

REPORT TO MELISSA ROGERS: Executive Assistant to the President of the United States and Executive Director of the White House Office of Faith-based and Neighborhood Partnerships



MOUNT ZION
BAPTIST CHURCH OF GREENSBORO, INC

No something bigger altogether

GUILFORD COUNTY COMMUNITY

HEALTHCARE FAITH SUMMIT

**A
PRESCRIPTION
FOR A
HEALTHY
COMMUNITY**

**NOVEMBER 14
2013**

R PHARMACY
82004
**WORKING TOGETHER WE CAN CREATE A
BETTER HEALTHCARE SOLUTION**
0.25 MG TABLET
1.0 Refill(s)

**AN OUNCE
OF PREVENTION
IS WORTH...**

K-12
FOUNDATIONS
MEDICALCOMMUNITY
PREVENTION
COMMUNITY
EDUCATION
COMMUNITY

Theme: "We Are All in This Together"

This report was written by Dr. Robert Wineburg, Professor of Social Work at the University of North Carolina Greensboro, Pastor Odell Cleveland, Chief Administrative Officer of Mount Zion Baptist Church of Greensboro, INC., and Dr. Vincent Francisco, Associate Professor of Public Health Education at The University of North Carolina Greensboro, the lead planners of the Summit and partners in community education and service. We believed and still do, that our community wanted a forum to discuss and take local action, to address manageable community health concerns. What follows is a snapshot of eight months of planning to bring concerned people together from across our county, Guilford County North Carolina for a day of teaching, learning, and making connections. We knew that if we could just bring people together in a friendly atmosphere good thing would happen. They did.

We outlined our vision, our mission, give more insight into what motivated us, who actually delivered the education at the Summit, who was represented, who supported us, and a vision for the future. We provided 10 hyperlinks to the web in an effort to show readers more of the actual Summit. And we provided primary material in the appendices for those who wish to follow our planning process. Why us? Each of us has devoted his life, through education and service, to addressing the needs of the underserved. Why now? There is a health crisis facing this country and our county and particularly the underserved and we couldn't just do nothing. Below is our mission and values statement. The Summit's attendance and aftermath confirms that many people in the community share our sentiments.

Mission: Assuring the conditions under which health can exist, where health is believed to be success across physical, social, emotional, economical and community contexts.

Values Statement: We believe that three disconnected systems can be connected to bring about better health for the poor. We, as a school devoted to health and human science and community engagement, are positioned to bring these systems together. Mount Zion, as a church dedicated to serving the least of these through faith and faith works, can partner with the School of Health and Human Sciences at The University of North Carolina Greensboro to connect these systems.

The Healthcare Faith Summit in Guilford County on November 14, 2013, was planned for 8 months. The original planners intended it to be the beginning of a long-term community response to making our community a healthier place for everyone. Our goal was to shift the discussion in our community from two big policy concerns that few at the grassroots level could do much about: (1) the Affordable Care Act and the political battle in the media about whether it should exist or not, and (2) whether the Governor and Legislature of North Carolina made the right decision not to accept expanded Medicaid. These policies meant that 80,000 people in our county did not and would not have health insurance in the near future. The Summit planners made an early choice based on the fact that these people would need more than a voice: they would need help getting access to care.

The questions that faced the planners throughout the process were these: (1) How do we get a community discussion under way, so that the needs of the voiceless would not be drowned in the larger policy debates? (2) Who are the best people in the community to initiate and broaden the discussion?

(3) How would we bring people together? (4) What would happen when they met? (5) What would happen after we brought the community together? Answers to these five questions formed the core of our planning activities and constitute the remainder of this report.

Starting a Community Discussion

What the Summit planners saw during the first two and a half years of the implementation of the Affordable Care Act was less important than what we didn't see. We saw no serious discussion about the healthcare crisis that led to the policy in the first place. We decided that we would bring members of the community together to talk to each other. As experienced clergy and educators, we knew that unless the community understood that thousands of people were left out of our health system, so that emergency rooms would be their first and last resort for health care, there would never be a community response to helping those who needed it most. During April and May 2013, we drew up broad plans for the Summit. (See Appendix A for the planning documents.) Equally important, each of the planners tested the ideas about the viability of having a Healthcare Faith Summit in two ways: (1) bringing health professionals to our planning meetings for what we called "lunch and learn sessions," and (2) talking to people in health, education and faith communities at every opportunity about whether people would actually come together to talk about broader community health issues. Both strategies informed us that the idea for a summit was a good one, and that people from different segments of the community really cared and would help us grow the idea into reality.

Best People in the Community for the Discussion

We simplified our planning efforts by asking ourselves one question with three parts: Who in the health and nonprofit community, who in the faith community, and who in the education community were concerned about the different dimensions of health for those most in need in the community (See Appendix B for our planning diagram and SWOT analysis.) The planning team began to find an extremely diverse group of people who were very concerned about the same issues: leaders of health systems, medical doctors, dentists, public health professionals, nonprofit professionals, business people, faith leaders, congregational members, educators, political figures, and of course the people we were concerned about as well. As we branched out with our discussions about a November 14 summit, our core group grew. We also began to get voluntary advisory groups offering ideas and help along the way. (See Appendix C for the list of sponsors. Many offered more than financial help: they became instrumental in generating support within their networks, and played key roles in the Summit's educational and networking underpinnings. We were so overwhelmed by the people's desire to participate we decided to make a [video](#) of the people wanting to support our efforts. It became a feature of the plenary session.



How We Would Bring People Together

Our past experience showed that people in our community knew that Mount Zion Baptist Church had held successful summits before, concerning poverty and community responses. We did not know if the health community, which hadn't been central to previous summits, would see it as a legitimate community venue to speak about the crisis facing the health needs of the community's most vulnerable people. We were not sure the educational community would be comfortable at a church. We constantly assured those audiences that we were conducting research about how to ensure that the Summit would be evidence driven, and it was. (See our Summit [Program](#), starting at Fact Sheet 1.) We created a 3-minute [teaser](#) video from the larger set of people we were taping who represented voices from the health, education, and faith communities. That short clip touched on concerns that would be interesting to members of each system. We distributed it widely for a month before the Summit.

We knew that the faith community and many from the nonprofit community had been to other summits and were sure they would return for this one. For the health and education communities in particular, we knew from our initial networking that they were interested, and as we went to more meetings and had more discussions, we learned that there was a pent-up desire for the health professionals to share what they knew.

The same could be said for professionals in all sectors. So we began to ask people to think of an issue in health that they would like to teach in a workshop session for the community. The ideas for sessions snowballed. As we began our community marketing, we asked workshop leaders to choose panelists from their networks and asked everyone to promote the day within their personal and professional networks. By the time we were ready to do a full-blown community marketing campaign, we had a core of 79 workshop panelists for the 23 workshops, working quietly in their networks to promote attendance.

For the most part, the themes of the workshops were community driven and facilitated by community practitioners. Our full-blown marketing campaign included the standard e-mailing, public service TV and radio promotions, stories and promotions in the health systems' newsletters, university news stories, and local news stories. We also purchased 40 radio slots from minority radio stations, which was part of the strategy to attract local neighborhood residents. Our other strategy to attract students and local residents was to make the event free and provide free lunches for attendees.



Holding the Discussion

Our message to the community was that we were shooting for 1,000 people. Privately, we would have been happy hitting the 700 mark, which would make this the best-attended of eight community faith summits at Mount Zion. By the day before the Summit, more than 600 had preregistered. At other summits we always had nearly 100 “day of” registrants: our official count on November 14 was 762 people. We had a walk-through two days prior, and assigned rooms for the sessions earlier in the week and made adjustments based on the number of pre-registrants for each workshop. Mount Zion’s Events Ministry, community volunteers, and our research and planning team members, some of whom were students, served as volunteer guides steering people to their desired workshops. Our evaluation shows that aspect worked well.

Our plenary session was simple yet carefully designed. Pastor Bryan J. Pierce Sr., Senior Pastor of Mount Zion, was the master of ceremony and welcomed people on behalf of the church. Dr. Terri Shelton, Vice Chancellor for Research and Economic Development at The University of North Carolina Greensboro the other major institutional partner, welcomed people. The Governor of North Carolina’s representative from the State Division of Aging and Adult Services Mr. Dennis Streets, said a few words.

Rabbi Fred Guttman of Temple Emanuel gave the Invocation. This was highly symbolic in a Baptist church. It meant that houses of worship can also be houses of service and find common ground in a day devoted to helping bring about community health. We showed a 23-minute video featuring the community’s mosaic—the young, the old, and health, education and faith leaders—addressing the community about the health concerns they would discuss during the session to follow.

Our keynote speaker was Melissa Rogers, Executive Assistant to the President of the United States and Executive Director of the White House Office of Faith-based and Neighborhood Partnerships, and her remarks, especially about the strength of our community collaboration, were warmly welcomed. Mr. Tim Rice, leader of Cone Health, our community’s largest employer, and then Dr. Grace Terrell, President and CEO Cornerstone Health Care, a major regional



health organization, followed the Assistant to the President. Both Mr. Rice and Dr. Terrell were key supporters of the Summit, giving the go-ahead for the foundations associated with their health organizations to support our efforts. AARP of North Carolina was a vital sponsor and participant in the workshops. Two local physicians asked that UNCG match their pledge, which it did, and combined all of the above, those donors gave \$30,500. Our other donors contributed a total of \$5,350.

Mount Zion Baptist Church was the largest donor to the Summit. The church was also our regular meeting spot since late April 2013 as well as housing the Summit. Altogether, 11,000 person hours were contributed to the Summit.

The sponsor list, reprinted here and listed in Appendix C and Appendix D demonstrates our efforts to build an affirmative community narrative and financial stakeholder base. Our next effort was to build an educational stakeholder base.

What followed were 23 educational sessions. We were able to film 14 sessions. The videos were consolidated to give participants a snapshot of the tremendous learning that transpired in the sessions they could not attend.

What Happens after Bringing the Community Together

The Evans Blount Center is a public/private partner between Guilford County and the neighborhood around Mount Zion Baptist Church. We are rolling out this report at the Evans Blount Center as a statement that the UNCG/Mount Zion partnership is willing to be in the community and to offer its help to make the community the healthiest it can be by “working together.” Our university and community partnership has been grounded in the mission that we would help the community implement its ideas. We are brokers of education and service development. There are 14 congregations along MLK Drive and Willow Road including Mount Zion, and are surrounded by a community with many of the health disparities shown in the Summit program. Now that the community has come together, our partnership will continue to bring it together to provide the best health by promoting and assisting community with our skills: that are convening people from different sectors, helping them turn their ideas into action, and providing consultation on how to sustain current projects and build new ones.

This partnership is not one that will be driven by the two partners, UNCG and Mount Zion; rather, our efforts focus on guiding development. We have weighed in with the grassroots community, the health community, the faith community and the education community by bringing them to one place to share ideas, network, and begin the long process of community change. We have ample evidence for tremendous demand in this community for better community health. We have been contacted by a number of participants who attended the Summit. We intend to serve as eyes and ears, to be catalysts, conveners and brokers for community change. We will act like venture capitalists, in that we will listen to ideas, support promising ones, help shape the development of brand new ones, and provide mechanisms for technical assistance to build solid capacity for long-term community change. As partners with nonmonetary missions to educate and serve, our profit will come by accomplishing our mission. When we do that, the community and its overall health will be better than it might have been had we not ventured into this challenge.

Our strengths lie in the community’s view that this university/faith-community partnership can help develop and grow ideas into evidence-based practices that make existing health practices better, and can help good ideas and new partnerships take root and shape. If we can serve as a model, demonstrating that two large community institutions can combine their strengths in working for a common goal, then it will be up to the community members themselves to follow our example, working

with us and we with them, for broad-based, long-term change, based on partners finding common ground. Here are four of the possible directions the community might take.

One. A partnership is evolving with the Evans Blount Center to move from acting as a clinic in the community to being a community-based health center that captures some of the resources and spirit from the 14 congregations in the immediate 2-mile quadrant that the clinic serves. Perhaps it will become a community medical home with increasingly supportive congregational neighbors. That of course is up to the community. There are, however, elements in place from existing community structures that could make this a reality. Congregational nurses and social workers are already working in programs that serve this quadrant, and these programs use university students for intervention, screenings, referrals and brokering of supportive services. It is not out of the realm of possibility to connect the existing resources in a planned and coherent way with evidence-based needs that merge from the clinic services. From our pre-Summit exploratory surveys of congregations nearby, we found existing congregational health ministries and a willingness to be part of community partnerships. The seeds for change are there, and we will help fertilize them if the community has the will to make it happen.

Two. We have a commitment to ensuring that the next generation of divinity students and health-profession students are on the ground floor of what we see as a movement toward community-centered health education, early intervention, and diversion from the emergency room, and moving to emphasize prevention. To further this, Mount Zion is in the preliminary stages of developing a summer internship program with Wake Forest University School of Divinity, focused on teaching one or more divinity students about nonprofit development and community ministry. Research has shown that when a community agency's staff includes a pastor without a pew, its congregational partnerships flourish. We believe that it would be essential for multidisciplinary teams to intern together, so that when they practice their professions they share a common understanding of how community systems operate. To further that, the university side of our partnership will work with existing congregational nursing and social work programs, and perhaps other professional academic programs, to have coordinated interdisciplinary internships, thus preparing the next generation for community health practice of the future.

Three. While the "politics of now" have dominated narrative from Washington and state capitals, we have focused on the needs we could manage locally. We are not unaware that enrollment in health exchanges is key to the long-term success of community health, but have taken the position that we might help with enrollment, especially of the "invincibles," over the long stretch, instead of meeting the frenzied March 31 deadline. Thus, we had an afternoon workshop at the Summit with 285 attendees specifically devoted to the Affordable Care Act, with our purpose being to truly start to educate our community about that policy. As the largest attended session suggests to us, there is a strong demand to learn much more about this policy and what it actually does.

Enroll North Carolina has contacted us for informal help in reaching into the minority community, as they have had difficulty approaching the hardest to reach in the community where Mount Zion and other African American churches are anchored. However, as a result of the Summit one of the congregations on MLK Drive is hosting an informational session at its church later this month. Ours is a

long-term community strategy that envisions more neighborhood congregations who see partnering with Enroll North Carolina in their interest, and thus will begin helping congregants learn about the policy and getting appropriate information in a comfortable environment. As it stands, there is community interest but no well-developed strategy for the long term. We understand what it would take to connect these two kinds of organizations and the time and commitments needed to make such partnerships an integral part of the community. We will offer our help and guidance for those wanting to change the community narrative through congregational partnerships.

Four. We have signed a year-long contract with Public Access TV to produce high quality and informative health education programs for the community. We had 79 willing health, education and faith leaders participate in our workshops, many of whom would be willing to expand on the content of their sessions and many health experts in the colleges and universities in the county whom we can tap for their expertise. Mount Zion has a video infrastructure, as does The University of North Carolina Greensboro. Public Access TV also does live video streaming, so we have the capacity to reach a wider audience as we develop popular educational programs.

Conclusion

As the three original planners for this event knew back in April 2013, the first day of our real work toward concrete community change would start on November 15, 2013, and it did. Change is not always easy and often is slow. We succeeded in bringing hundreds of people to Mount Zion to begin the long process of community change. The three of us, Reverend Odell Cleveland, Dr. Vincent Francisco, and Dr. Bob Wineburg, have over 75 years of collective experience in community work. Dr. Francisco is an internationally recognized community health expert and founding editor of *Global [Journal of Community Psychology Practice](#)*, a journal promoting community practice for social benefit. He is also one of the architects of the Community [Tool Box](#). Dr. Wineburg and Reverend Cleveland have been community partners for 18 years. Our relationship with Dr. Francisco began nearly 3 years ago when an unsolicited [review](#) of our book appeared in his journal. Until then, we didn't know each other.

Since then, we have taught twice together in the community and worked daily on planning the Summit. Our commitment is the same: to promote community health, to educate and to serve.

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Appendices

Appendix A: Broad Plans for Summit

Appendix B: Strengths, Weaknesses, Opportunities, Threats (SWOT)

Appendix C: List of Sponsors

Appendix D: List of Financial Stake Holders

Appendix E: Program Components and Elements Brainstorming

Appendix F: Mount Zion Project

Appendix G: Early Event-Planning Template

APPENDIX A
Mount Zion Project
Logic Model

DRAFT Mission: Assuring the conditions under which health can exist, where health is believed to be success across physical, social and emotional, economic, and community contexts.

DRAFT Values Statement: We all believe that three disconnected systems (e.g., faith community, health service delivery, and university) can be connected to bring about better health for the poor. We as a school devoted to health and human science and community engagement are positioned to bring these systems together. Mount Zion as a church dedicated to serving the least of these through faith and faith-works can partner with HHS to connect these systems.

Inputs	Outputs	Outcomes	Impacts
<ul style="list-style-type: none"> • Health education activities (e.g., health coaching) • Awareness building activities (e.g., health fairs and screenings) • Community identification of concerns • Community mobilization for system improvements via University, Health Service Delivery, Congregational Partnership • Improvements in community data used to track outcomes and impacts • Workshops and other capacity building activities • Mentoring for increasing community engagement in problem identification and facilitating business creation 	<ul style="list-style-type: none"> • Increase access to screening • Increase access to health care • Increase access to follow up and support services • Family and community engagement in health service provider organizational decision-making • Community-wide discussions of issues affecting healthy and sick persons • Congregations become community health teaching centers 	<ul style="list-style-type: none"> • Improved living conditions • Reduction in fear of health systems among marginalized community members • Increased self-reported satisfaction with care • Increased proportion of people with insurance • Increased proportion of people with a medical home • Increased proportion of people reporting regular access to care • Increased engagement of community members in affecting broader social conditions - especially for youth • Increase in systems improvements (new and/or modified programs, policies and practices) facilitated by community members • Increase in financial investments in black community 	<ul style="list-style-type: none"> • Reduction in disparities in outcomes • Reduction in personal health problems • Improvements in community health indicators • Increase in prosperity (e.g. Jobs, median household income, education) • More positive outlook on the community • Increase in personal and community empowerment

Appendix B: Strengths, Weaknesses, Opportunities, Threats (SWOT)

Rev. Odell Cleveland, Bob Wineburg, Vincent Francisco

23 May 2013

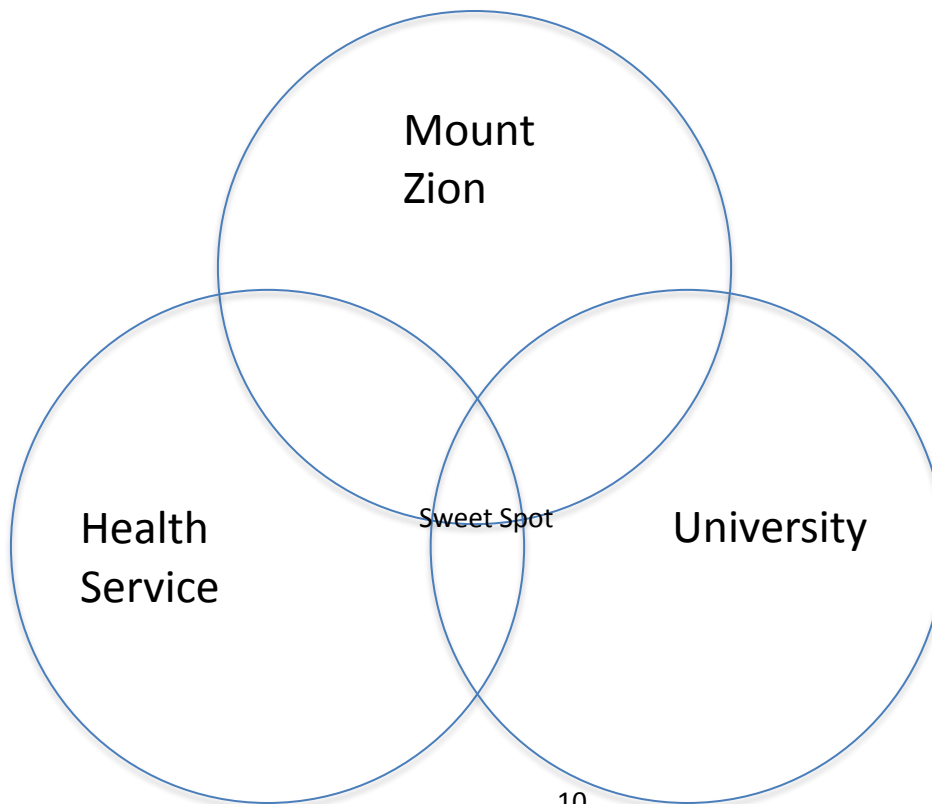
Broad discussions of opportunities and resources:

- Development of a community support network for medical services
- Mount Zion as the tool to allow the university and other community entities to be a focal point and think tank for health
- Lynn Wells - chief development for Cone Adult Pediatric Health, medical home
- David Talbot and Grace Terrell at Cornerstone Health
- Opportunities for extending African-American leadership

Vision

- Access to care for the most marginalized communities, especially those neighborhoods that are majority African American
- Involvement of Black Churches in access to care, empowerment, systems improvement, and improved health outcomes
- Create a model of effective community engagement between Black Churches, Universities and health service providers
- Transform universities through community mobilization and engagement

Venn diagram (triquetra) of intersection between MZ, health services, University



SWEET SPOT : We all believe that three disconnected systems can be connected to bring about better health for the poor. We as a school devoted to health and human science and community engagement are positioned to bring these systems together. Mount Zion as a church dedicated to serving the least of these through faith and faith-works can partner with HHS to connect these systems.

Strengths

Overall

We, core leaders, have done this work before. We have tremendous academic, experiential, and religious experience with each system ,and have proven outcomes strength in the talents and experience of the people involved to seamlessly bring people from each system to a common sweet spot while ensuring their systemic identify.

Mount Zion

- Black Church
- Community Legitimacy
- Assets
 - Vans and space
 - Membership/professionals
 - Financial stability
 - Leader in Full Gospel Baptist Fellowship national and international network
- Location and size
- Proximity to other Black Churches and low income neighborhoods

Health Services

- Know medicine
- Some are committed to community
- ACA is forcing their engagement
- Know service delivery
- Know about disease prevention (but don't necessarily do it)

University community engagement

- Research oriented and experienced
- History of capacity building
- Students within system and want to have a career in this work
- Experience in community engagement
- Diversity of faculty
- Diversity of students

Weaknesses

Mount Zion

- Black Church (takes it out of the private funding loop)
- No history of real community outreach for health

- New administration
- Experiencing disproportionate share of adverse health outcomes
- Does not know its internal assets (membership)
 - Some in health systems
 - Some in public health systems
- Don't know what we don't know

Health Services

- Operating in a bubble and use medical model
- Don't know community intervention model
- Technology and profit driven
- Top-down structure
- Slow to move
- Buy-in to science, but not to social science
- Arrogance
- Zero understanding of community supports and intervention potential beyond the broader health system (e.g. individual, family, neighborhoods and churches)
- Hounded by liability insurance, Medicaid and other systems that hold them back

University

- History of strip mining the community
- Faculty committed to publications, rather than effectiveness and outcomes
- A reward system that does not reward local outcomes
- Steady-state curriculum that does not respond to change
- Few have the concept of community education (e.g., use of social media and modern communications outlets)
- Hierarchical arrogance with the community

Opportunities

Mount Zion

- Address systematically the disproportionate burden of disease and impact on family and community.
- To provide grassroots modeling and leadership, all the way up to the White House using networking theory, practice and community education
- To serve the community
- To serve individuals
- Technologically advanced
- Infrastructure and space
- Can be a hub for a lot of activity
- To create hybrids where community organizations can THINK and CREATE without fear
- \$\$ - Legitimacy and the need others have for its legitimacy
- Opportunity to be heard by audiences that won't listen to the university and medical systems (trust)

Health Services

- Opportunity to extend their reach
- Reach the people the way they (Health Service Providers) want and need to reach them
- Reduce the need for services through prevention and early intervention
- Be a leader in developing new community supports
- Opportunity for them to win through mutual benefit and shared work

University

- Diverse expertise in:
 - Science, social sciences
 - Health behavior
 - Community systems
 - Data management
 - Capacity building
 - Case management and continuum of care
- Idea leaders
- Students to play-it-forward
- Create the next generation of applied researchers and community-engaged scholars

Threats

Overarching threats

- Need to get the right stakeholders
- Lack of credibility with each other –meaning each system doesn't know how the other can help it.
- Prior negative experiences

Mount Zion

- Poor communication
- Being believed by the university and health delivery systems

Health Services

- Poor communication
- Arrogance
- Budget cuts
- Mandates from Feds

University

- Poor communication
- Intellectual arrogance
- Intransigence
- Budget cuts and entrenchment

Potential Next Steps

- Extend SWOT analysis and continue to elucidate opportunities
- Build relationships with potential health service delivery partners
- Build relationships with area funders
- Develop relations with other religious institutions
- Develop a plan for financial management
- Develop a plan for community capacity building and empowerment
- Develop a plan for University engagement
- Develop funding strategies
- Develop roles for students
- Develop roles for other academics

- Develop roles for medical professionals
- Develop roles for allied health organizations

APPENDIX C List of References and Partners, as of July 2013 and List of Financial Stakeholders

- Sorien Schmidt Enroll America North Carolina Director
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- Dr. Robert Doolittle, Urgent Med and Family Care
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- Dr. Jerry Plovsky, Psychiatrist, Maimonides Health Forum speaker
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- Dr. Tim Lane
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- Tom Cone, Board Member Cone Health Foundation
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- Dr. Bert Fields Cone Health Faculty UNC Medical School
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- Paige Redpath, Cornerstone Health Care

- Pastor Jeff Pascal, Guilford Park Presbyterian Church
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- Dr. Gladys Ashe Robinson, Executive Director, Piedmont Health Services and Sickle Cell Agency

- Dr. Randy Jackson, Greensboro Radiology
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- Mount Zion Baptist Church
- League of Women Voters

APPENDIX D

Financial Stakeholders

Dr. Kurt Lauentien

Dr. Sherry Dicksien

Ms. Caroline Maness

Dr. Jerry Plovsky

Dr. Debra Shoenhoff

Dr. Melissa Lowe

Dr. David Lowe

Dr. Gary Fisher

Dr. Randy Jackson

Greensboro Radiology

Dr. Bert Fields

Dr. Debbie Fields

Rob Luisiana

Dr. Bobby Doolittle

Dr. David Talbot

Ms. Robin Lane

Bob Cone

Dr. Vernon Stringer

Lakeview Memorial Park

Greensboro Radiology

AARP

UNC Greensboro

Mount Zion Baptist Church

Cone Health Foundation

Cornerstone Health Foundation

Appendix E: Program Components and Elements Brainstorming

Component/Elements	Desired Outcome	Potential Funder
Faith Summit		
<ul style="list-style-type: none"> • Relationship building • Agenda setting • Program planning • Establishing our legitimacy among systems (both outcome & element) <ul style="list-style-type: none"> • Using common & new language • Student participation • Data gathering • Social media 	<ul style="list-style-type: none"> • Become leaders in community education • New partnership development between Mount Zion, health service providers, university, residents of neighborhood <ul style="list-style-type: none"> • Agenda for improved health & development outcomes • Agenda for primary prevention • Community support as fleshed-out model <ul style="list-style-type: none"> • Preparing next generation • Start planning with evidence • Legitimize social science in religious & medical community 	<ul style="list-style-type: none"> • KB Reynolds Charitable Trusts • NIMHD • United Way • Community Foundation • Cone • Jessie Ball DuPont???? • Mount Zion • Other faith communities
Health Service Delivery		
<ul style="list-style-type: none"> • Becoming equals in new conception of support 	<ul style="list-style-type: none"> • Trust in faith & education communities <ul style="list-style-type: none"> • Improved help in developing allied care systems <ul style="list-style-type: none"> • Increased access to care • Improved health outcomes • Reduction of racial & ethnic disparities in outcomes • New technological interfaces 	<ul style="list-style-type: none"> • Health service providers • ACA • Microsoft, Twitter, Apple, Facebook all have foundations
Health Service Delivery Follow-Up/Aftercare		
<ul style="list-style-type: none"> • Health coaching • Case management 	<ul style="list-style-type: none"> • Increased follow-through with aftercare & compliance with treatment <ul style="list-style-type: none"> • More successful treatment outcomes 	<ul style="list-style-type: none"> • Health service providers • ACA

Component/Elements	Desired Outcome	Potential Funder
Primary Prevention		
<ul style="list-style-type: none"> • Capacity building with community • Capacity building with students • Community systems improvement • Promotional/marketing strategies • Replication elements (why we need data & video data) 	<ul style="list-style-type: none"> • Community health education as norm within faith community • Stop health problems before they occur • Community leadership development • Capacity to influence • Empowerment • New or modified programs, policies & practices that add up to community solutions 	<ul style="list-style-type: none"> • OFBNP • Templeton Lilly • NIMHD • ACA & health service providers • KB Reynolds Charitable Trusts • Other foundations
Community Consultation Center		
	<ul style="list-style-type: none"> • Capacity building (group & individual) • Idea incubator • Program development 	<ul style="list-style-type: none"> • Fee for service • United Way • Community foundation • Consultation fees

Appendix F: Mount Zion Project

August 2014.

Name of event—what	Guilford County Faith Community Health Summit (and subsequent project)
Date of event	Thursday, November 14, 2013
Time of event	9 am to 4 pm
Location of event	Mount Zion Baptist Church 1301 Alamance Church Road Greensboro, NC 27406 336-273-4292 Fax: 272-4224
Mission	Assuring the conditions under which health can exist, where health is believed to be success across physical, social, emotional, economic and community contexts.
Event coordinator/contact person	Rev. Odell Cleveland, Dr. Vincent Francisco, Robin Lane, Dr. Bob Wineburg
Target audience—who <i>Who is this promotion targeted at?</i> <i>What does the audience need to know?</i> <i>What will hold their interest?</i>	<ul style="list-style-type: none"> • Health care consumers, especially minority, low wealth, immigrant and other marginalized groups. • Individuals who deliver care: physicians, nurses, direct care workers, therapists, community support staff. • Members of communities of faith: Christian, Buddhist, Hindu, Muslim, Jewish, nonaffiliated. • University faculty and students.
Message—what <i>What do you want to say to the target audience?</i> <i>What do you want them to know/do?</i>	<ul style="list-style-type: none"> • The faith community is potentially a willing partner in developing long-term community supports in collaboration with health and education communities. • To increase the knowledge, especially in the faith community, of the availability, enrollment and use of health insurance among the poor and working poor in Guilford County. Build a foundation of collaboration among health, faith and education systems. • Educate each other about current and prospective health-related promoting ventures. Create conditions that may spawn new and lasting partnerships in neighborhood and community health. • The subsequent “project,” expected to be in operation at least 3 years, will be aimed at strengthening the voices of those consumers of health care who have traditionally been left out of policy making. The goal is to transform the health care they can access, so they may achieve the state of health they desire for themselves and for their families.
Objectives—why <i>What do you hope to achieve with this event?</i>	<ul style="list-style-type: none"> • Insurance outcomes: 10,000 people enrolled in health insurance through the ACA's Health Insurance Marketplace and other programs.

	<ul style="list-style-type: none"> • Health outcomes: significant improvement in health outcomes most sensitive to access to health care. • Community engagement: create a model of effective community engagement between black churches, universities, & those who deliver care.
Description of event—what	<p>Welcome (faith representatives, health community representatives, university representatives)</p> <p>Keynote address (nationally known speaker)</p> <p>Participants divide into workshops (max. 30 each)</p> <p>Lunch—plenary address</p> <p>Workshops</p> <p>Summary and next steps</p>
Risk assessment—what <i>Identify possible risks and develop strategies to minimize risks.</i>	<p>1. Reaching target audience, as they may not be participants in community agencies and programs. Strategy: Enroll America data banks and volunteers.</p> <p>2. Shift power dynamic and give voice to those not used to speaking on their own behalf. Strategy: Anonymous survey, social media to collect input anonymously, new ideas for workshops</p> <p>3. Communicate objectives to audience for long-term engagement. Strategy: Demonstrate respect and welcome from first encounters (survey), listen and record stories and share with story banks, ensure feedback.</p>
Coordinate with (<make these into sentences>oral or written progress reports, naming in program, follow-up)	<ol style="list-style-type: none"> 1. Funding organizations committee (Wineburg/others as appropriate) 2. Individual donors (Wineburg) 3. Mount Zion Church (Cleveland) 4. UNCG (Wineburg, Francisco) 5. LWVPT (Lane) 6. Enroll America (Lane)
Other items for to-do list	<p>Survey</p> <ol style="list-style-type: none"> 1. Construction and revision 2. Focus group—assemble, survey testing and retesting 3. Training for “surveyors” 4. Administration to identified groups <p>Other?</p>

Appendix G: Early Event-Planning Template

Early event planning	Person responsible	Action	Date to be completed
Budget <ul style="list-style-type: none"> • Source identified • Sponsorship • Break-even point established • Communicated to Mount Zion, university, LWVPT 			
Invitations <ul style="list-style-type: none"> • Mailing list generated/updated • Invitation composed • Invitation checked • Printer • Calligrapher • RSVPs (responsible person briefed) • Invitation list compiled • Names on list and titles/addresses checked for accuracy • Special guests/speakers alerted to make time in diaries • Invitations sent 			
Advertising <ul style="list-style-type: none"> • Press, radio TV • Media release • Print/post fliers • Social media 			
Panel/Moderator <ul style="list-style-type: none"> • Book • Brief 			
Value added for guests <ul style="list-style-type: none"> • Voter registration table (will be after election, still good) • Health Insurance Marketplace application assistance • Materials to support summit objectives • Social media 			
Facility <ul style="list-style-type: none"> • Tickets?? • Tips/compensation 			
Audio/visual requirements <ul style="list-style-type: none"> • PA system • Lapel or handheld microphone • Panel seating • Videotape event for YouTube 			

Early event planning	Person responsible	Action	Date to be completed
Staffing <ul style="list-style-type: none"> • Extra required?? • Staff to meet and greet guests, direct to theater 			
Guest comfort <ul style="list-style-type: none"> • Wheelchair access • Hearing devices 			
Hospitality <ul style="list-style-type: none"> • Welcome signage at entrance • Ushers (LWVPT volunteers) briefed 			
On the day <ul style="list-style-type: none"> • Time for setup, by whom • Time for dismantle, by whom • Name tags • Pencils and note cards for questions 			
After the event <ul style="list-style-type: none"> • Debrief • Comments • Guest feedback • Guidelines for improvement next time • Evaluation against criteria • Celebration • Thank-you's 			

