



# FAITH LEADERS NETWORK:

BUILDING COMMUNITY  
PARTNERSHIPS

TRAINEE  
RESOURCES



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***“We extend our deepest gratitude to our colleagues listed below for their tireless dedication, perseverance, and commitment to this important field.***

***Through their hard work, passion, and unwavering efforts, they are making a meaningful difference in the lives of individuals and communities.”***

GLORIA THOMAS ANDERSON, PhD, LMSW, Founder, Let's Talk About ACP@ Program and ACP Program Lead, Center for Practical Bioethics

DARRYL BLACKWELL, Community Development Department, DeKalb County\*

REV. DALE SUSAN EDMONDS, M.Div, Founder, Talk Early Talk Often

REV. GEORGE C. GILBERT, Jr., M.Div, Executive Director, Center for Racial Equity and Justice

CASSANDRA D. HARRIS-GRAY, LCADC, LMFT, BIP, Chief Executive Officer and Clinical Director, Creative Spirits Behavioral Health

MARISSETTE HASAN, RN, BSN, Vice President, Community Action and Policy, C-TAC

MARILYN FRENCH HUBBARD, Ph.D., MSA, Lead Consultant, Living Our Legacies

JULEUN A. JOHNSON, DMin, Vice President of Mission and Ministry, AdventHealth Southeast Region

COREY L. KENNARD, MACM, CPXP, Pastor, Amplify Christian Church and Director of Patient Experience, Henry Ford St. John Hospital

MONA NEGM, President and Founder, American Muslim Senior Society

ELDER ANGELA OVERTON, M.Div., C-TAC Senior Advisor and Pastoral Care Overseer, Burnett Avenue Baptist Church

JESSICA M. RUSSELL, Director of Operations, Arthur Vining Davis Foundations

CHRISTOPHER THOMPSON, Director of Development, Reimagine

REV. GLORIA E. WHITE-HAMMOND, MD, M.Div, Co-Pastor, Bethel AME Church in Boston, Massachusetts

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## FAITH LEADERS NETWORK: BUILDING COMMUNITY PARTNERSHIPS

*The Coalition to Transform Advanced Care (C-TAC) gratefully acknowledges the vision and financial support of the John and Wauna Harmon Foundation and the Arthur Vining Davis Foundations to create a “Resource Road Map.” It is designed specifically for faith communities who serve underserved populations and are engaged in grassroots advocacy to meet the needs of not only their congregations including surrounding communities.*

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*In preparation to launch the Resource Road Map, we convened a group of culturally and religiously diverse faith and community-based organizational leaders from across the country to share candidly their lived experiences. We took the time to listen to what they believe are the greatest needs and challenges in providing relevant and timely support for their congregants and affiliated communities. **We discovered that many are providing disparate services such as:***

- *Food pantries to support communities when there is a shortfall of monies or food stamps.*
- *Financial support for maintaining utilities, housing, and transportation.*
- *Volunteers to aid in providing sustenance for emotionally exhausted caregivers with limited physical, emotional or financial support.*
- *Hosting educational forums related to advanced directives, grief, trauma, and financial literacy.*
- *Collaborative training and continual education between clinical, faith community leaders and their congregations.*
- *Disease specific education awareness and health interventions to improve health disparities. (i.e., diabetes, heart disease, cancer, etc.)*
- *Serving as a liaison between the health systems and community to bring health services to minimize chronic disease disparities.*
- *Intermittent counseling services to support those experiencing transitional life crises.*

***Despite the short-term benefits of these type activities, it was vocalized repeatedly that their greatest needs lie in their ability to sustain their efforts.***

*This includes an organizational strategy to secure funding and maximize partnerships to serve their communities in a holistic, person-centered manner that aligns with their faith and cultural traditions.*

The Resource Road Map is designed to help Community Faith Leaders create strategic plans to build sustainable programs and partnerships

***These chapters in our Resource Road Map will dive into effective best practices for:***

- *Defining Goals That Meet Community Needs*
- *Discovering and Establishing Partnerships*
- *Data Collection and Evaluations*
- *Funding and Sustainability*
- *Population Health Data & Evaluation Action Plan*
- *Resources and Tools*

*Our goal is to serve all people with serious illness experiencing disparities. This will create a non-biased system that can work anywhere. All that is needed is a group of people whose interests align with your community's vision and needs.*

*As you read the pearls of wisdom shared by our Faith and Community Leader experts, we encourage you to become an enthusiastic and involved advocate in meaningful ways to support the vulnerable populations and caregivers in your community.*

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***“Nobody has had the conversation. The nurses say the doctor should have the conversation. The doctors say the nurses should have the conversation. The doctors and nurses say the family should have had the conversation. At the end of the day, the family is unaware that their loved one is transitioning.”***

*Elder Angela Overton*

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***“Advance Care Planning (ACP) – Narrowing the gap discrepancy between what the doctors think and what the family thinks.”***

*Dr. Gloria White Hammond*

# 1. DEFINING GOALS THAT MEET COMMUNITY NEEDS

“**Normalize the word legacy.**”

*Cassandra D. Harris-Gray*

“**Listen to the goals of community and connect appropriately**”

*Juleun A. Johnson*

## 1. Engage the Community

- Conduct focus groups, community dialogues, and one-on-one interviews with key stakeholders (seniors, caregivers, faith leaders, providers).
  - Use culturally respectful communication to build trust.
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## 2. Administer Needs & Gather Data

- Administer surveys and assessments at gatherings.
  - Identify gaps in care and services based on collected insights.
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## 3. Develop a Logic Model

- Use the gathered data to build a structured framework for goal setting.
  - Ensure goals address the hierarchy of needs (e.g., alleviating immediate pain before preventative measures).
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## 4. Collaborate & Co-Create Solutions

- Form advisory councils, coalitions, and focus groups with trusted community members.
  - Partner with organizations, healthcare providers, and places of worship.
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## 5. Implement & Evaluate

- Develop programs based on the expressed needs of the community.
- Foster ongoing dialogue to refine goals and adapt strategies.

## 2. DISCOVERING AND ESTABLISHING PARTNERS

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***“Start local. Start small. Create an ecosystem with committed people.”***

*Rev. George C. Gilbert, Jr.*

### 1. Map the Landscape

- Identify profit and nonprofit organizations already serving target populations.
- Focus on partners trusted by the community to build on existing strengths rather than duplicate efforts.

### 2. Engage Key Stakeholders

- Connect with mission-aligned organizations supporting underserved and under-resourced populations.
- Identify trusted community leaders, influencers, and academic institutions engaged in related work.
- Build relationships with organizations addressing social drivers of health—housing, employment, education, faith, food access, and behavioral health.

### 3. Build a Capable Team

- Recruit team members and volunteers with the expertise needed to achieve objectives (e.g., legal, financial, behavioral health, advance care planning).
- Partner with professionals willing to donate time and knowledge to support and educate the community.

### 4. Initiate Partnerships

- Send introductory letters outlining mission, goals, and shared objectives.
- Hold “Getting to Know You” sessions to explore collaboration and align efforts.
- Attend community events to build trust and visibility.

## 2. DISCOVERING AND ESTABLISHING PARTNERS (CONT.)

### 5. Align and Formalize Collaboration

- Match identified needs with partner programs and services.
  - Develop MOUs (minimum one year) to formalize commitments and increase accountability.
  - Engage in existing community initiatives with strong local support.
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### 6. Promote and Strengthen Engagement

- Communicate progress regularly to current and prospective partners.
- Highlight outcomes and impact through storytelling in local and national media.
- Showcase how partnerships foster innovation, equity, and empowerment within the community.

# 3. DATA COLLECTION AND EVALUATIONS

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**“Do not focus on a set of predefined outcomes.”**

*Christopher Thompson*

## 1. Quantitative Data

- Gather population health data from hospitals, state and county health departments, Medicaid/Medicare databases, and national sources.
- Include disease-specific, mortality, home health, hospice, and palliative care utilization data (ex. County Health Rankings & Roadmaps, National Alliance for Care at Home, and Center to Advance Palliative Care)

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## 2. Qualitative Data

- Conduct focus groups with community members and healthcare stakeholders to understand:
  - Who is being served?
  - Needs and preferences
  - Goals of care and reflections on care experiences

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## 3. Build Relationships & Define Goals

- Engage clergy, community health programs, and education departments.
- Compare health and school data to identify gaps and priorities.
- Collaborate to solve problems and set measurable goals.

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## 4. Identify Community Partners

Some examples include:

- Clergy groups
- Department on Aging
- AARP
- Alzheimer’s Association
- Hospitals
- Academic institutions
- Hospice/palliative care providers
- FQHCs
- American Cancer & Heart Associations
- DHHS/Medicaid,
- Local payers.

## 3. DATA COLLECTION AND EVALUATIONS (CONT.)

### 5. Data-Driven Action

- Build demographic profiles through application forms and quarterly surveys.
  - Capture insights via meeting notes, testimonials, and pre/post event surveys.
  - Partner with academic institutions for ethical and rigorous evaluation.
  - Publish findings and community stories to demonstrate impact and support sustainability.
  - Use developmental evaluation to track real-time learning, engagement, and key drivers of change.
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### 6. Evaluation, Outcomes & Reporting

- Collect post-event qualitative surveys and quarterly satisfaction surveys.
- Engage an external evaluator when feasible.
- Track attendance, participation, and feedback.
- Report emerging issues, outcomes, and value-added impact.
- Share stories that shift narratives from vulnerability to empowerment.
- Communicate results through local and national media to inspire action.
- Highlight how stakeholder engagement builds individual, congregational, and community capacity.
- Ensure all reporting focuses on what drives meaningful change and includes a call to action.

# 4. FUNDING AND SUSTAINABILITY

## 1. Establish Funding Channels

- Form a **501(c)(3)** or partner with one for grant eligibility.
- Apply for **grants** with a skilled writer who knows funding sources.
- Seek **non-traditional donors** (banks, hospital foundations, businesses).
- Explore **public funding** (HUD, US Treasury ERA funds).

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**“No money, no mission.”**

*Marisette Hasan*

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**“Underlining the innovation is just as important as evidence based.”**

*Dr. Marilyn French Hubbard*

## 2. Leverage Partnerships & Networking

- Engage community leaders, county executives, and legislators.
- Ask partners to sponsor events, provide venues, or donate staff time.
- Connect with philanthropic individuals and businesses.

## 3. Create a Strong Funding Pitch

- Develop a one-pager outlining goals, budget, and expected outcomes.
- Emphasize innovation + evidence-based approaches when pitching funders.
- Show impact: How does your initiative solve a problem for funders, health systems, or providers?

## 4. Maximize Resources & Alternative Support

- Accept in-kind support (property, resources, services).
- Offer tiered subscription models for online services.
- Explore reimbursement for community healthcare worker services.

## 5. Build Credibility & Visibility

- Acknowledge funders publicly (banners, social media, events).
- Use early funding commitments to attract additional donors.

# 5. RESOURCES AND TOOLS

ALL RESOURCES HYPERLINKED

## Community Engagement, Data Collection, & Assessments

- [County Health Rankings & Road Maps: State Reports](#)
- [Visible Network Labs: Community Engagement 101](#)
- [Community Needs Assessment Resource Tool](#)
- [National Alliance for Care at Home](#)
  - [Expanding Access through Hospice Insights](#)
  - [Family Experience and Rural insights Report](#)

## National Resources

- [The African American Advanced Care Planning Network and Health Living Through Faith](#)
- [CMS Frameworks](#)
  - [Health Equity](#)
  - [Healthy Communities](#)
- [American Academy of Pediatrics Equity and Inclusion Efforts](#)
- [Collaboratives for Health Equity](#)
- [Hope Initiative: National Project Designed to Advance Health Equity](#)
- [Resources of Health Related Equity Data Definitions, Specifications and Stratification Processes](#)
- [Health Equity Atlas](#)

## Serious Illness Health Equity Resources

- [Center to Advance Palliative Care: Project Equity](#)

## Advance Care Planning and Other Community Model Resources

- [AC Care Alliance](#)
- [Serious Illness Messaging Toolkit](#)
- [Person-Centered Care: Respecting Choices](#)
- [Five Wishes](#)
- [MyDirectives - A Digital Advance Directive](#)
- [Louisville Community of Care Model](#)
- [The Conversation Project - Have you Had the Conversation?](#)
- [The African American Spiritual and Ethical Guide to End of Life Care – What Y'all Gon' Do With Me? By Dr. Gloria Thomas Anderson LMSW & Tracee T Holloway.](#)
- [The Advance Care Planning Toolkit: How AAAs Can Better Support People Living With Serious Illness - Aging and Disability Business Institute](#)