



Health care has become an issue of increasing political debate and national concern over the past few years. At the time of this report, health care reform is rapidly becoming a reality. Though there will continue to be arguments for and against the decisions reached by our nation's leaders, the points of agreement lie in the fact that our nation is faced with a serious need for better health care for all our citizens.

Infants die in the U.S. at a rate of approximately 6 per 1,000 births, which ranks in the top five of developed countries. The Infant Mortality Rate (IMR) is calculated as the number of infant deaths per 1,000 live births. Many argue that this is due to inadequate or lack of proper prenatal care. The Centers for Disease Control and Prevention has stated that at least a third of all infant mortality in the United States is attributed to complications of prematurity;<sup>1</sup> other studies assert that the figure is closer to half. With this information, it may be fair to state that infant mortality in the U.S. is principally a problem of premature birth, which is a complication of just over one in every 10 pregnancies.

Our expanding girth is America's most visible health problem. Not only are most adults too heavy, but obesity rates for children have more than doubled in the past 30 years. Americans today are heavier and less active than at any point in history. Two thirds of adults are either overweight or obese, and fewer than one third exercise at least three times a week. Excess weight is a significant factor in four of the six leading causes of death: heart disease, cancer, stroke, and diabetes. Obesity has also fueled a 45% rise in diabetes over the past 20 years. A person born in 2000 has a 1 in 3 chance of developing the disease. According to the most recent data from the American Diabetes Association, 23.6 million people have diabetes mainly due to lifestyle, and an additional 57 million are pre-diabetic. At the same time, by 2010 nearly 46 million Americans, including 8 million children, lacked health insurance.

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The news is not completely discouraging, though. In recent years, dramatic successes have been achieved in the fight against some of the most deadly illnesses. The death rate for heart disease, the number-one killer, has declined by 26% since 1999. The occurrence and death rate for cancer, the second most common killer, are in decline for the first time.

The challenges for the City of Memphis are not very different from the challenges of the nation. Infants are dying at the staggering rate of approximately 14 per 1,000 live births. The most common cause of death among all Shelby County residents is heart disease, which accounts for almost 30% of all deaths each year. Following heart disease, cancer is the second most-common cause of death among Shelby County residents at approximately 20% of all annual deaths.<sup>2</sup> The third cause is cerebrovascular disease, which includes strokes, followed by accidents, chronic lower respiratory disease (bronchitis, asthma, and emphysema), and diabetes mellitus. The next set of common causes of death among the general population fluctuate from year to year to include influenza and pneumonia, Alzheimer's, assault (homicide), HIV, septicemia, and essential hypertension.

#### **Health Assets:**

Memphis health resources include the hospital systems and numerous community partners and other organizations. These include local partners such as congregations under the Congregational Health Network (CHN) umbrella, Christ Community Health Services (CCHS), Church Health Center (CHC), Metropolitan Inter-Faith Association (MIFA), community agencies and state agencies, and coalitions like Healthy Memphis Common Table. The coalition also has national and international partners who will provide tools, materials, trusted relationships, infrastructure, volunteers, technical support, research design, possible grant funding, and more. Integrating and

building a seamless care delivery pathway that starts in and extends back out of the hospitals and community health clinics is key to an increase in the well being of the entire city.

**Health Challenges:**

The Shalom Health Committee studied reports of these facts and identified the following as the leading challenges to address, which are focused on improving access to healthcare and improving health outcomes for Methodist LeBonheur Healthcare’s Center of Excellence in Faith and Health, as originally formulated by Senior VP, Rev. Dr. Gary Gunderson:<sup>3</sup>

- Infant and Maternal Health
- Mental Health and Domestic Violence
- Chronic Care Conditions
- Frail Elderly and End-of-Life Care

**Infant and Maternal Health**

Shelby County and Zimbabwe have roughly the same incidence of infant mortality: 14 per 1,000 live births! Infant mortality is defined as death within the first year of life. From 2002 to 2005 the number of infant deaths decreased by approximately 17% in Shelby County. Nevertheless, the rate is alarming within the context of cities of comparable size and the number of families in our community who are forced to deal with such a traumatic experience. A clear disparity exists between African-American and white mothers in the rate of infant deaths. African-American mothers are three times more likely to have an infant die within the first year of life than their white counterparts in Shelby County. Factors contributing to infant death include prematurity, low birth weight, congenital abnormalities and Sudden Infant Death Syndrome (SIDS).

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**Mental Health and Domestic Violence**

Memphis has egregious problems with violence and mental health issues that do not stem simply from lack of care for the chronically mentally ill but from the unremitting stress of poverty, economic disparity, and lack of safety. For example, an African-American male between the ages of 18 to 54 is 13 times more likely to die of homicide or suicide

than his European-American counterpart. Roughly 60% of the recidivistic patients seen in the Med and the Methodist-LeBonheur Health System (MLH) emergency rooms have a co-occurring mental health or stress issue (such as low-grade stress and depression) along with another chronic condition (such as diabetes). Domestic violence is the source of 60% of all crime and 30% of murders.

**Chronic Care Conditions**

Memphis is the limb-amputee capital of the southeastern U.S., due to high incidences of untreated diabetes and subsequent limb amputations, primarily in African Americans. Memphis is also considered the “stroke belt” of the U.S., and cardiovascular rates for African Americans are double those of European Americans in Shelby County. Obesity, diabetes, hypertension, and strokes are pandemics in Shelby County, all closely tied to poverty level and ethnicity.<sup>4</sup>

**Frail Elderly and End-of-Life Care**

*The New England Journal of Medicine* study (1 April 2009) on costs of recidivism in Medicare patients (those rehospitalized within 30 days of discharge) reported that in 2004,<sup>5</sup> \$17 billion dollars were lost due to this problem, not to mention the suffering and poor quality of life for patients who must return to the hospital prematurely. In the case of Memphis and Shelby County, approximately 10% of residents are over the age of 65, and many live alone or in isolation yet may be in need of supervision. Some receive inadequate medical attention and along with their families are placed in the challenging position of deciding how to allocate available resources for basic living needs or medication and medical-related expenses. A significant number of these citizens have to forego the option of living in their homes to become residents of assisted living facilities and other hospices.

According to statistics by the Center for Disease Control (2006), Tennessee had the second highest state death rate from Alzheimer’s disease. Older people with Alzheimer’s usually have other health problems such as heart disease or diabetes. Alzheimer’s disease makes the treatment of other health problems more difficult and drives up the cost of care for many Mid-South families.

## Proposed Actions:

### The Memphis Model

The Health Committee will focus on these four challenge areas and ways to improve them in the future, using the Memphis Model, as originally conceived by Dr. Teresa Cutts, Program Director of Research and Practice in the Center of Excellence in Faith and Health.

The core of this strategy rests on use of the “love economy” of nonpaid volunteers to expand access, services, teaching, and healthcare resources further out into the community and congregations. Innovative ways of funding, or “seeding,” volunteer staff in the community must be taken into thoughtful consideration. That is, if there is need for gas money, continuing education, paying of licensure fees for retired nurses and physicians and ancillary staff, these needs must be met to allow such loving volunteers to be able to continue to work for love rather than money. Also, each of these volunteers could then ideally serve at a chosen local community health clinic, where he or she is known, respected, and trusted

The Memphis Model aims to use the best learning from the Chronic and Collaborative Care Model of the IHI and Wagner’s group, as well as public health initiatives like Healthy People, Healthy Communities and expand it further to build a delivery-care system that strongly emphasizes and activates involvement of the faith communities, community coalitions, and not-for-profit social service entities. This system will be integrated seamlessly with excellent primary care centers to be in six to eight neighborhoods of Memphis. The difference in the Memphis Model and the Chronic and Collaborative Care Model is the more intentional focus on building out the community resources (for patients and community), creating a delivery system design that starts in the community and links inside the hospitals and primary-care centers, built upon the scaffolding of the Christ Community Health Services, Church Health Center, MIFA, and MLH’s congregational partnerships (Congregational Health Network, CHN). Additionally, a tight link will be built between healthcare-organization leadership and that of community leaders, along with champion providers to expand the Clinical Information system support further into the community.

Leveraging and aligning fragmented community assets will expedite quality of life and broadly define community

health outcomes in Memphis. Addressing the social or root determinants of health (such as poverty, educational level, and safety) are all critical elements of The Shalom Project. All of Memphis will pay now or pay later for poor health status, and taking a proactive stance in preventing high-end tertiary care needs of indigent populations and redirecting care to more appropriate sites will be a win-win proposition for all.

The neighborhood church should use community and congregational intelligence rather than knowledge that is hospital-driven. Patient-centered care models start at home, not in the hospital. However, the ideology of community engagement in this model must shift from the concept of seeing involvement as an act of charity to that of improving overall community health. This is not those who “have” doing good deeds for those who “have not.” It is all of Memphis partnering together to improve the health of all Memphians.

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Integration of all systems of care delivery is vital in this model, with a major focus on shifting care further into the community and away from emergency departments at the Med and MLH University and other hospitals, which are used currently by many Memphians as their medical homes and for any and all health problems (up to 60% non-emergency). The Memphis Model will measure at individual patient levels the undergirding structure of congregational partnerships embodied by the Congregational Health Network (CHN), a growing partnership between MLH and more than one hundred congregations. Also, Christ Community Health Services (CCHS, circa 1996), the Church Health Center (CHC, circa 1987) and Metropolitan Interfaith Association (MIFA, circa 1968), three durable and not-for-profit faith-based organizations that provide primary care, preventive services, outreach to faith communities and social services, will undergird the work of integrating systems of care delivery in Shelby County. These structures of care delivery as described will be predicated on trusted relationships with CHN navigators and congregational liaisons, many of whom likely wear multiple hats. (For instance, one of



these people may be a nurse at the Med as well as a health liaison at a large African-American Baptist church as well as a volunteer for a ministry that supports victims whose families have experienced violent deaths). Improving self-management of care for individuals outside of hospitals and ambulatory care offices is vital and can be accomplished with greater effectiveness and efficiency via trusted liaisons in congregations. Building capacity for activated self-management of disease processes, such as care-giving, teaching, screening, and other healthcare efforts in the community, often offered by volunteer staff, is also key to sustaining this model.

Decreasing institutionalized services and building intentional and seamless pathways for care will be of great importance, but the effectiveness of how care flows through these pathways is contingent upon relationships and trust. Community engagement will be ongoing, in terms of each neighborhood and congregation offering their wants, needs, intelligence, and assets to the conversation about building this community-wide care delivery model. Transparency and sharing of data will come from use of the Religious Health Assets mapping strategy, which engages community leaders and gleans both what assets are available, as well as identifying exemplary service providers and programs and leveraging networks and relationships. The hospital care delivery system will be tightly linked with excellent primary care community health clinics, but the focus of this proposal will be on linking those traditional healthcare delivery systems tightly into the congregations and community at large, via CHN and other faith-based organizations' efforts. We believe that this approach will also leverage and activate the viability and resources of community coalitions, many of whom struggle to have good communication with traditional healthcare organizations.

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- 1 Center for Disease Control and Prevention (2006)
  - 2 Shelby County Health Department
  - 3 Methodist LeBonheur Healthcare's Center of Excellence in Faith and Health – Dr. Gary Gunderson
  - 4 Healthy Memphis Common Table
  - 5 The New England Journal of Medicine, April 2009