GARY GUNDERSON: There are a couple of things I want to touch on today. In effect, the purpose of this conference, as I look over the 10 years of it, is partly to give those of us who have a personal interest in geriatric medicine-- I'm 62-- and those of us who are providers and who care with great passion about those who've entrusted their lives with us, in both cases, we're curious about what comes next, what's the moving edge of science allow us to see about what is possible to hope for, for ourselves, for our communities, for our patients. So think about this, say, 15 minutes as a little glance into what I think is coming next.

I appreciated especially following Dr. Shelton and looking at the very roots of that extraordinarily smart model, financially smart, medically model, and a hugely decent model came out of the grounded intelligence of the integrated understanding of faith and health from the Chinese community in San Francisco. And in a way, what I want to share with you is just a glance at what's coming out of the grounded intelligence of the faith and health community of North Carolina.

The map here is how a non-geriatrician looks at life. I thought it would be useful to take a glance at how a normal person thinks about life over a span of life. So on the left hand, of course, you come into life. It's important to think about. And unlike a lot of our Institute of Medicine timelines and graphs and stuff, I don't know if you are a mammal, you will have noticed that it doesn't go in a straight line. Actually, this is probably more an accurate course of life over this space.

Now it is a journey. And the fundamental logic of FaithHealth North Carolina is that we're on a journey. And most fundamentally, it's not a journey as an individual, rational, choice making, autonomous individual person. We are mammals. We come in in networks of love and care. Some of those networks are damaged from the very beginning. And some of those networks are beautifully crafted to nurture us along that journey in an optimal way of health.

And as we move through that journey, the quality of our life, the length and quality of our life, is largely shaped by who shares that life with us. One of the best indicators of long-term quality of life, including longevity, is participation in a congregation. And there is some mystery, like much of the medical indicators of longevity and quality of life. There is some mystery to that indicator.

I'm a little bit curious. Now let me, before you hold up your hand, let me frame my question correctly. What I want to ask is whether you are part of a faith community. But before you answer it, what I'm really asking is not, do you attend every Sunday? But if your mother thought you were in a congregation on a Saturday or Sunday, would there be one which you would feel obligated to be at?

So the actual data suggests that it's the sense of affiliation. It's not like a statin. It's not like just clicking the box and taking the pill every Sunday or Saturday, as your faith tradition might indicate. But I'm curious about how many people have a sense that if you had a spiritual crisis or a spiritual delight that you wanted to share, would there be a place that you could call spiritual home? I'm just sort of curious.

Most folks in the American South would answer like that. When we looked at the data in Memphis, we noted that about 70% of our emergency room clients said that they had been in a house of worship within 30 days of being in the emergency room. And there wouldn't be any other social space that would come close to that number.

Now among other things, I'm an ordained minister. And I know for a fact they were lying. [LAUGHTER] But I promise you, on a Sunday morning in Memphis after Beale Street, 70% of Memphians are not in a church.

But it's significant that if they had a crisis, if they were hungry, if they were ill, if they didn't know what to do with their mom, they did have a place that they knew would feel obligated to receive them as a member, as someone who is part of that community.

So the basic logic of FaithHealth NC, which is partly imported. Let me just pass as we go by. This is a nod to the Chief Financial Officers of our insurance companies and of our hospital. This is how they see that same life map. And part of the reason we're together, of course, is the end of life tends to be where an enormous amount of the medical expense of the industry really is concentrated.

Interestingly, as I look at who we are today, demographically we sort of look like about what a typical congregation would look like in North Carolina. Although we're about three times the average size of a typical congregation in North Carolina, we have roughly the same amount of white hair. Actually, we're probably slightly younger than the typical congregation in North Carolina.

So if you're looking around for who else cares about older citizens in our towns, congregations care, because they are that way. We think of congregational members, who are typically older than the average American, as being profoundly valuable, because they are the heart of the caregiving volunteer communities in all of these communities. But they're also vulnerable, for all the reasons we'll talk about the rest of the day.

Now what we're planning in North Carolina, I like this map for several reasons, was inspired by the effort, as Rich Lord mentioned, what happened in Memphis, Tennessee, called the Memphis model. And if you're academically inclined, you can Google it, and what it will take to you is a string of both peer reviewed articles and articles from the AHRQ and other governmental publications and some popular articles, most notably in the New York Times recently.

And what happened in Memphis was an alignment based on a covenant developed by a group of clergy at the invitation of Methodist Le Bonheur Healthcare to create a covenantal relationship between the faith-based health care system and the true health care system of the community, which were the congregations.

Now from the beginning, we estimated that what we wanted was about 20% of all the congregations in the service area of Methodist Healthcare to be in an alignment with what really is only a treatment system. And when I left Memphis, we had slightly over 530 congregations, mostly African-American, but about 100 Euro American and other varieties of American, in the community that were in a covenantal relationship.

And when we unpacked, did a retrospective analysis over what was the differential outcomes for patients who came from those connected congregations versus patients in the universe of other Methodist Healthcare patients and we took out of the comparison population those who expressed no religious affiliation at all-- so we were trying to compare connected congregations to less connected congregations-- what we found was that the patients who came from those connected congregations had much lower cost, for many of the reasons the PACE program has lower costs. There's an intimate daily attentiveness to those who are most vulnerable.

We now create coffee cups. I should flip to that one. Nope, nope, nope. I have another slide a little later on, I'll show you. Let me stay to the outcomes.

They cost lower. But most significantly, we found over a five-year period of time that patients from our connected congregations stayed out of the hospital after discharge, not 30 days, but about 120 days longer than our less connected congregants. And when you frankly, we weren't doing anything different clinically. I can promise you, clergy do not read any of the guidelines that we're discussing. What they do is preach. But most importantly, they provide a encouragement for the volunteer caregivers in the congregation to act like a swarm of caregivers over people who need that care.

And what we actually saw in Memphis was the release of competence and connection that created a radically different outcome in the aggregate. And so there are a number of different upside down, inside out bodies of logic to FaithHealth NC that is really inspired by what happened in Memphis.

Now North Carolina is a very, very different social, religious, economic, healthcare ecology than Memphis, Tennessee. It's mostly a small town culture in small towns that used to have a factory. And the level of poverty is quite similar in most of the small towns in North Carolina to Memphis. And so the difference isn't poor to middle class.

But the social culture of North Carolina is actually a small town culture, as we're finding. And as we take the Memphis model, bring that seed and drop it into this soil, what we're seeing is a very different, but more comprehensive, model of connection that is very encouraging. And it is just a seed, at this point. But the heart of it is still the same.

We ask clergy, beginning in Lexington, the fount of both barbecue but also healthcare innovation in our region, we asked the clergy to draft a covenant. And their covenant is based on their life experience of what is going on in the lives of their community and their members. And that covenant tends to be very, very smart, because it's built around the lifespan journey that tends not to be overly medicalized, but it's also not naive about the primary and profound importance of health in that lifespan journey.

And that covenant crafts then sort of writes the specifications around which the hospital needs to redesign itself and become compliant with, so that we are a teachable hospital, not just a teaching hospital, a connectable hospital, not just a connecting hospital. So this model, you hear how radically it turns things inside out, upside down.

The other clue of the radicality of this model, when you really listen carefully to those who understand the lifespan of the people we care about, part of what it tunes our attention to is those who are frequently the most overlooked in the entire health care apparatus are very commonly those with exquisite intelligence about those who are triple eligible, who live in communities of great vulnerability.

And one of the accidental pieces of brilliance that happened to us this year, when we started listening and we mapped where exactly are the census tracks, where exactly are the streets where our most vulnerable patients live, and who else might live there. And we will train and deploy some of our janitors and housekeepers to be community health workers in these communities of greatest vulnerability.

I say this. And so that training is underway. We've just hired the first full-time housekeeper and put her over to be a co-leader of this program. And they have chosen their own name as supporters of health.

So you sort of hear this upside down, inside out logic that is driving this. And I suspect as we get to the 11th and then 15th anniversary of this event, what you will find is more and more of all of our disciplines being turned inside out, upside down, but also de-centers the preachers, quite frankly. The healing agent in Memphis was not the preachers, it was the volunteer, mostly women who are caregivers in their congregations, who were released and not just empowered, but had their power that they already had recognized and connected in ways that they'd already had the power, but finally that power was connected to the treatment system, the hospital. And that's really what drove the very powerful incomes.

Now the last thing I want to hear about the upside down logic of all this that will be very different from today, and I'm just going to let you feel this language, because it's very different from the medical language. And this is the logic of not leading causes of death and risk factors, but actually leading causes of life.

I'm a Public Health Professor and a Professor of Divinity. And about 10 years ago, I had an allergic reaction to all the medicalized fascination with death. And being a person, A, and B, who was alive, I thought it would be important intellectually that surely, surely there is a rich language and logic over against the language of death and pathology and vulnerability and risk. Surely, we have a way to talk about life. But it turns out the medical field almost does not have those words.

So there is a group of academics and some normal people who are exploring this language of leading causes of life. And I just sort of signaled to you what is coming. And that would be a very rich set of conversation for us to come. But see if this doesn't remind you of what in your practice, in your life, in your family's life, in your communities' life, isn't actually what's going on.

So it turned out, there are five very simple words. And I want you to hear these. They're easy to remember, because you'll know it. You probably have a hand, as well. Connection, coherence, blessing, or you might use the word generativity, agency and hope. I just want you to sort of hear this language. And then I'm going to stop.

Connection. This, like my earlier map, this is actually how the world is connected. There are no straight lines in the world of any kind ever. This is a telephone pole in Vellore, India. And I think this is not just the way the brain is designed, it's also the way our communities are actually connected. This is the way we're perfectly adapted for the radical complexity of the way human beings are connected and our brains are well organized to handle complex relationships that we don't even have names for that turn out to be causal to our life, literally causal to our life. And our broken communities are no problem for our brains to figure out how to find our life. So the most fundamental cause of life is our ability to connect with each other in time, over time in ways that are meaningful and rich.

Coherence. Gorgeous body of long literature that was begun by Aaron Antonovsky, a Jewish sociologist, medical sociologist, working after World War II, that understood that the common experience in human life is actually struggle, stress, distress. If you get to be 62, like me, or 72, you will have experienced stress in your life. That's normal.

What the mystery that appealed to Antonovsky was, how is it that we find our life, that is a normal life of stress, how is it that we find health at all? Not what are the risk factors, but the real mystery is health, not disease. And he understood that the fundamental cause was coherence, our ability to find some logic and coherence to our life. And if you are an internal medicine doc working with older patients, you will know that when their life is incoherent, your meds are pretty near useless. And if their life is coherent, you will look like a genius. Because coherence will find its way.

I specifically don't mean the sort of rigid, creedal sort of religious model of lists of things we believe. I mean the deep understanding in our gut about that life makes sense, and especially this next, the third cause, of agency, that my choices, my behaviors, my decision to be here, not somewhere else, to do this today, not tomorrow, my ability to act as a choice making grown up is profoundly causal, not just of my life, but of those things that give meaning to my life.

So you've heard connection, coherence, agency. The fourth is blessing. We found that this word is a little bit too religious. What I actually was speaking to is the African sense of generativity, where we find ourselves in right relationship to the generation that came before us and to those whose lives depend on us, not just in time and sequence, but also sideways, our colleagues, our families who are alive in our life right now.

Many of your patients' life is defined by their sense that they are a vital part of a web of generativity that depends on them. So some of your patients who are medically vulnerable beyond counting still are able to be highly functional because someone needs them. Someone needs them to generate that life. So hear how this is a logic of understanding what's going on in the life of your patients and your community that's not just medical. So generativity.

And of course, the fifth, overwhelmingly best documented in any of our sub specialized literatures, is hope. There's gorgeous literature that simply says, if I think Rich is my doctor and he's smart because he's at Wake Forest, Rich's pill will work better than-- I won't think of another institution off hand, but it might be blue, say. No, I'm going to think the pill is going to work better simply because I'm optimistic about the quality of the advice I'm getting.

I don't mean that by hope. I mean the kind of deep, powerful human hope that is about what matters most to me, will live after me. So my mom, who died at 88, good United Methodist woman her whole life, died healthy because she was confident that the things that mattered most in her life were alive. And many of our older patients will live well, even as they move towards the great passage, if they know that the things they hope for the most will live beyond them.

So I want you to hear these leading causes of life as very grounded in science. You can imagine all of the sub literatures that actually make sense in the context of this and the enormous implications, not just for patient by patient medical practice, but for the opportunity we have to build, let us say, a web of healing throughout our communities.

I'm very proud that Wake Forest is working on this. I can't tell you how many physicians have been part of the discussions around this. And I think we're going to see it make a big difference in our communities. So I'm going to stop right there.