know far more than biology about the potentials of life well lived that bears the fruit of the Spirit: love, joy, peace, patience, gentleness, goodness, faith, kindness and modesty. Those are health. And they determine health, not only of the individual but of the social webs in which those fruits are expressed.

Movements are always inconvenient for those who like the way things are. Many in religious life like to live on the sidelines where they are free to pretend they know the secrets of the universe after handing off to nonprofit organizations most of the heavy lifting of family and social services. These spiritual specialists are called out into the open when something like a pandemic comes, exposing that we are all tightly interwoven and need to at least learn the names

of those in the public health department. Likewise, on the health side where those running the business are happy to do so with preachers and prophets at a safe distance from the operational decision-making of who gets access to what services at what price, if at all. FaithHealth moves institutions and leaders into close relationship that may not be entirely comfortable or controllable by either.

**FaithHealth is a set of ideas and practices that link *healthy faith* to *relevant science*.**

FaithHealth is an annoying challenge to all who dumb down faith into a spiritual sideshow. The Pew Research Center predicts that one in five churches will likely disappear in the next few

years. Spirit is not enough by itself. FaithHealth may be an even more annoying challenge to those who dumb down the human experience to a set of interventions stripped of spirit. Jesus would have wept over a city that had a vaccine but did not know the things that make for shalom, the same fruits of the Spirit the Galatians knew long before germ theory.

**FaithHealth is a set of ideas and practices that link healthy faith to relevant science.** This picks a necessary quarrel; not all faith is healthy and not all science relevant. The point isn't to suppress the unhealthy or irrelevant; just don't feed it with your attention or energy. Let it go. Focus on the ideas and practices that lead toward life and away from the emptiness that signals death. The FaithHealth movement has produced a rich library of validated practices that help one distinguish life from death, if you need help. But in real life (the thing we live), our muscle memory is dependable as the Samaritan who did not need a single footnote to recognize the injured fellow human. Most FaithHealth practices at congregation or community system level are that obvious. The Samaritan spent little time on listing all the wounds; he began with what was possible and relevant—pick the guy up and get them to a hospitable place where he could heal. Pay a qualified inn-keeper. Promise to come

back and to see what happens. Come back. If you notice people lying by the road every time you come this way, get some friends together to figure out what is creating the pattern, and try to fix it. Don't overthink or underthink.

FaithHealth learned in the Memphis model that large networks of congregations can join with a hospital system to create a kind of compassionate social cloud that had demonstrated power far beyond a hospital alone to change patterns. The data showed that people from the congregations who had covenanted for health with each other tended to come to the right door (usually not just the emergency room), at the right time (depends on the problem or opportunity), ready to be helped (usually that meant not afraid), and not alone (meaning with somebody from their family or church who loves them).

This is both simple and not simple at all because there are so many possible doors and a fantastic array of conditions, each with its own ideal time for engaging a healer or helper. Ready to be helped and not alone are more profound since both are almost purely relational—am I known and welcome, not just insured; am I alone, or can those who love me come with me in this healing journey?

Health care operational technicians tend to focus on the right door and right time as obvious issues of "access," which tend to be dumbed down into cost and payment. Much of why health care organizations have wanted to embrace FaithHealth is because it has demonstrated financial value in lowering the unpredictable cost of charity care and unnecessary utilization. It turns out that relationships of higher trust are cheaper for everyone. But here FaithHealth gets a bit annoying again in that trust can't be claimed or declared on a brochure.

**FaithHealth is a web of practices that crosses over the boundaries between faith and health institutions, disciplines and structures.** This is not just about the practices of the institutions on the faith side of the health journey that might deliver to the hospitals patients who are more compliant, more convenient and efficient to treat. Mature FaithHealth networks do accomplish that over time but

only after the health care and public health institutions also comply with the most elemental moral characteristics of mercy and justice. Who exactly gets the vaccine when and at what cost? Where do the next millions of dollars of health care capital get invested? How far from the neighborhoods that need them most? How much of the hospital's investable funds comply with the instructions of the New York bond rating agencies versus how much with anything that the prophet Micah might recognize as loving mercy and doing justice? Just as a virus crosses over and changes everything, so too does the integrated and subversive knowing at the heart of FaithHealth.

**FaithHealth moves us into places and relationships that give life a chance to express the generous heart of a loving God.** If all we knew was biology or economics, the role of faith in health care would be simple—all about compliance with medical best practices and some prevention tips about flossing, jogging, and avoiding fat and sugar. It might tiptoe into some of the Medicaid models that are beginning to pay for some "social" things such as transportation and short-term housing. Faith radicalizes health, just as health radicalizes faith. Both sides of what is really one word make clear how much more mercy and justice it is possible to hope for. The early Christian movement drew people into a radical transparency of need and assets that made none go hungry and none go wealthy on their own. Only a mighty spirit can make that happen, but everywhere we are beginning to notice "unacceptable disparities" where we had only seen "normal," and far more to work with where we had once complained of what we did not have.

A core tool of the FaithHealth movement is Community Health Assets Mapping. This process nearly always brings to visibility about six times as many organizations and networks relevant to health than anyone had thought about. The highly participatory process always flips the problem from having too little, to bringing order and priority to what to do first with all the community assets. The answer calls forth a whole new leadership talent, "boundary leadership," that focuses on aligning the many kinds of assets previously hidden.

### Patterns of Expression

Just as there are patterns in the mature expression of the fruits of the spirit in a person, we have begun to see predictable phases of mature expression of FaithHealth within a congregation. A first-step congregation may understand that its members have a stake in a healthy community. A fully mature one may feel its muscles rippling to engage beyond its members, even sending them for service in other places and organizations. It may have an active process for evaluating its efforts against a more sophisticated bio-psycho-social-spiritual understanding of FaithHealth. Its capacity to reflect and evaluate long-term missionary efforts makes it a respected leader among the ecology of organizations in the community. Others listen to its prophetic voice on stewardship, especially toward the poor and those left behind. It draws members in who want to be transformed and sent out. It becomes key to webs of trust that make possible bold dialogue and practical co-labor across boundaries.

We don't need every congregation, much less every hospital and clinic, to allow themselves to be moved in the FaithHealth manner of movement. There are roughly 20,000 congregations between Winston-Salem and Macon, Georgia. This is the blended geography of Wake Forest Baptist Health and Atrium Health. If the doleful experts are right, the aftermath of COVID will bring that number down to 16,000 congregations in a couple years. That's still a massive array of social and spiritual assets. What if even 10% of those—only 1,600—were mature in five years? What if their muscles rippled and reached for the wounded, lost and left behind on all the pathways and streets of that region? What if they had such local and regional trust that every public health, social service and medical institution was drawn into a close working partnership that blended all we know that matters to health over a lifespan?

In the first issue of The Carter Center magazine that was one key wellspring of FaithHealth, Jimmy Carter said, "we must all make the choices that lead to life." Today, the ideas of FaithHealth find expression in the thousands of practical acts of kindness, healing, mercy and justice-making underway in communities and neighborhoods across the nation.





# RADIO ONDA DE AMOR CONNECTS HISPANIC COMMUNITY

By Tom Peterson

In his day job, Enrique Catana is a community health advocate in the Division of FaithHealth at Wake Forest Baptist Health. And he takes it seriously enough that in 2018, the city of Winston-Salem presented him with the Martin Luther King Jr. Young Dreamers Award for his work in community inclusiveness and race relations, citing his efforts to “uplift the marginalized in our community” and his dedication to “walking alongside individuals that are experiencing a health crisis.”

But he also transmits his passion for connecting faith and everyday life through a radio station.



Radio Onda de Amor (Wave of Love) is an online and streaming local community radio station, based in Winston-Salem. Through it, Catana reaches out to the local Hispanic/Latino population through their computers, tablets and smartphones.

Roughly half of the air time is contemporary Christian music (in both Spanish and English). The other half is programming that covers topics such as community resources, education, culture, news, immigration, financial challenges, mental health and general well-being. The tone is positive and meaningful. Lately, Pastor Daniel Sostaita, the station’s director, and Catana have been taking turns interviewing leaders working with the Hispanic community across North Carolina about COVID-19-related topics. Rev. Francis Rivers is behind the scenes lining up guests.

## RADIO ONDA DE AMOR CREATED FOR SERVICE

Catana, 37, is from Mexico City and grew up in Veracruz, but has been in North Carolina for 18 years, attending school in Winston-Salem. “I’m a beneficiary of the DACA program, a Dreamer since 2013.” He has a bachelor’s degree in theology from Selah University in Miami, Florida.

Catana says he always knew that he wanted to serve his community. He started working in radio bringing the drinks to the DJs in Winston-Salem as a volunteer at a local station. Then he learned how to be a DJ and worked for Christian and secular stations in North Carolina. “I decided to start my own station because of my own vision about what I wanted to do for the community,” he says. “I started saving money for equipment while working at other jobs.”

With a decade of radio experience, Catana started Radio Onda de Amor three years ago using his computer and some basic recording equipment. The content has grown and so has the audience—to several thousand listeners a month, mostly from the Piedmont Triad and across the state but also as far away as South America and Europe.

Because the Hispanic community accounts for almost half of the COVID-19 cases in Forsyth County, connecting listeners to community and available health resources is even more important to Catana. The station shares food pantry locations, mask and food giveaways

**With a computer and basic recording equipment, Enrique Catana started Radio Onda de Amor (Wave of Love) three years ago to reach the local Hispanic/Latino population through their computers, tablets and smartphones.**

and helps organize community events. On a recent Saturday, the Hispanic Community Task Force of Forsyth County held its first mask and food giveaway event. A broad coalition of groups focused on helping the Hispanic community deal with COVID-19. They helped 1,000 families, giving away 600 bags with food, more than 2,000 face masks, hand sanitizers, books and education about COVID-19, including why it’s important to wear the face mask consistently and correctly.

“The response from the community was amazing,” says Catana. “We care for the community between all these organizations, and we want to encourage others to join in future events.”

The station partners with a number of groups, including Wake Forest Baptist Health’s FaithHealth work, the Hispanic Community Task Force of Forsyth County, the city of Winston-Salem, the Hispanic League, Sin Fronteras Church, Forsyth Health Department and the Maya Angelou Center for Health Equity. “We share one mission,” says Catana, “bringing healing to the community.”



# A Unique Lifeline That Kept Workers *Financially Afloat* During Pandemic

By Les Gura

Rev. Maria Teresa Jones knew, as she learned about the potential effects of the COVID-19 pandemic in February, that it would likely devastate many of her fellow employees with Wake Forest Baptist Health.

Jones, chaplaincy program manager for staff support, was in a unique position to help along with fellow staff support team members, Bruce Johnson and Chris Ehrlich, as well as chaplains James Ingram and Corinne Causby. One of the responsibilities of the support team is managing Wake Forest Baptist's Employee Emergency Fund (EEF), which helps employees in financial distress because of an unexpected life circumstance that might prevent a mortgage, rent or car payment.

Working with her boss, Gary Gunderson, vice president of the Division of FaithHealth, they came up with a most simple idea when "shelter in place" orders were issued: How about the fund be used to pay two months' worth of rent or mortgage (shelter) for employees' loss of income as they were required to take unpaid furloughs averaging one week per month for four months during a time when Wake Forest Baptist had to focus all of its attention on potential COVID-19 patients and forego many of its regular clinical services? The decision was made to do this through the end of the fiscal year, by which time it was hoped some of the work restrictions would be eased.



**The requests to the EEF — and the stories the accompanied them — came by the hundreds.**

Jones' voice betrays her emotion in recalling hearing from so many people as applications for assistance arrived from across the spectrum of Wake Forest Baptist's 25,000-plus employees, representing medical centers, clinics and affiliated practices. She listened to or read stories of people coping with unique and emotionally wrenching personal crises—while also facing furloughs because of pandemic-related job changes.

"We had colleagues from the mountains to the coast reaching out for help," Jones says. "There was no specific category of people we were looking to help, no target group. Everybody that needed assistance received it. We lived our EEF commitment to inclusion and care for all our employees."

Normally, the EEF might take on a couple of hundred applications a year; the maximum gift given out is \$1,000. During the crisis period from February through the end of June, the fund handled 288 additional applications and paid out about \$340,000; the \$1,000 limit was allowed to be exceeded so that shelter payments were covered in full. The EEF absorbed the tax burden, too, so those receiving money will not have to declare it as income. Jones notes that 288 funded EEF applications equates to about 1,000 contacts, or people touched by spiritual care and financial support.

Recognition of the critical role employees have played throughout the pandemic has been in the minds of Wake Forest Baptist leadership throughout the crisis. Julie Ann Freischlag, MD, FACS, FRCSEd(Hon), DFSVS, chief executive officer of Wake Forest Baptist Health, and Kevin High, MD, MS, president of the Wake Forest Baptist Health system, acknowledged the "selfless contributions" of all employees by announcing a \$500 bonus to all staff in September.

"You administered or processed thousands of COVID-19 tests, quickly learned new workflows, delivered outstanding bedside care, comforted those who could not be with family, helped research new information about COVID-19, guaranteed medical supplies were available, cleaned rooms, delivered meals, and provided many other critical needs for both our patients and organization that are too numerous to count," they wrote to staff. "Your patience and kindness have been as evident as your devotion to protecting the health of the communities we serve."

Jones says the outpouring of thank you notes in writing, voicemails, emails and calls from those who received assistance from the EEF often brought her to tears.

"People were crying, overjoyed. Lots of employees were surprised," she says. "They never in their wildest dreams expected their employer would cover the rent or mortgage for a couple of months. It gave employees peace of mind, especially those with minor children now needing to be home-schooled."

The EEF typically has an annual budget of about \$250,000, and the effort to cover the additional funds needed to pay for the pandemic assistance was wide-ranging. There were individual gifts, employee contributions via payroll deduction, a donation by the Wake Forest Baptist Board of Directors, and, perhaps most important, a partnership with the Wake Forest Baptist's Philanthropy division, which wound up contributing \$357,000.

Jones says the partnership with Philanthropy will continue; the EEF must continue to replenish to cope with an anticipated difficult winter.

"We don't have a vaccine yet, and flu season is around the corner," Jones says. "Parents are home schooling, winter is coming with its higher utility bills. So yes, we're preparing for the standard peak of the EEF in the fall and winter months, combined with the fact that we're still in the middle of the pandemic."

# Buffalo Congregations, Others Make Real Difference in COVID-19 Response

**In Buffalo, New York, faith-based, community, government and health care leaders join together to effectively respond to the disproportionate impact of COVID-19 on the African American community**

By Tom Peterson

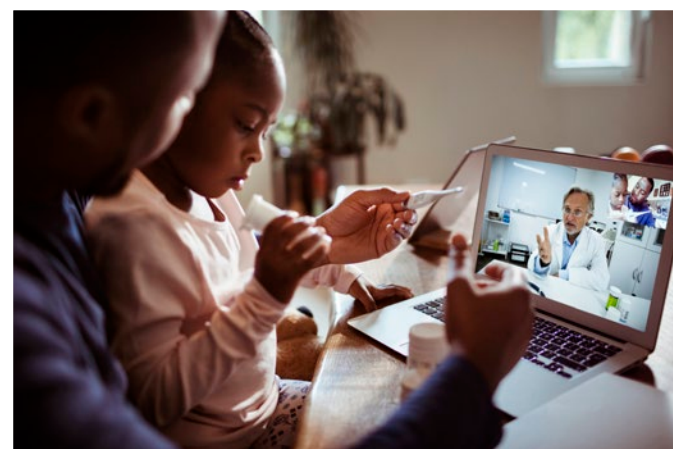
Rev. George Nicholas is pastor of the historically black Lincoln Memorial United Methodist Church in Buffalo, New York, in which he was reared. He had great concern for the Black community in Buffalo, which for generations has suffered from neglect and poor public policy decisions by corporate interests, and where 40 percent of the people live in poverty. Around 2014, he and some other Black pastors were approached by a group with a query around colorectal

cancer: How do we get information about colorectal cancer out into the African American community? Nicholas challenged the group to have a bigger vision. "Let's dig deeper and not just focus on one particular disease but on the general health of African Americans in Buffalo to see if there's a common thread as it relates to chronic diseases." So, they formed a small group of mostly clergy and a few other community leaders who then reached out to some technicians who could help them look at state and county data and to understand the health of Black people in Buffalo.

From this work, the group learned of the high numbers for the preexisting conditions of asthma, diabetes and heart disease in Buffalo's Black community. And they realized that "when COVID-19 came into this region, it was going to have a potentially devastating impact upon Black folks," says Nicholas. "We lost people early on in the process. We lost some prominent people."

The data that informed their work was that, in the five or six ZIP codes where about 80% or 90% of African Americans live in Erie County (where Buffalo is), African Americans were off the charts in terms of the health disparity around every chronic disease: diabetes, heart disease, cancers, asthma. They were 300% more likely to have a chronic disease if they lived in those communities versus a white person who didn't, and that translated into shorter lifespans, roughly 10 to 12 lost years of life and a lower quality of life for many.

A historic tension, even some hostility, between the Black community and the University of Buffalo stemmed from a sense that the academy was not really trying to solve problems within



A coordinated response got information into the hands of at-risk members of the Erie County community, which has seen a lower percentage of COVID-19-related deaths in its African American community compared to similar size cities.

the Black community and because Black people were research subjects but never received any benefit from the results of the research. The university had just built a major medical school right in the Black community that was disrupting the neighborhood in a lot of ways, including displacing people, according to Nicholas. But that didn't deter him. "If there are institutions within your communities that have not been ... good partners with the Black community, don't let that history prevent you from holding

them accountable and making them work with you on current challenges."

So, they created the African American Health Equity Task Force with many partners, such as the schools of education, law, nursing, management, social work and urban studies. They all came around the table to look at the data. The task force wanted an independent institution that would do research advocacy of program development and strategic planning

around how to move systems to positively impact the health of Buffalo's Black citizens. The group established the Buffalo Center for Health Equity, which included not only the various schools at the university but other groups such as Concerned Clergy of WNY and Hope Buffalo. The center's goal is to "eliminate race, economic and geographic-based health inequities by changing the social and economic conditions that cause illness and shorten lives."

“We created a safe space but also a transparent, open and honest space where some white institutions were really confronted with their own internal racist practices that contributed to these negative outcomes,” says Nicholas.

Fast forward to 2020 when COVID-19 was about to hit the community. The group already knew that the existing health systems were not sensitized for the priority of Black health. So, a phone call gathered community leaders, including public health officials, to ask “what’s our plan to deal this great threat?”

### Infecting with Information

Raul Vazquez, MD, is chief executive officer of the Greater Buffalo United Accountable Healthcare Network (GBUAHN), an independent association of physicians organized to contract as a group to provide health care services. Having practiced in the area for 30 years, Vazquez understood the value of being rooted in the community, and that made a big

“To solve the right problem, you have to have proximity to the problem,” says Whyte.

difference when the pandemic hit. The group developed a community

response by creating different buckets. Because they had data on thousands of people, some dealt with population health (focusing on cohorts or groups vs. just individuals). They offered COVID-19 testing because at the time there was almost none going on. “My office had been running a drive-through testing site. We were just trying to keep up with these supplies because there was not enough at the time,” says Vazquez.

And they thought about the 15,000 people they were managing through care coordination and wondered about infecting those 15,000 lives with information. Those people could then share that information. Meanwhile, to avoid spreading the virus, the group shut its offices in March and shifted to telehealth. Then, Vazquez reports, the group decided “let’s do the chase list. Let’s find out who’s at risk, collaborate with the churches, collaborate with the behavior entities and the coordination arms. We have about 240 employees, we have an IT infrastructure that can handle two to three thousand calls.”

“We looked at high-risk individuals,” says Vazquez, “We looked at people that really were affected by social determinants of health and would have the potential to get into trouble.”

With telehealth—if not through video then through phones—the number of visits almost doubled. “We were

telling them to stay away from the emergency rooms. We told everybody to stay home.” If people tested positive, they were told how to look out for others.

The Buffalo Center for Health Equity, in partnership with the many churches, created a phone bank system using phone number data from the Board of Elections. The group knew that when someone from the church calls, they’re going to get a better response because they’re already known. “It was great because we were able to kind of put them on our platform so ... they had chase lists,” says Vazquez. “The churches are often the trusted entity in both the Black and brown communities.” From this large-scale, HIPAA-compliant “tele-triage,” the group was able to tell people about testing availability, send out equipment, create virtual visits to bring in specialists, make sure people had food, personal protective equipment or other help. And they were able to go to the homes to provide needed services. “In the old days, the sick people did not come in, you took care of them at home,” says Vazquez, “so we just went back to that model.”

The group hired COVID response team members, mostly out of the churches or students who were home from college, and trained them, got them on the phones to make appointments and to just do the tracking and the follow-up. “They had a level of compassion and patience and an understanding,” says Nicholas. “It’s tough because when you’re cold-calling people, the response rates aren’t great—but they’re good—because a lot of people don’t want to talk to somebody they don’t know. But we persisted. We got on the Black radio and said to the community, ‘Listen, these calls are coming. They’re not bill collectors. These are people trying to help you out.’

“We’ve made over 100,000 phone calls now,” says pastor Nicholas. “We partnered with GBUAHN, Dr. Raul Vazquez’s organization.” Of course, some people don’t have phones, so the group contracted with the National Witness Project, which sent teams door to door in the midst of the pandemic to check on people and ask if they needed help. The group and others set up testing inside sites at a local library and in other places and made sure that the community-based health centers had access to tests.

### What Were the Results?

According to the Centers for Disease Control and Prevention, race and ethnicity can point to “risk markers” for conditions that can worsen COVID-19 outcomes, such as poverty levels, access to health care and increased exposure to the virus due to jobs as essential workers. Nationwide, the rate of cases for African Americans compared to white, non-Hispanic people is 2.6 times higher and the death rate is 2.1 times higher.

The first issue, according to Maria Whyte, deputy county executive in Erie County, was a commitment to transparency about the data. The second was the political and community will to work together. And the third was creativity about what strategies to employ, including those by partners outside the health care provider systems. For example, says Whyte, transportation to testing locations was identified as a barrier. So, they engaged with Erie County health nurses and the Department of Public Works vehicles to take the coronavirus test directly to individuals. This was in addition to the mobile testing units set up by Vazquez.

Beyond the many local churches, the effort included the library system, private health care systems and others. Labor unions were able to identify 5,500 essential workers who lived in the three ZIP codes with the highest concentration of COVID-19 cases.

These phone banks not only connected people to resources, but they also gave in-the-moment direct feedback about what people needed. “To solve the right problem, you have to have proximity to the problem,” says Whyte. “Being in touch with folks like Rev. Nicholas who conducted these phone banks helped us maintain that proximity to the problem and really make sure we properly understood which problems needed solving.”

And how did their problem-solving turn out when compared to similar sized cities? While African Americans make up 13% of residents of Erie County, they account for 16% of the COVID-related deaths, a pretty close number. A research assistant in Whyte’s office looked at other municipalities across the country similarly sized to Erie County (with roughly 1 million population) that were also tracking COVID-19 data. For example, African Americans in St. Louis County, while 25% of the population, made up 39% of the COVID-related deaths. In Milwaukee County, Wisconsin, African Americans represent 27% of the population but 40% of the deaths, reports Whyte.

The focus on the social determinants of health is essential, and although COVID-19 has exposed the great cracks in the system that were already there, Erie County itself was already working on it, says Whyte. Years of building trust and working together allowed the various groups to move quickly—and together. Last September, they launched Live Well Erie, a partnership of more than 90 nonprofits, businesses and others, to eliminate many of the health disparities. “We know that we have a great deal more work to do, says Whyte, “but we are on the right track and trending in the right direction.”

*This article draws, with permission, on a National Academies of Sciences, Engineering and Medicine webinar with Live Well Erie, a coalition that focuses on the social determinants of health.*

Nationwide, the rate of cases for African Americans compared to white, non-Hispanic people is 2.6 times higher and the death rate is 2.1 times higher.

GOOD IDEAS < REAL SOLUTIONS

DESPAIR < SUPPORT

## THE MISSION CALL OF HOME:



LONELINESS < CONNECTION

## DAYTON, OHIO, TAKES CARE OF ITS OWN

By Melanie Raskin

HOPELESSNESS < OPTIMISM

Like a lot of American cities, Dayton, Ohio, has problems that create despair, loneliness and hopelessness. But it is also full of bright and shining people turning good ideas into real solutions that transform despair into support, loneliness into connection and hopelessness into optimism. And it is all because of alignment—knowing the right people with the right resources at the right time, and connecting them in the right way. Often, the intersection of need and help is Kettering Health Network (KHN). This not-for-profit group of eight hospitals, Kettering College and more than 120 outpatient facilities serving southwest Ohio is the perfect nexus of support, according to Peter Bath, vice president for missions and ministry. In charge of building and nurturing intentional partnerships in the community and an integral part of community efforts and programs, Bath believes deep problem-solving requires a broader view. “The real need is to move farther upstream and look at social determinants that drive people to moments of despair, hopelessness, helplessness and lack of community, and address those core needs of housing, food and work,” he says. “These are the true challenges at-risk populations face. Imagine life as a river. Things unaddressed upstream have bad outcomes downstream: lacking food and work manifests in diabetes, high blood pressure and heart disease. We have to address core needs.” Day by day, step by step, Dayton is answering the mission call of home.

### MEETING THE OPIOID CRISIS WITH CARE

The opioid crisis in Dayton has decimated families and addicts, but also first responders, who suffer from compassion fatigue and burnout. The community has risen to the challenge and created a number of programs to answer the myriad needs. KHN worked with other health systems and first responders to create OneFifteen, a whole-person addiction and recovery residential program that includes crisis stabilization, social consultation, peer support and vocational training.

Brigid's Path is Ohio's first newborn recovery center for babies exposed to or addicted to drugs. With a capacity of 24 babies, the facility has cared for 100 infants since 2017. Mothers in recovery choose to send their newborns suffering withdrawal from addiction straight from the hospital neonatal intensive care unit to Brigid's Path, instead of into foster care. This 24/7 service offers moms in recovery compassionate support, community connections and resources, and continuing care, standing by mothers on their journey to recovery. It provides babies a healthy start, family care and safety first. In a word, hope.

### CREATING 'HOME' FOR EVERYONE

As the number of African refugees from Rwanda and Democratic Republic of Congo grows, so does the opportunity to connect and support. Currently, the approximately 300 refugees are being helped by organizations, advocates and volunteers, including KHN, to navigate the Immigration and Naturalization Service (INS), overcome language barriers, find housing and jobs, and access the education system. The African church meets on the campus of Grandview Hospital.

The nonprofit Good Neighbor House (GNH), a collaboration of Dayton-area Seventh-Day Adventist churches, provides food pantry services, clothing and household items to underserved people. The challenge of affordable health care for Dayton's working uninsured populations expanded the original GNH vision to include additional partners, resulting in a clinic providing a full range of medical, dental and vision services, as well as health education and screenings.



## WEATHERING THE STORM

On Memorial Day 2019, 15 tornadoes swept through town, devastating homes and families. For three weeks, KHN and a team of area nonprofit organizations, the Rotary Club and even area banks cooked and delivered meals to people in need. Once again, it was an opportunity to make the area churches the local hubs of engagement and support for local people. Creating a coalition of the faith community and networking area churches and congregations to minister to the spirit, as well as the mind and body, day-to-day and during disasters, are key to a healthy community. "This is what people need," Bath comments. "To gather and find hope, encouragement, health, education and resources."

## CARING THROUGH COVID

As in countless cities across the nation, COVID-19 is shining a relentless and glaring spotlight on communities,

revealing gaping holes in the societal safety net, showing just how gossamer-thin that fabric has been stretched, to the point of nonexistence. Bath and Dayton clergy have been stitching up those rents and tears as quickly as they can. Bath has hosted several Zoom conferences for hundreds of faith leaders to share the facts about the virus, talk through new ways to minister, identify sources of and responses to stress and anxiety, and understand and relieve isolation. For instance, partnering United Way agencies report the challenges of serving people experiencing domestic violence during COVID, since the abused are stuck at home with abusers. Downtown Dayton is one of the largest food deserts east of the Mississippi River. People didn't realize the importance of the school lunch program until COVID shut it down. "Local therapy is the answer," Bath says. "The sense of community that has always been there will see us through this. COVID has simply illustrated that we need to be creative and practical with our solutions."

KHN's Grandview campus has amped up its internet so the community can come in and use it. And KHN has created respite rooms for hospital staff, filled with donated gifts from churches and neighborhood people and businesses. One florist donated 250 Easter lilies last spring to show support for staff. Churches are leading prayer walks around the hospital, as well as parking lot pray-ins, flashing their car headlights toward the hospital as they pray. "All of these efforts are a message from the city to our staff and patients that we are not alone, we are all here for each other," Bath says. "Candy bars come and go, but you will never forget a prayer circle that encompasses your entire hospital."

## A TIME FOR CHANGE

Substance abuse or tornadoes, refugee resettlement or COVID, Bath believes it is time to move from mere drive-by concern to in-the-trenches care. "So often driving home at night, we

...IT IS TIME TO MOVE FROM MERE DRIVE-BY CONCERN TO IN-THE-TRENCHES CARE.

commute through downtown areas of need," Bath explains. "We don't linger, taking time to understand and address those needs. I think that's a checkbox way of looking at life. To incarnate, abide with, dwell within and build those partnerships has been a blessing. Many of my Sundays have been spent attending church downtown in West Dayton. I-75 is the dividing line in our divided city. The west side is challenged, but it doesn't need to be. Expecting people with need to get on a bus that doesn't exist to come get services in the suburbs doesn't work. Meeting people where they are—moving services and support downtown—does." Bath is quick to point out that this is not a rescue mission. "These are resourceful people of great wisdom who know exactly what is needed; they just need the tools to meet the challenges. Dayton is stepping forward and helping provide those tools."

Knowing where to start is often the biggest challenge. A spirit of discovery doesn't hurt. "As you begin to engage in this work, you find there's always so much more to do," he explains. "It's like an iceberg: We're only seeing the 10% on the surface and the other 90% is hidden underwater." But Bath sees problem-solving as a snowball effect: One person brings a skill and invites someone with a different skill to join in, that person invites another, and so on. "We know people have an innate desire to help make a difference," he points out. "They just need an invitation. Coordination is crucial. You have to know the core vision and mission of potential partners and agencies, and then you have to invite them to the table. The Greater Dayton United Way's 211 information service has been instrumental in our efforts. They've done a remarkable job. When we sit down and do an inventory of the extensive assets around us—food, housing, health care, work opportunities, social programs—we see that many of these problems exist because we are not connecting people with needs to people with resources." To Bath, alignment creates sustainability. "If it's one person doing the work, it's good as long as that person has energy and resources. If it's us doing the work, we can create a lifetime of empowerment and change. The call is to build bridges and create the space for folks to step in."

Bath dreams of a day when suburban churches partner with downtown churches for real change. "Mission work isn't always international," he says. "It's right here in our own backyard." Kettering Health Network's nine campuses are intentionally reaching out to local clergy and providing first responder education so pastors have a better understanding of what's confronting their

communities and to gain confidence in the strength of their health care outreach. Bath believes these downtown churches can become the center of local information and resources in their neighborhoods, a place where neighbors can experience health care, worship and community.

Another dream is to harness the democratizing power of technology; if you have a phone, you can get support. "My vision is for our devices to geolocate us, and when we push a button, 'I need food,' 'I need a dentist,' 'I need a job,' an inventory scrolls a list of resources near us," he says. "We have to look to technology to be the bridge that links us to the people and resources that can help. Then we need a supporter, a friend, someone who can help the refugee, the marginalized person, the underserved and uninsured worker navigate health care, food deserts, language barriers and employment opportunities. The goal is to create that same safety network that's here for the rest of us for them."

Dayton, Ohio is a city divided. Add to that the recent tsunami of trouble, from the devastation of families living the opioid crisis that confronts most American cities, to the destruction that came from a swath of deadly tornadoes that ravaged neighborhoods, to the social, health and economic impacts of COVID. But this city discovered divides were made to be bridged, chasms were made to be crossed and separation was made to be knitted together again. They learned success hinged on the alignment of assets—bringing together disparate people in one cause: the healing of whatever is happening to them and through them, as a community, for the community.

"The whole point is to be with each other, to walk together, not just pass through, drive by or write a check," Bath concludes. "It's being a friend, sitting down and helping people plan the practical stuff. Love shows up and says, 'Let me make dinner for you, let's do a healing service after nine people are shot and killed downtown.' We are our neighbor's keeper, and we need each other. In Dayton, we don't do things to or for someone. We do things with each other." And that makes all the difference.



# Healing through Community Investment

In the late 1980s, the crack cocaine epidemic was hitting its height in the southeast part of Stockton, California. At the intersection of Airport Way and East 8th Street, there would be 50 or 60 people dealing crack cocaine, says Fred Sheil, executive director of STAND. “People learned to not even stop at the red light because it was too dangerous.” Partly because they were outgunned, the police would show up only when there was a body to pick up, he says.

## Taking a STAND

Neighborhood residents, mostly people of color, waited for years for the city to do something, and the city never did. So, they organized and formed Stocktonians Taking Action to Neutralize Drugs (STAND). Around 150 members got together and started going to the city council, the school district board and the newspaper to point out what was happening.

The chief of police began working with STAND to start community policing, and within five years they were able to reduce crime by 80%, according to the organization. This partnership between residents and the city was so successful they won national awards. Around that time, STAND began buying and rehabilitating foreclosure properties and houses drug dealers were kicked out of. And they never stopped.

Neighborhood healing happens slowly, says Sheil, so you may not notice. “But year by year, you just see

crime going down, you see kids doing better in school. All those indicators of wealth and health are slowly, gradually going up instead of down. Cost to the city and the county in terms of welfare and everything else is going down.”

## Help from the Retirement Fund

As STAND began to rehab more properties, it struggled to find lines of credit for buying properties and financing the rehab work. “Local banks didn’t want to work with us for the same reasons the city didn’t want to work with us,” says Sheil. “Everybody says they want to, but they don’t understand these low-income minority neighborhoods.” Enter Sister Judy Rimbey and the congregations of women who co-sponsored Dignity Health and founded many of its hospitals. Rimbey had managed Dignity Health’s community benefit work and its community investment program. They offered STAND a couple-hundred-

thousand-dollar line of credit from their own retirement fund to develop three or four properties at a time.

When the 2009 real estate crisis hit, Stockton was ground zero. Homes were either being foreclosed or people were just abandoning their property. Dignity Health provided STAND with a million-dollar line of credit for them to buy every piece of property they could get—at five cents on the dollar—to resell to a low-income family at a very reasonable rate so the families could own their property, says Pablo Bravo, system vice president of community health for CommonSpirit Health and Dignity Health. And for those families who could not afford the mortgage, STAND would lease the properties back as rentals and help the families prepare for possibly buying them back when their circumstances improved. “This helped stabilize neighborhood after neighborhood,” says Bravo, “because they could keep the families in their properties by refinancing them at a lower level. If they were buying a house that the family bought for \$100,000 and STAND bought it for \$30,000, then the family could basically remortgage the house into a \$30,000 loan.”

In 2019, when Dignity Health and Catholic Health Initiatives formed CommonSpirit Health, they both already had community investment programs that provide access to capital in low-income communities. “If you look at all the Catholic-rooted health systems that were started by Catholic Women Religious, they all have a community investment program,” says Bravo.

CommonSpirit’s program now has an allocation of around \$400 million, of which close to \$200 million has already been deployed to support efforts of groups like STAND. And CommonSpirit’s involvement often attracts other investors.

Today, STAND keeps three general contractors and their subcontractors going on a regular basis. When you turn some of the most blighted properties into nice homes for families you’re going to improve the neighborhood. But when you do it, as STAND has, with 350 properties, you impact an entire community.

## What is Community Investing?

These investing programs provide below-market interest rate loans and other investments to nonprofit organizations that are improving health and the quality of life in their communities. “There’s a trust factor there and historical engagement,” says Bravo. And they get to know new borrowers pretty well before any application is ever submitted. As a result, since conception, the loan default rate of the Dignity Health program is less than 1%, says Bravo.

STAND recently received a \$1.8 million Homeless Health Initiative grant from Dignity Health to provide permanent supportive housing for those most in need. “Through this collaboration between multiple partners, we are able to address both the social support and housing needs in our community, through this sustainable

model,” said Don Wiley, president and chief executive officer of St. Joseph’s Medical Center in Stockton.

*“This helped stabilize neighborhood after neighborhood,” says Bravo*

But it’s not all about housing. While 40% of CommonSpirit’s portfolio is in housing, it also funds arts and education, clinics, business and job creation, environmental programs, and food production and distribution. For example, it invests in California FarmLink, a group that provides low-interest loans not only for the production of food but also the stabilizing of minority farm owners and capital for equipment and other things that they would not have access to otherwise.

Why isn’t every health care system doing community investing? “I wish I could tell you,” says Bravo. “You have to have a pocket of unrestricted funds that you’re not going to use any time soon.” These unrestricted funds are usually used to replace equipment, provide cash flow, make repairs or grow the business. Bravo was part of a group that in 2017 established the Healthcare Anchor Network to help health care systems across the country improve their communities “by leveraging all their assets, including hiring, purchasing and investment for equitable, local economic impact.” Around 50 health care systems have already joined the network, so watch this space!

By Tom Peterson



SALE PENDING



SALE PENDING



SALE PENDING



The Huntington Quick Response Team:

# The Face of Opioid Overdose Healing

By Melanie Raskin

It was a bad day in Huntington, West Virginia. In an eight-hour period in 2016, 26 people overdosed on opioids. And then something worse happened: **Not a single one of them received a follow-up.** They were alone. That was the tipping point that turned a bad day into a powerful catalyst and united an entire community — the local hospital and EMS, government, small businesses, and agencies — to step in and heal the problem, together. The face of healing the opioid overdose crisis in Huntington is the QRT, Quick Response Team.

Inspired by an Ohio model and funded by two 2017 federal grants, the Huntington QRT visits people with substance abuse disorder (SUD) who have recently overdosed to check in, share information about helpful resources and ask the all-important question: Are you ready to enter a program? Composed of a paramedic, a counselor/recovery coach and a law enforcement member, the team works its mission of care and support with a philosophy of meeting people where they are. But they are also willing to go beyond where people are, taking them where they want to go, too. If a person with SUD says yes to getting help, the QRT stands by them, right then and right there, as they make that first critical phone call to a treatment program.

## Help Is Good — More Help Is Better

It's powerful work, but the team quickly discovered something vital was missing. The area's 300 churches knew exactly what it was: them. Initially, the faith community was invited to make peanut butter and jelly sandwiches for the QRT to share with the people they visited and to open their food pantries to people with SUD. Led by the Huntington Black Pastors Ministerial Association, the ministers decided they wanted more: They yearned to be on the front line, walking side-by-side with the team, knocking on doors and solving the problem. The Huntington QRT became the first in the nation to include a pastor as a spiritual safe haven, caring listener, and gentle encourager. And for an addict who feels unseen, unheard and unworthy, that can be a gift from heaven.

"In the beginning, several pastors came to me and said, 'I'm tired of doing funerals for young people. I want to change all that and help.' Participating in the QRT was the answer," says Connie Priddy, former ER nurse and the Huntington QRT program coordinator. The program is based at the Cabell County EMS, the ambulance service that serves every overdose call in the county. From the beginning, the churches were all in. The team has had as many as 30 ministers working four-hour shifts, Monday through Friday, noon until 8 p.m. Churches still donate peanut butter and jelly for the signature team offering of a sandwich to the people the team visits. But they also show their support in other ways. One woman at a local church knitted scarves and hats for the team to distribute in the winter. Another group organized a coat donation. The work can be hard sometimes, but it is always rewarding. It's so rewarding that the pastors have upped their game—and their investment in the community—by expanding their support beyond SUD. Pastors have attended education sessions on HIV, rape and human trafficking as well.

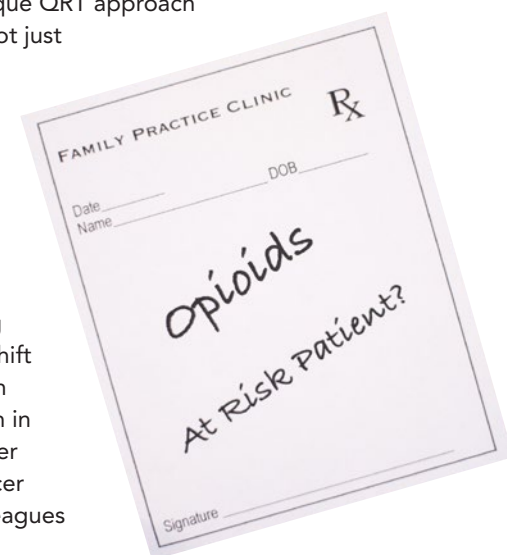
Sometimes, things happen, and we are called to do and be more. Jana Stoner, former director of FaithHealth Appalachia and now health program officer for Pallottine

Foundation, which supports transformative health initiatives that empower all individuals to lead lives of optimal health, self-reliance and self-respect, was one of those people. She was serving a local church when she heard the news of the 26 overdoses. "I was struggling with how in the world a community with 300 churches got here, where there is such hopelessness and despair and loneliness," she says. "If I am a person of faith, then why am I not doing something? My personal journey is, if I believe what the scriptures tell us, then why not be brave and loving and look at those who are struggling as if they are the face of our loving God? So, I made a commitment to be a part of what is happening here—the good, the bad, the ugly, the joyful—and help create a solution." Stoner, a part of the QRT program from the beginning, recruited and trained pastors for the team.

## A Continuum of Care That Benefits All

A surprising outcome of adding a faith component to the QRT was that the pastors quickly began pulling double-duty, ministering not only to the people struggling with SUD but also to the first responders who were experiencing compassion fatigue from visiting the same addicts countless times. Change is hard. Sometimes addicts overdose again. And again. Some die. Frustration, stress, loss and grief are constant companions to the QRT, along with hope, passion, dedication and care. While the QRT is designed to help stop the opioid overdose cycle and support people choosing treatment and wellness, often the people in need of support were the team members themselves. The pastors were good listeners and spiritual advisers, helping QRT members through the tough times—and feelings. It's a well-rounded continuum of care for both the receiver of services and the giver.

"Our law enforcement and paramedics have been dealing with this for so long, it was easy to get compassion fatigue and burn out, to feel cynical about the problem," Priddy says. "Our unique QRT approach of truly helping and not just applying a band-aid has renewed the spirit of everyone on the team." Success stories fuel Huntington's human engine of care. One off-duty QRT member working his law enforcement shift stopped a vehicle with two users. The woman in the car wanted to enter treatment, so the officer called in his QRT colleagues



to help. A year later, he was in a gas station, and a woman he did not recognize came up and thanked him: It was that same woman. She had successfully completed treatment and was now on the other side of the intake desk as a counselor in the facility. Now, she was in the position to help someone, all because of him and the QRT. “The QRT changes the way you feel about people with SUD,” Priddy says. “Now we have a tool for doing good—and it’s a tool we can share. We keep our EMS ambulances stocked with QRT cards that EMTs pass out. They don’t want to go back to the same person over and over. They want more than just a band-aid, too. Many times, they have brought in an addict they’ve shared information with and told them, ‘Hang on, someone is coming to see you and help.’”

But being all in doesn’t necessarily mean being in charge, Stoner is quick to point out. The QRT’s role is not to have all the answers; it’s just there to support. “Sometimes there can be a top-down approach to

creating change from funders, government, advocates and other community decision-makers,” she explains. “But really, the local people experiencing the problems and working for solutions are the experts. The person with SUD has a long journey of recovery—we can’t do that for them. They have to be willing and want to change. But it doesn’t hurt to have a friend. We can be that friend. Our role is to help, walk beside them and support their decision.”

**But it's our job to care enough to find them — whether it's at a gas station, at the overdose scene, in a house or in a park.**

## Connection, Not Intervention

Priddy feels the strengths of the Huntington QRT are their genuine care and diversity. “We have men and women of all races and ages, ranging from in their 20s to 70s,” she explained. “And our churches come from every denomination—and no denomination. We’re all united in one purpose.” People with SUD feel that care, see that diversity and are lifted up by that purpose. Regardless of the outcome of the visit—and there have been hundreds since 2017—the gratitude is profound. “I was getting to be a cynical, old nurse, and God put this in my path,” Priddy says. “It’s been humbling. Some people fall through the cracks and get lost. But it’s our job to care enough to find them—whether it’s at a gas station, at the overdose scene, in a house or in a park. And just about every person is nice. Even if they’re not ready for treatment, they appreciate someone checking in, asking how they are, bringing them resources. To have people looking—and looking out—for you and saying, we care and are here for you, is powerful.”

The QRT’s work is not an intervention, it’s a connection. And connection can be hard during the coronavirus pandemic. Plus, the pandemic revealed a bleak picture of the disparities in Huntington neighborhoods. The first seven weeks of COVID, the QRT did not make face-to-face visits. In May, they began their work again, inviting a smaller pool of about a dozen pastors to join them, slowly incorporating them into the new process.

## Real Care for Real Results

Ten years ago, if you polled Huntington’s citizens, you’d find a handful who knew someone with SUD. In the last five years, it seems everyone has lost a loved one to opioids. Giving a real face to addiction and meaningful support through the QRT has resulted in real results: The first two full years of the program (December 2017 through 2019), the overdose rates dropped an impressive 52%. The team has engaged with 900 people (and tried to locate others) and have helped nearly 300 (approximately 30%) enter treatment. The hope is that Huntington’s model of including the faith community on the team will go national.

The biggest lesson the town has learned—and is teaching—is that no single person or group is healing this community. Everyone has a role to play. “It’s a multifaceted approach,” Stoner states. “It’s the use of naloxone to revive people who have Od’d. It’s harm-reduction with needle exchange. It’s the front-line workers in the homeless and domestic violence shelters helping to direct people to resources. It’s the health care system that leveraged \$2 million to launch ProAct, which provides multiple services in one building for people with SUD. It’s our law enforcement, our mayor’s office and small businesses. It’s a total team approach of collaboration, communication and cooperation.”

Huntington Mayor Steve Williams told Stoner something she will never forget: You have to find your assignment. Ask yourself, what is God calling you to do? For Stoner, Priddy and the dedicated members of the QRT, the answer is easy. “What I’ve seen in my community brings me so much joy, I am glad to be raising my kids here,” Stoner concludes. “So many people in Huntington have found their assignment and are working collaboratively to make things better for someone. We know the big picture here, and that’s where our hope comes from.” Mother Teresa said it best: We can’t all do great things; but we can all do small things with great love. That’s what Huntington is doing, and it’s working.



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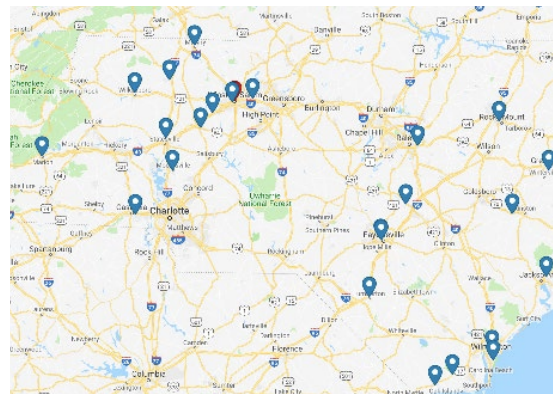
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