



**FAITH LEADERS NETWORK:
BUILDING COMMUNITY PARTNERSHIPS
TRAINER'S GUIDE**

“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.”

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The Coalition to Transform Advanced Care (C-TAC) gratefully acknowledges the vision and financial support of the John and Wauna Harman Foundation and the Arthur Vining Davis

Foundation 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.

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 Roadmap is designed to help Community Faith Leaders develop strategic plans to build sustainable programs and partnerships.

THE FOLLOWING CHAPTERS IN OUR RESOURCE ROAD MAP WILL DIVE INTO EFFECTIVE BEST PRACTICES FOR THE FOLLOWING:

- *Defining Goals That Meet Community Needs*
- *Discovering and Establishing Partnerships*
- *Data Collection and Evaluations*
- *Funding and Sustainability*
- *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.

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

Dr. Gloria White Hammond

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.

CHAPTER 1: DEFINING GOALS THAT MEET COMMUNITY NEEDS

Goals are defined based on focus group input where members of the community are asked about their specific needs, and inclusive of their trauma and pain.

DEVELOP A LOGIC MODEL TO PROVIDE CONTEXT FOR WHAT ONE IS TRYING TO DO

Apply the documentation of information gathered; learnings, views, feelings, challenges, and needs to build a foundation for defining goals for the prospective initiative that offers comfort and understanding in their context. Surveys and needs assessment will define next steps.

Address hierarchy of needs; cannot think preventatively if one is in pain. You must address that pain.

- Goals must be inclusive in solving that problem.
- Goals must be indicative of capacity.
- Goals must be qualified as long term or short-term goals to track outcomes achieved.

KEY POINTS FOR INTERACTING WITH COMMUNITY:

- Speak a language that includes their culture so that you can earn their trust.
- Focus on culturally respectful care goal conversations and transforming the systems where they take place.
- Look at mental health, spiritual wellness, self-discovery, and health disparities.
- Foster an experiential learning approach based on the premise that lived experience proceeds learning, and that the learning or meaning derived from any experience comes from the learner.
- Establish partnerships with faith and community-based organizations and health provider organizations.
- Get data on the population for the communities you desire to serve.
 - For example: Area Office on Aging Agencies and disability, seniors, and caregiver support agencies.
 - Collaborate with partners to include an inclusive, participatory co-creation approach to build authentic relationships.
 - Increase learning and resource capacity to gather community members and/or advisory influencers to host community dialogues and open engagements with diverse groups where they can share ideas and get their feedback on what they see as their needs, gaps in care, etc. such as:
 - Seniors
 - Individuals with serious illness
 - Caregivers
 - Community leaders
 - Service providers.

- One-on-one interviews with our target population, family caregivers, faith leaders, and resource providers.
- Foster a reciprocal culture of learning (for example between clinicians and community faith leaders).
- Administer needs assessment surveys.
- Create advisory councils and coalitions who have established trusted relationships with target populations/community and then create work groups to implement strategies and solutions.
- Identify gaps in services based upon assessments and conversations from gatherings.
 - The expressed needs of the community at sessions determine and define the goals and how reaching those goals will be addressed.
- Share feedback of learnings, views, feelings, challenges, and needs from community gatherings to build a foundation for defining goals for prospective programs.

CHAPTER 1 SUMMARY

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

Juleun A. Johnson

“Normalize the word legacy.”

Cassandra D. Harris-Gray

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.

2. ASSESS NEEDS & GATHER DATA

- Administer surveys and assessments at gatherings.
- Identify gaps in care and services based on collected insights.

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).

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.

5. IMPLEMENT & EVALUATE

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

CHAPTER 2: DISCOVERING AND ESTABLISHING PARTNERS

Establishing community partnerships is essential in achieving successful outcomes for any community initiative.

- Facilitate the identification of tangible and intangible assets with the community.
- Suggest ways to gather information and potential partners via their own infrastructure.
- It is a privilege to be invited to the table, but it is crucially imperative that everyone participates in serving the targeted population.
- Determine those who are willing to have cultural compassion, not just cultural competency.
- Cultural compassion is the ability to understand, respect, and appreciate the diverse cultural backgrounds and experiences of others. It involves recognizing and valuing the unique perspectives, beliefs, and practices of individuals from diverse cultures, and responding to their needs with empathy and understanding.

STEPS TO DISCOVER AND ESTABLISH PARTNERS

- Identify who is already doing work. (Profit & non-profit)
- Identify partners who are already or should be connected to the community. There is no need to reinvent what already exists.
- Change Traditional Mindset –
 - Create a system trusted by target populations that will result in Medicare or Medicaid eligibility.
 - Increase access and connections for needed services.
 - As a result, organizations can expand their reach and strengthen credibility.
- Identify who is already engaged in helping target community/populations which will have the following characteristics -
 - Underserved & under-resourced.
 - Those who are having difficulty navigating care and/or services.
 - Mission-aligned organizations
- Identify who community members seek out for information.
- Identify community influencers.
- Identify academic institutions and other stakeholders who are already doing aspects of the work you desire to do.

- Recruit team members with skill sets that are required to reach goals and satisfy objectives.
- Gain understanding of community organizations that strengthen individuals and families impacted by mental health, violence, addictions, and its related traumas.
- Work to establish relationships with those who have been identified as supports in various community sectors.
 - Housing, employment, education, cultural access to mental health and medical health care, churches, food banks, and family support.
- Align assessed needs with potential provider programs and services.
- Send introductory letters to include who you are, mission, goals, and objectives.
- Request meetings with potential partners who provide solutions to needs and gaps outlined in sessions.
- Hold series of “Getting to Know You” events to engage them, clarify the importance of their roles in the empowerment and participatory actions of target community/population.
- Develop appealing outreach flyers and social media posts.
- Share progress with prospective partners of developments made.
- Gain trust, credibility of prospective partners through attendance of their events.
- Connect with organizations who are not typically considered for partnerships but have philanthropic history of support for those living with serious illness and/or their caregivers.
- Secure a volunteer base of diverse professionals (inside and outside the congregation) that will donate their expertise to support and educate the community on a variety of topics. These may include, but are not limited to:
 - Financial Advisors
 - Attorneys
 - Funeral Directors
 - Advance Care Planning Facilitators
 - Behavioral Health Therapists
- Increase trust between stakeholders, organizations, providers, and participants by all partners signing a Memorandum of Understanding for a minimum of one year.
- Join community initiatives that have extensive community support that are needed according to surveys.
- Share stories through local and national media to showcase how diverse partnerships foster innovation and equity.
- Highlight how stakeholder engagement builds community learning, capacity, and shared ownership.
- Encourage members to discuss goals of care with clinicians and reflect on their experiences.

- Shift the narrative from vulnerability to empowerment through storytelling that inspires collective action.

CHAPTER 2 SUMMARY

“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.

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.

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.

CHAPTER 3: DATA COLLECTION AND EVALUATIONS

Community assessments play a vital role in identifying gaps in knowledge and caregiving resources. Faith communities can better understand the health care, health literacy, and social needs of the populations they serve by examining available public health data. However, quantitative data alone is insufficient. It must be complemented by qualitative insights from community members, whose perspectives help clarify priority needs within their neighborhoods. Once needs are identified, faith community leaders must engage diverse community stakeholders and partners to craft a customized plan of action that includes measurable outcomes to determine the success of community initiatives.

PART 1: COLLECTING QUANTITATIVE DATA

- Get data on population health disparities for communities you desire to serve.
- Secure Hospital Community Assessment Reports.
- Public Health State Department of Health Data (disease specific data, mortality data).
- Department Health and Human Services (MCD).
- [County Health Rankings & Roadmaps](#)
- [National Alliance for Care at Home](#) (can retrieve data on home health and hospice utilization).
 - Hospice Facts & Figures
- [Center to Advance Palliative Care: Tools and Training for Clinicians - Palliative Care](#)

PART 2: QUALITATIVE DATA-FOCUS GROUPS:

- Engage community members and health care stakeholders.
 - Who are you going to serve?
 - What do they need?
 - What do they want?
- Support members to talk about their goals of care with their clinicians.
- Provide an opportunity for them to surmise how that went.

PART 3: BUILD RELATIONSHIPS, SHARE DATA, PROBLEM SOLVE, DEFINE GOALS

- Start with appropriate clergy.
- Research community health programs.

- Engage Department of Education/City and County Schools.
 - Compare and contrast the county and hospital data with the city and county school data.

PART 4: CREATE A LIST OF COMMUNITY PARTNERS TO BE CONSIDERED.

Examples below.

- Clergy Groups/Denominations
- Department of Aging
- AARP
- Alzheimer's Association
- Hospital Systems
- Academic Institutions
- Hospice and Palliative Care Providers
- Federally Qualified & Rural Health Care Centers
- American Cancer Society
- American Heart Association
- Department of Health & Human Service (DHHS)(Medicaid)
- Department of Health & Environmental Control
- Health & Community Payers

PART 5: IDENTIFY AND ADDRESS POPULATION HEALTH DISPARITIES IN THE COMMUNITIES WE SERVE:

- Build demographic profiles through application data and quarterly satisfaction surveys.
- Capture community insights through meeting notes, testimonials, and pre/post event surveys.
- Partner with academic institutions to ensure ethical, rigorous data collection and independent evaluation.
- Publish findings and community stories to demonstrate impact, attract funding, and drive sustainability.
- Embrace **developmental evaluation** to capture real-time learning, track engagement, and focus on what drives meaningful change.

PART 6: EVALUATION & OUTCOMES & REPORTING

- Post Qualitative Surveys
- Satisfaction Surveys distributed quarterly
- Secure an outside program (Academia) to serve as your Evaluator if feasible.
- Share through national and local media outlets how the community; those with different values, perspectives, and relationships influenced the innovation.
 - Change the narrative through personal stories.
 - For example: My life improved because I was approached in this way and now this is what I am going to do because I learned about this.

- Publish the results including the stories; this can lead to additional funding and long-term sustainability.
- Apply a systematic approach to understand and capture the elements that influence the outcomes.
- Reporting should focus on capturing what drives meaningful change.
- Keep track of Engagement: attendance, participation, and feedback.
- Share emerging issues, outcomes, results, value adds and impact.
- Share how stakeholder engagement informs individual, congregational, community and capacity building encourages continuous learning and sharing.
- Share stories that move communities away from being victims to someone that could empower others.
- Mandate a call for action.

CHAPTER 3 SUMMARY

“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 (e.g., CAPC, National Alliance for Care at Home).
- Include disease-specific, mortality, home health, hospice, and palliative care utilization data.
 - [County Health Rankings & Roadmaps](#)
 - [National Alliance for Care at Home](#)
 - [Center to Advance Palliative Care: Tools and Training for Clinicians - Palliative Care](#)

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

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.

4. IDENTIFY COMMUNITY PARTNERS

- Examples: 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.

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.

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.

CHAPTER 4: FUNDING AND SUSTAINABILITY

Sustaining community-based programs for vulnerable populations requires a strong, strategic approach to funding. Faith communities often express a need for clear guidance on identifying partners who can contribute both tangible and intangible resources. Building these partnerships is essential to ensuring long-term program viability, particularly for initiatives supporting individuals living with serious illnesses and their caregivers.

To achieve sustainability, faith communities must look beyond traditional funding sources and cultivate collaborative relationships with health systems, nonprofit organizations, philanthropic groups, and local agencies. These partnerships can leverage shared goals, reduce duplication of effort, and expand access to resources that might otherwise be unavailable. A diversified funding strategy—one that blends grants, donations, community collaborations, and in-kind support—strengthens a program’s resilience and reduces dependency on any single source.

Equally important is demonstrating the measurable impact of faith-based health initiatives. Clear outcomes, data-supported results, and compelling community stories help attract funders who prioritize meaningful, evidence-informed investments. By communicating value and documenting success, faith communities position themselves as trusted partners committed to improving the quality of life for those facing serious illness.

Ultimately, sustainable funding is rooted in relationships, accountability, and a shared vision for healthier communities. When faith leaders engage in intentional planning and cultivate strategic alliances, they create a strong foundation for programs that endure—and continue to serve those who need them most.

STEPS TO ENSURE FUNDING AND SUSTAINABILITY

- Trust-based philanthropy is desired.
- Create a 501(c)(3) to apply for funds or partner with a fiduciary that has a 501(c)(3).
- Co-create a concise 1-page funding request document that includes:
 - Mission, Goals and Objectives
 - Expected Impact Outcomes for the Initiative
 - Budget, to include stipends and incentives for the community members who will be actively engaged in the success of the initiative.
- Network.
- Recruit those who can serve as connectors to make the ask of organizations you do not have access to.
- Present your initiative and/or project to organizations who have attained funding for the work being done. For example, hospice and palliative providers and healthcare systems who are in alignment with mission, but do not have the cultural and spiritual capacities or trust that is necessary for program success for target populations.
- Leverage partnerships to meet with the county executives and legislators.
- Leverage partnerships to secure meetings, events and gathering spaces. While they may not have funds, they can spread the word through their own community and see who might be interested.
 - You may not have money, but you have assets.
- Ask partners to utilize their staff to augment administrative needs.
- Leverage partnerships to sponsor and host events that align with already outlined goals.
- Identify and strategize to meet with philanthropic individuals in community with history of supporting mission align initiatives.
- Networking through referrals, conferences and community events is a way to meet potential sponsors who may share similar missions and values.

- External community gifts to the church for special programming.
- Grant writing -- get a national researcher who understands how to write a grant around ACP for specific target populations. You need to have someone who understands where the money is to write an effective grant.
- Look for non-traditional donor support for dollars. Example:
 - Banks, hospital foundations, hospice foundations, payer foundations (insurance), small community foundations, attorneys, financial advisors, businesses who have a passion for supporting the community, etc.
 - Do not overlook in kind support for those who may not have financial resources, but they have other assets like property that can be used as a multipurpose building.
- Leverage community relationships with prospective investors or provider services to pay for community engagement events that simultaneously spread the word of said initiatives and providers with potential solutions.
- Federal, state and county public funding. For example:
 - HUD, ERA, and SBA funding from the US Treasury Department.
- Evidence based practices may not work with communities that differ from WASP. Go to prospective funders and develop innovative proposals developed from learned experiences within the community to bridge evidence-based models of care.
- Innovation takes risks. If relationships are established, they can be trusted and are committed to the team; with some learning this will allow partners to be fortified by that trust. This will allow movement from theories of change to models of change based on innovative learning.
- Create a “CLEAR ASK” to each prospective funder.
- Create a banner with a funder/sponsor name or logo on it for the purpose of highlighting support of the initiative.
- Agree to share, for example, “We are the proud recipient of a leadership gift, or a multi-year leadership gift from the _____.”
 - Leverage the gift now to cultivate similar foundations to say, “Hey, this organization has committed to this, how are we showing up?”
- Offer tiered subscription models for online services.
- Explore opportunities for reimbursements to provide community health worker services from payers and other community stakeholders.

CHAPTER 4 SUMMARY

“No money, no mission.”

Marisette Hasan

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

Marilyn French Hubbard

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).

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.

CHAPTER 5: RESOURCES & TOOLS

Below are several resources and tools designed to support and enhance this important work. Each offers practical guidance, data, or frameworks that can help strengthen your efforts.

COMMUNITY ENGAGEMENT, DATA COLLECTION & ASSESSMENTS

County Health Rankings & Road Maps: State Reports: countyhealthrankings.org/reports/state-reports

Visible Network Labs: Community Engagement 101:
visiblenetworklabs.com/guides/community-engagement-101/

SparkMap Community Needs Assessment Resource Tool: sparkmap.org/report/

National Alliance for Care at Home

- **Expanding Access through Hospice Insights:**
allianceforcareathome.org/wpcontent/uploads/Alliance-CONNECT-Care-Report.pdf
- **Family Experience and Rural insights Report:**
[thealliance.informz.net/thealliance/pages/RuralAmerican Hospice Insights Report](https://thealliance.informz.net/thealliance/pages/RuralAmerican%20Hospice%20Insights%20Report)

NATIONAL RESOURCES

The African American Advanced Care Planning Network and Health Living Through Faith: sites.duke.edu/acphltf/

American Academy of Pediatrics Equity and Inclusion Efforts: aap.org/en/about-the-aap/american-academy-of-pediatrics-equity-and-inclusion-efforts/

CMS Framework for Health Equity: cms.gov/files/document/cms-framework-health-equity.pdf

CMS Framework for Healthy Communities: cms.gov/priorities/health-equity/minority-health/equity-programs/framework

CMS Resources of Health Related Equity Data Definitions, Specifications and Stratification Processes: cms.gov/files/document/cms-2024-omh-data-definitions.pdf

Collaboratives for Health Equity: nationalcollaborative.org/our-work/trht/collaboratives-for-health-equity-che/

Hope Initiative: National Project Designed to Advance Health Equity: hopeinitiative.org/about

National Equity Atlas: nationalequityatlas.org/

SERIOUS ILLNESS HEALTH EQUITY RESOURCES

Center to Advance Palliative Care - Project Equity:

capc.org/project-equity-improving-health-equity-for-people-with-serious-illness/

ADVANCED CARE PLANNING AND OTHER COMMUNITY MODEL RESOURCES

AC Care Alliance: care-alliance.org

Serious Illness Messaging Toolkit: seriousillnessmessaging.org

Person-Centered Care: Respecting Choices: respectingchoices.org

Five Wishes: fivewishes.org

Louisville Community of Care Model:

community.louisville.edu/news/uofl-community-project-changing-lives-vulnerable-populations

MyDirectives - A Digital Advance Directive: mydirectives.com

The Conversation Project - *Have you Had the Conversation?*: theconversationproject.org

***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:** amazon.com/African-American-Spiritual-Ethical-Guide-Life/dp/0962319139

The Advance Care Planning Toolkit: How AAAs Can Better Support People Living With Serious Illness - Aging and Disability Business Institute:

aginganddisabilitybusinessinstitute.org/the-advance-care-planning-toolkit-how-aas-can-better-support-people-living-with-serious-illness/

CLOSING

In conclusion, this roadmap was designed to guide the development and implementation of effective models of care. This work cannot be accomplished in isolation; the roadmap illustrates how to engage and collaborate with all relevant partners.