The Critical Need For Partnership

Theresa Green, PhD, MBA
Associate Director, Associate Professor,
Center for Community Health & Prevention
Public Health Sciences URMC, SON

Agenda

- Introductions
- Our partners
- Session 1: The critical need for partnership
- Questions & Answers

HANYS Care Connections Team

Kathleen Rauch, RN, MSHQS, BSN, CPHQ
Vice President, Quality Advocacy, Research and Innovation and Post-acute and Continuing Care

Christina Miller-Foster, MPA
Senior Director,
Quality Advocacy, Research and Innovation

Morgan Black, MPA
Director,
Care Connections

Maria Baum, MS, RN, CPHQ
Project Manager,
Western New York

Kira Cramer, MBA
Project Manager,
New York City

Rachael Brust, MBA
Project Manager,
North Country

Jonathan Serrano
Communications Coordinator

Alexandra Galle
Project Coordinator,
Care Connections

Theresa Green, PhD, MBA
Associate Director, Associate Professor,
Center for Community Health & Prevention
Public Health Sciences URMC, SON

Our partners

Mother Cabrini HEALTH FOUNDATION

DataGen® Insights for Healthcare®

OUR FUNDER

Funding from the Mother Cabrini Health Foundation allows HANYS to expand its capacity to provide education, direct support, tools and data to our members. With Care Connections, we strive to build hospital-community partnerships and share evidence-based chronic disease prevention and management strategies to address healthcare access barriers at the local level.

OUR PARTNER

DataGen®, Inc. develops custom analytics for participants to help them understand healthcare access barriers and the chronic disease burden in their communities so they can develop tailored interventions.

Building Community Partnerships

Theresa Green, PhD, MBA
University of Rochester Medical Center
Care Connection Virtual Learning Series
March 4, 2026

Anesthesiologist Assistant
for 20 years
MS in Anesthesiology

Community Health Planner for
7 years
PhD in Interdisciplinary Health
Sciences (WMU)

MBA in Health Care Administration

URMC - Education

- Teach medical, nursing and graduate students about population health, health systems and community health
- Partner with 20+ community agencies and community driven initiatives for student active learning experiences
- Director for the URMC Public Health Grand Rounds that engage speakers locally and nationally for continuous medical education
- Lead the Health Equity Education task force to support resident education in health equity

URMC - Policy

- Lead the Monroe County Community Health Improvement Planning for 4 hospitals/health department (CHNA/CHIP)
- President of the Monroe County Board of Health

WHAT is “Partnership”?

What is partnership? (community engagement)

Community engagement

defined as collaboration between institutions and the larger communities (local, regional/state, national, global)

Goal!

for the mutually beneficial exchange of knowledge and resources in a context of partnership and reciprocity.

Carnegie Foundation for the Advancement of Teaching. *The 2024 Elective Classification for Community Engagement*. https://carnegieelectiveclassifications.org/the-2024-elective-classification-for-community-engagement/. Published n.d. Accessed March 16, 2022.

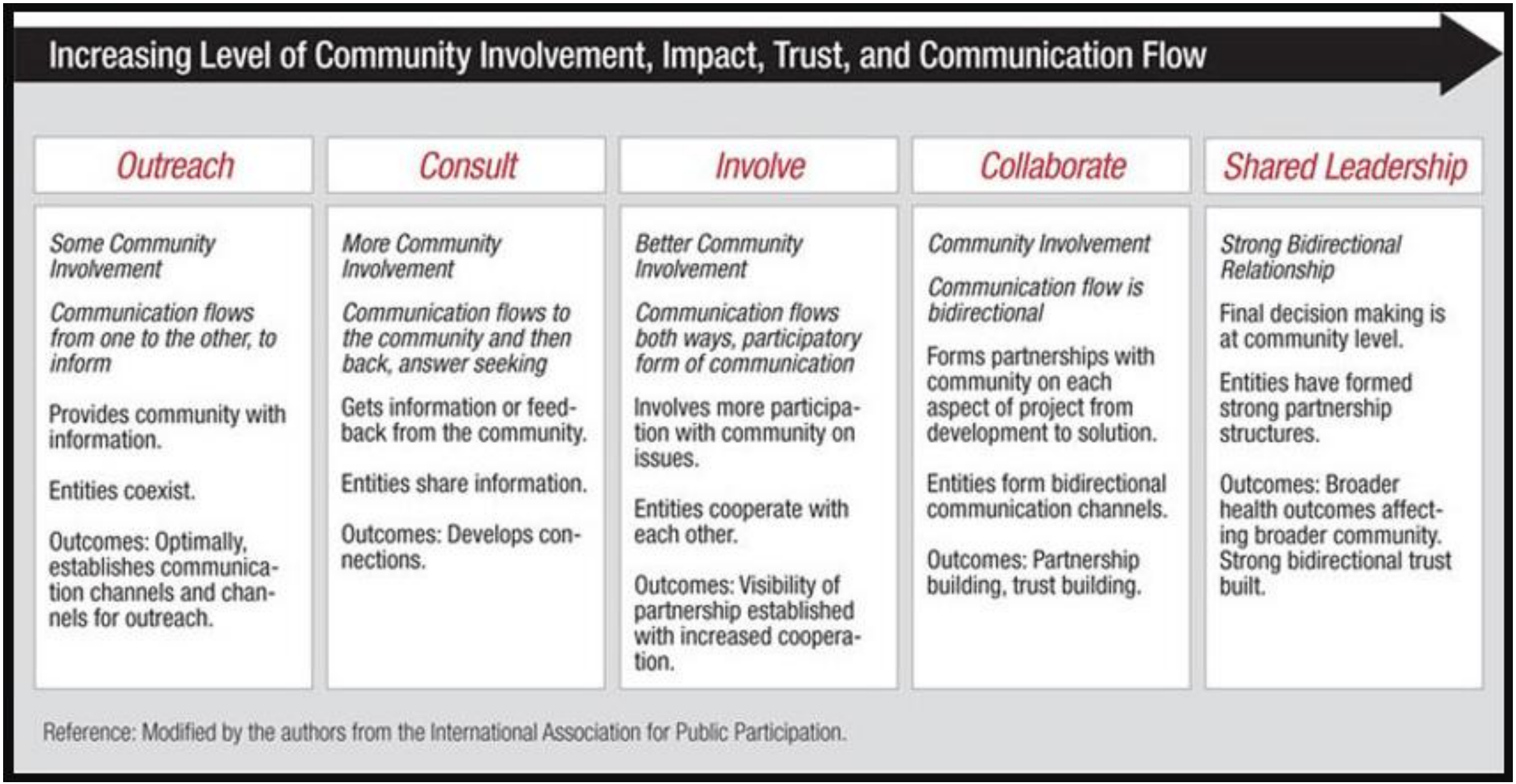
IAP2 Spectrum of Public Participation

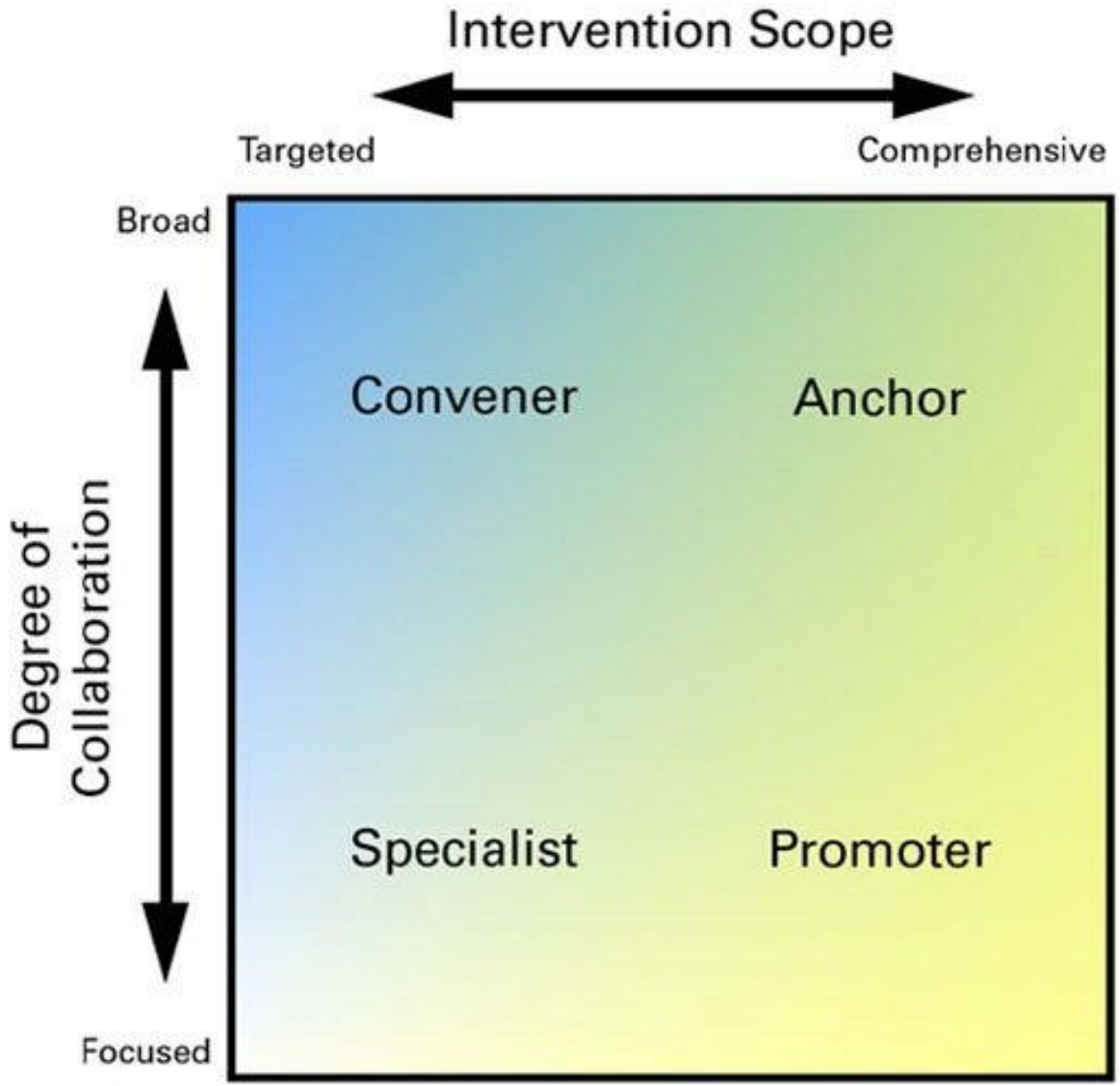
IAP2's Spectrum of Public Participation was designed to assist with the selection of the level of participation that defines the public's role in any public participation process. The Spectrum is used internationally, and it is found in public participation plans around the world.

INCREASING IMPACT ON THE DECISION →

	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
PUBLIC PARTICIPATION GOAL	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision making in the hands of the public.
PROMISE TO THE PUBLIC	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.

Build trust by acknowledging the past mistakes, setting expectations and then be true to your word!


Increasing Level of Community Involvement, Impact, Trust, and Communication Flow
Outreach
Some Community Involvement
Communication flows from one to the other, to inform
Provides community with information.
Entities coexist.
Outcomes: Optimally, establishes communication channels and channels for outreach.
Consult
More Community Involvement
Communication flows to the community and then back, answer seeking
Gets information or feedback from the community.
Entities share information.
Outcomes: Develops connections.
Involve
Better Community Involvement
Communication flows both ways, participatory form of communication
Involves more participation with community on issues.
Entities cooperate with each other.
Outcomes: Visibility of partnership established with increased cooperation.
Collaborate
Community Involvement
Communication flow is bidirectional
Forms partnerships with community on each aspect of project from development to solution.
Entities form bidirectional communication channels.
Outcomes: Partnership building, trust building.
Shared Leadership
Strong Bidirectional Relationship
Final decision making is at community level.
Entities have formed strong partnership structures.
Outcomes: Broader health outcomes affecting broader community. Strong bidirectional trust built.
Reference: Modified by the authors from the International Association for Public Participation.



» **Specialist:** Concentrates on a few specific issues

» **Promoter:** Supports other organizations' initiatives

» **Convener:** Brings together hospital and community stakeholders

» **Anchor:** Leads initiatives to build a Culture of Health

Principles of Partnership

- **Community driven:** Engage a diverse group in your community that strives to address a problem common to all.
- **Achieve more together:** Leverage each partner's complementary talents and resources to create synergy among partners that accomplishes more.
- **Meaningful engagement:** Include representation by all community stakeholders in determining, planning and executing priorities.
- **Partner equity:** All stakeholders are considered equal, regardless of size or financial or in-kind contributions to the partnership.
- **Shared purpose:** As stewards of the community's resources, partners are committed to working collaboratively for the benefit of the community.
- **Best practices and innovation:** Community health is complex, involving multiple social needs. Best practices and innovative approaches are required.
- **Systems approach:** A systems approach can better create a foundation for integrated community delivery systems.
- **Goals and progress reports:** Change requires focusing on results. Measures or indicators of progress and communication to the community offer direction, inspiration and motivation. Monitoring demonstrates partner accountability, earns community trust and builds hope.
- **Governance structure:** Sustainable governance structure is dependent on a clear purpose, partner commitment, a plan of action, adequate funding, effective implementation and demonstrated progress.

Adapted from "Learnings on Governance from Partnerships that Improve Community Health: Lessons Learned from Recipients of the Foster G. McGaw Prize for Excellence in Community Service," Center for Healthcare Governance, American Hospital Association, 2016.

Be TRUSTWORTHY

AAMC | Center For Health Justice

Home News Our Work Get Involved Resources Career Development About Us

Home / Trustworthiness / The Principles of Trustworthiness

MENU

AAMC Center For Health Justice

The Principles of Trustworthiness Toolkit

This toolkit of materials is for organizations to download and use to facilitate discussions within their communities, develop relationships with a broad coalition, and track lessons learned. It includes the kinds of questions, discussions, and activities that will help an organization and its community to unpack the Principles of Trustworthiness, explore how they come to life locally, and determine what local actions might be taken to demonstrate trustworthiness.

These resources can be used to help build vaccine confidence as part of the AAMC's cooperative agreement with the Centers for Disease Control and Prevention (CDC). Learn more about this effort at VaccineVoices.org.

- Toolkit at a Glance: 10 Principles of Trustworthiness (PDF)
- Video Guide: 10 Principles of Trustworthiness (PDF)
- The Principles of Trustworthiness Community Video
- The Principles of Trustworthiness Community Video (Spanish Subtitles)
- The Principles of Trustworthiness Orientation Video
- Interactive Discussion Guide (Word)
- Discover Your Community via Appreciative Inquiry (PDF)
- Community Engagement Action Guide (Word)
- Community Engagement Reflection Guide (PDF)

The Principles of Trustworthiness

Since 2015, the AAMC has produced an annual series of Community Engagement Toolkits in collaboration with our members and their communities. These toolkits provide unvarnished community perspectives on crucial issues and views about how our members can be better partners.

The AAMC Collaborative for Health Equity: Act, Research, Generate Evidence (CHARGE) — the AAMC's national collaborative of health equity scholars, practitioners, and community partners — gathered perspectives from a diverse set of 30 community members from across
trust, COVID-19, and clinical trial participation.

These 10 Principles of Trustworthiness integrate local perspectives with
community engagement to guide health care, public health, and other
demonstrate they are worthy of trust. The AAMC Center for Health Justi
support organizations right now and in the future as they partner with co
sectors that serve them to develop ways to shift our society toward healt

10 Principals of Trustworthiness

1. The community is already educated; that's why it doesn't trust you.
2. You are not the only expert.
3. Without action, your organizational pledge is only performance.
4. An office of community engagement is insufficient.
5. It doesn't start or end with a community advisory board.
6. Diversity is more than skin-deep.
7. There's more than one gay bar and "Black church" in your community
8. Show your work.
9. If you're gonna do it, take your time, and do it right.
10. The project may be over, but the work is not.

WHY is partnership important?

Community partnership is critical for improved health outcomes, increased health equity and for the long-term success and sustainability of any intervention

Upstream

Downstream

Social Inequities

Class
Race/Ethnicity
Immigration Status
Gender
Sexual Orientation

Institutional Inequities

Policies, Programs, and Practices in:

Government agencies
Schools
Laws and Regulations
Non-Profits
Businesses

Living Conditions

Physical Environment:
Land use
Transportation
Housing
Exposures

Economic Environment:
Employment
Income
Retail businesses
Occupational risk

Service Environment:
Health care
Education
Social Services

Social Environment:
Violence
Culture
Media and ads
Experience of social inequities

Behaviors

Smoking
Nutrition
Physical activity
Sexual behavior
Drugs and alcohol

Health Outcomes

Chronic disease
Communicable disease
Injury
Mortality
Life expectancy

In COMMUNITY

In Health Systems

The WHY…

- Hospital mission: improve the health of (members of) the communities they serve
- Largest driver of health: social circumstance + behaviors

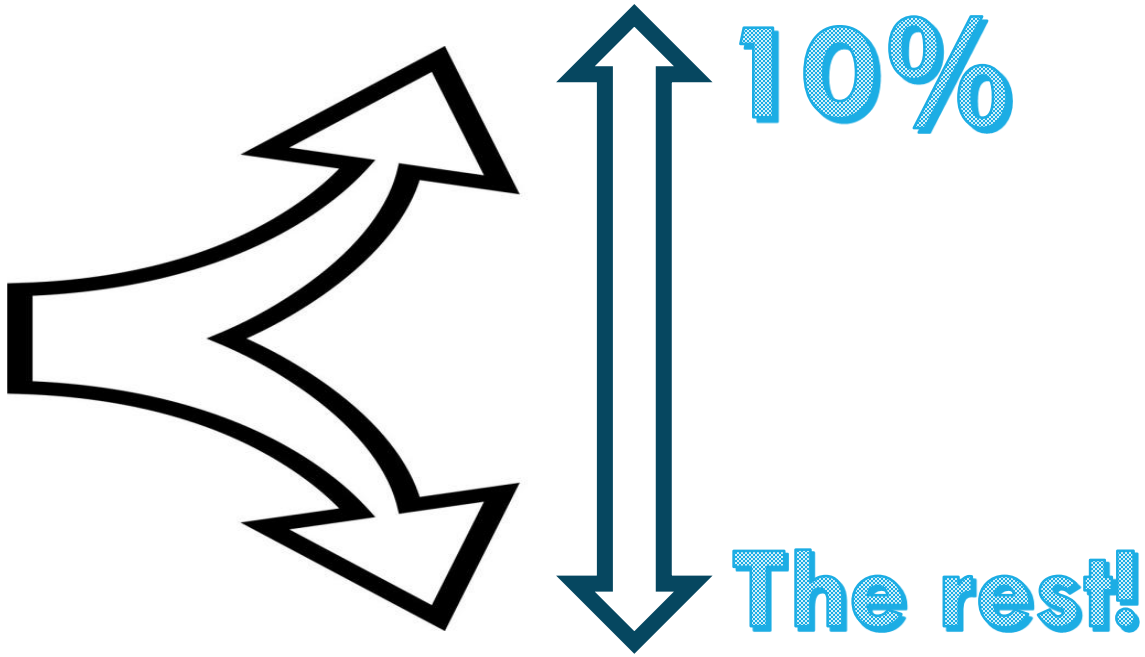
Hospitals are ideally positioned to improve health; but to improve health, hospitals need to align their organizational efforts and partner with communities

HEALTH VS HEALTH CARE

QUALITY HEALTH CARE = hospitals, health care systems, clinics and other places where care is provided. Primarily interested in treating disease and illness, screening, treatment

Diabetes
Asthma
Heart Disease
COPD
Mental Health
Cancer

HEALTH = A state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity



Community-based partners work here!

HEALTH outside of HEALTH CARE = social, economic, education, and/or environmental systems that keep us healthy. Social systems, public health,

CMS HEALTH EQUITY

Hospital Commitment to Health Equity

Screen for Social Determinants of Health (SDOH)

Report Positive Screening rates for SDOH

Covid screening and vaccination

All removed in 2026 CMS Final ruling

"These changes indicate a shift toward focusing on standardized data collection and specific, high-priority access areas rather than broad SDoH reporting"

Hospital Readmission Reduction Program

JOINT COMMISSION HEALTH EQUITY STANDARDS

- **Designated Leadership:** Organizations must identify a specific leader responsible for reducing healthcare disparities.
- **Health-Related Social Needs (HRSNs):** Requirement to systematically assess patient HRSNs.
- **Data Stratification:** Identification of healthcare disparities within the patient population by analyzing quality/safety data based on socio-demographic characteristics.
- **Action Plans:** Development of a written plan to address at least one identified disparity.
- **Language Access:** The 2026 goals explicitly connect communication to patient safety, requiring organizations to capture preferred language, use qualified interpreters, and ensure informed consent.
- **Performance Measurement:** The new NPGs (replacing old NPSG) will be used during surveys to monitor how organizations identify and mitigate disparities. Joint Commission +5

Accreditation 360 – Focus on outcome-based performance New National Performance Goals (NPGs) that elevate health equity, language access, and social needs to core safety requirements.

Investing time and resources to community is building strategic assets!
Including infrastructure, organizational knowledge and relationships

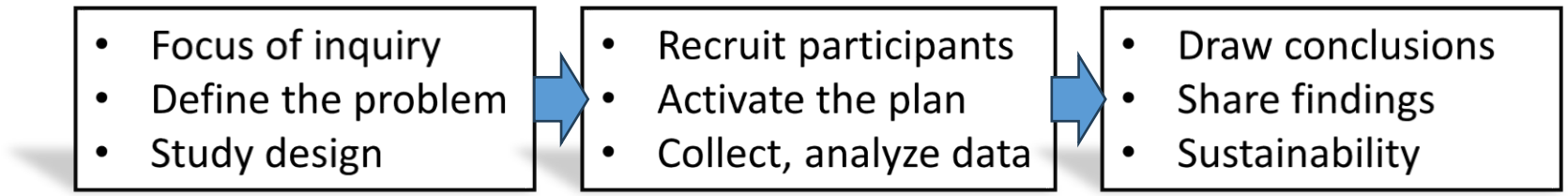
Community

KEEPS PROJECT RESPECTFUL, ACCESSIBLE, AND SOCIALLY RELEVANT

Meets community priorities
Assures community relevance and feasibility, grounds the project

Ensures effective recruitment that community members will get behind,
Ensures acceptable instruments
Level-set the results

Understandable messaging
Ownership to build sustainability
Assures conclusions are palpable



Infrastructure
Evidence Base for Interventions
Experience with funders and reporting

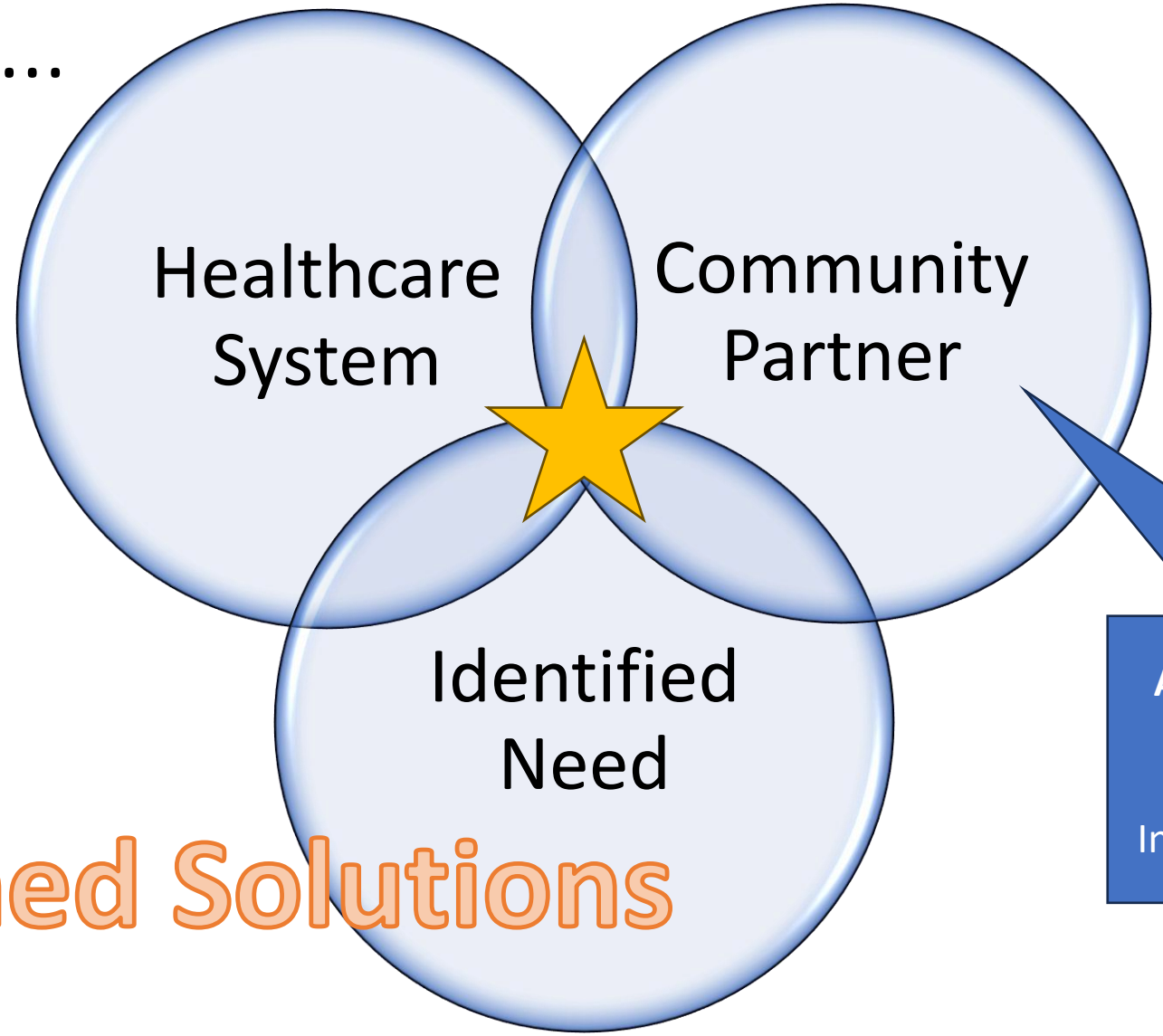
IRB for safe recruitment
Scientifically appropriate work
Academic rigor and processes

Build on theory
Publish findings in scientific journals
Create policy/leadership for sustainability

KEEPS PROJECT SCIENTIFICALLY SOUND AND ACADEMICALLY RELEVANT

Health Systems/Academics

In all we do…



Authentic Community VOICE
On your boards
Leading your interventions
In your patient advisory groups

Co-designed Solutions

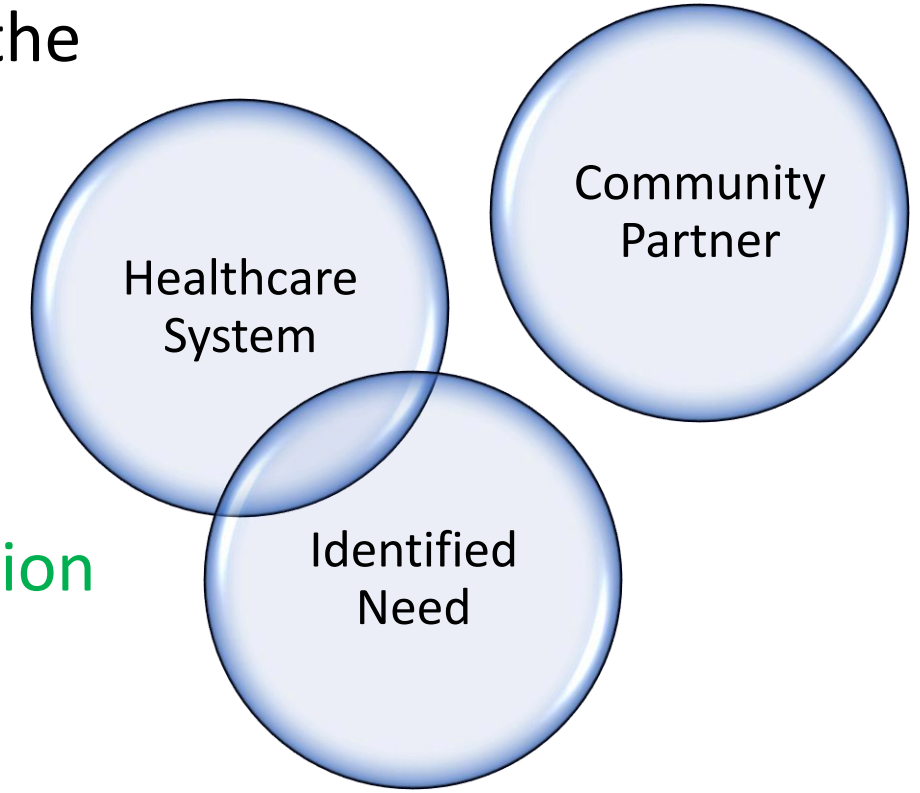
…as a system or a program

WHO are your community partners?

Seeking community partners

1.
IDENTIFY AND ENGAGE PARTNERS

- Who is needed to make solutions successful?
- Who are the people already doing this work in the community?
- Do your homework:
  - Who in your institute is already working with this partner, and can they introduce you?
  - What is the history of working with this partner?
- Reach out with a low-risk, high-reward proposition



MEET WITH YOUR PARTNER

Competency/Capacity Matrix

	COMPETENCY/CAPACITY	PARTNER	PARTNER	PARTNER
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Sample Partnership Capacities

- Reference materials
- Subject matter expertise
- Lived experience
- Clinical expertise
- Grant-making expertise
- IT and technical support
- Expanded staff and volunteers
- Meeting and event space
- Data sharing, collection and analysis
- Project management expertise
- Cultural understanding
- Funding
- Brand value/reach
- Linguistic competence
- Leadership support
- Cultural competencies
- Relationships with communities
- Business connections
- Political connections
- Access to neutral/ third-party facilitators
- Social media followers/ reputational reach
- Service delivery capacity including staffing, expertise and availability

Who is needed to make this successful?

HOSPITAL COMMUNITY COLLABORATIVE

Empowering Partnerships for Health Equity

AHA CENTER FOR HEALTH INNOVATION

About Discover Engage **Explore Center Programs**

Search AHA...

AHA Home Page

The Hospital Community Collaborative

HCC | The Hospital Community Collaborative

https://www.aha.org/center/hcc

The AHA Hospital Community Collaborative (HCC) provides proven ideas, insights and resources for creating effective collaborations between hospitals and community organizations across sectors to reduce disparities in health outcomes.

WHY JOIN US?

The Hospital Community Collaborative online program aims to make it easier for hospitals and community organizations to develop and lead strategies that reduce disparities in health outcomes. The program coaches community partners to effectively work together and develop initiatives that transform the conditions and outcomes that matter to their communities.

HCC's learning lab approach informs and nurtures the development of hospital-community partnerships, encourages peer-to-peer knowledge exchanges and sets the foundation for success.

Delivered in an online platform, users can progress through the six-module program at their own pace, and engage with peers in an online community and participate in live virtual coaching sessions throughout the year.

Enroll in HCC today!

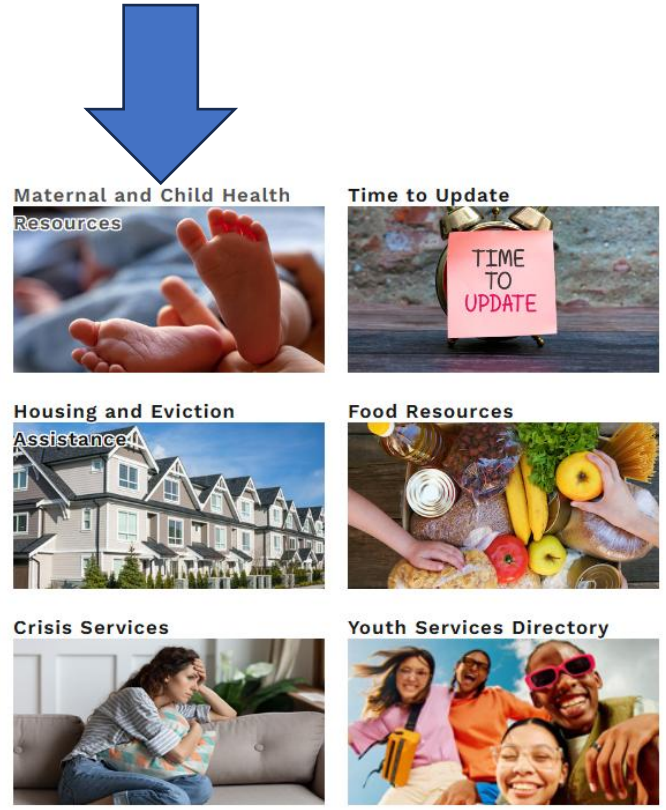
HOSPITAL COMMUNITY COLLABORATIVE

- Enroll
- About
- Curriculum
- Calendar
- Teams
- Resources

Where is the community expertise for needed competencies?

- Ask the community!

211



- Explore community coalitions
- Check community resources
- Ask community members – community advisory groups
- Ask the local public health department
- Review CHNA/CHIP
- Don't assume there is an existing coalition!

Be creative in identifying partners – Look for assets!

- Community organizations
- Faith based organizations
- Education
- Housing, transportation, food
- Government
- Public health
- Service organizations
- Local businesses
- Health care organizations

Great resource!! With examples

HOW do I cultivate a community partnership while working on a project?

Community Partnership Roadmap

1.
IDENTIFY AND ENGAGE PARTNERS

2.
DEFINE GOALS AND ROLES

3.
IMPLEMENT AND EVALUATE

4.
SUSTAIN PARTNERSHIP

Plan for engagement of external partners - You have options!

2.
DEFINE GOALS AND ROLES

Add a partner to the internal team

- Reach out to potential partners and explain your request, including why you are asking them to join you
- Be flexible and accommodating
- Collaborate on the agenda and outline clear expectations for all

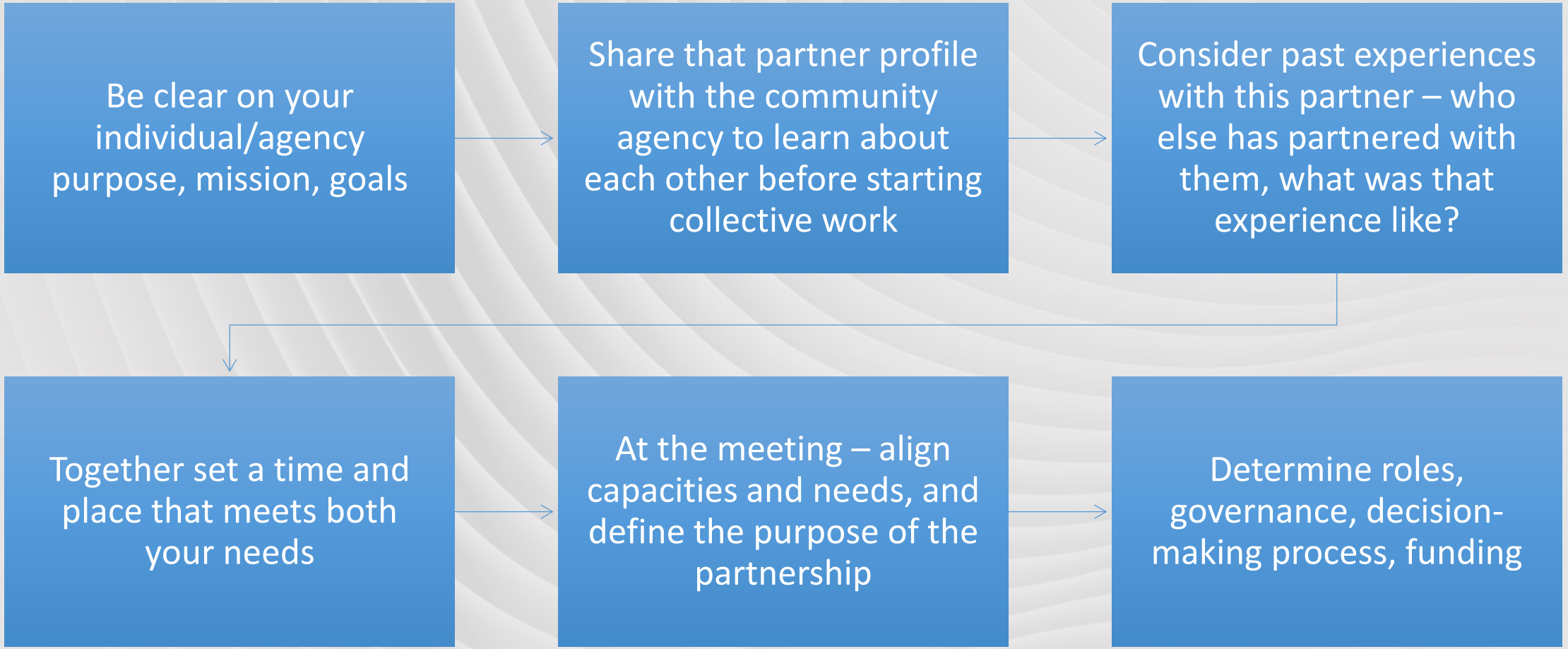
Join an existing coalition

- Reach out to the leadership to describe your needs and discuss options, be humble and accommodating

Create a new coalition

- Kick off meeting with new partners, maybe in the community
- Retreat or synergy meeting option

Get to know your partner



GET STARTED

15-MINUTE ACTIVITY

Develop Your Partner Profile

Before you meet, each partner should take stock of their own organization's purpose, goals, operating practices, culture, and vocabulary. These are the key building blocks of your partnership alignment and ability to collaborate effectively. Take a look at the questions and prompts below with the goal of being able to provide a high-level response to each question.
You can jot down your responses if you'd like, and keep your answers to a few sentences or bullets per question. You can also share a link with one other.

WHOM DO YOU SERVE?

- What's your role/mission?
- Where do you operate?
- Whom do you serve? (socioeconomically, demographically, by health status, social need, payer)

WHAT DO YOU DO?

- Purpose?
- Timeframe?

WHY DO YOU DO IT?

- What need are you fulfilling?
- How does it support your organization's strategic goals?

HOW DO YOU DO IT?

- Deliver services?
- Operating/leadership structure?
- Key operational terms and definitions?

WHAT ARE THE UNIQUE CONTRIBUTIONS YOU BRING TO THIS PARTNERSHIP?

- Technical?
- Relational?
- Clinical?
- Other?

WHY ARE YOU PURSUING THIS PARTNERSHIP?

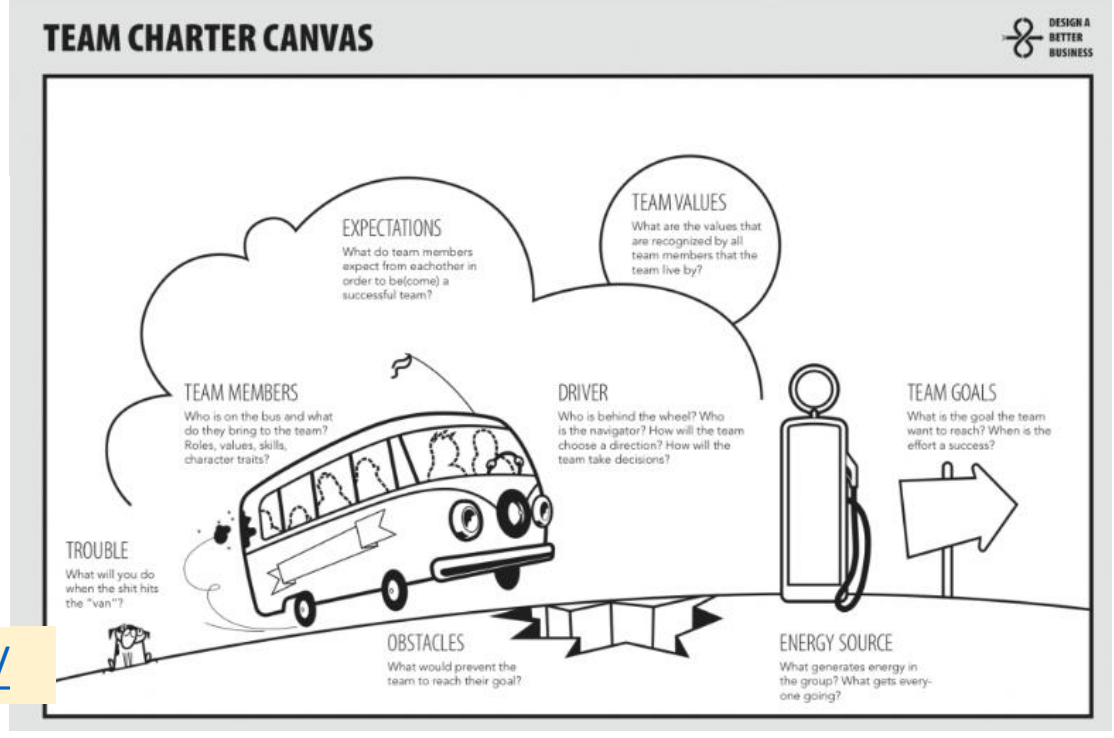
- What need are you fulfilling?
- How do you know this is a need?
- How does this partnership goal support your organization's strategic priorities?
- What are the revenue/funding opportunities that factor into this partnership?

HOSPITAL COMMUNITY COLLABORATIVE
Empowering Partnerships for Health Equity

To help assure achievability of shared goals

Develop a **TEAM CHARTER**

- How will you agree on your goals, expectations and values?
- How will you deal with challenging situations?
- What is the goal of the partnership?



https://designabetterbusiness.com/2017/08/24/team-charter-canvas/

EXPECTATIONS

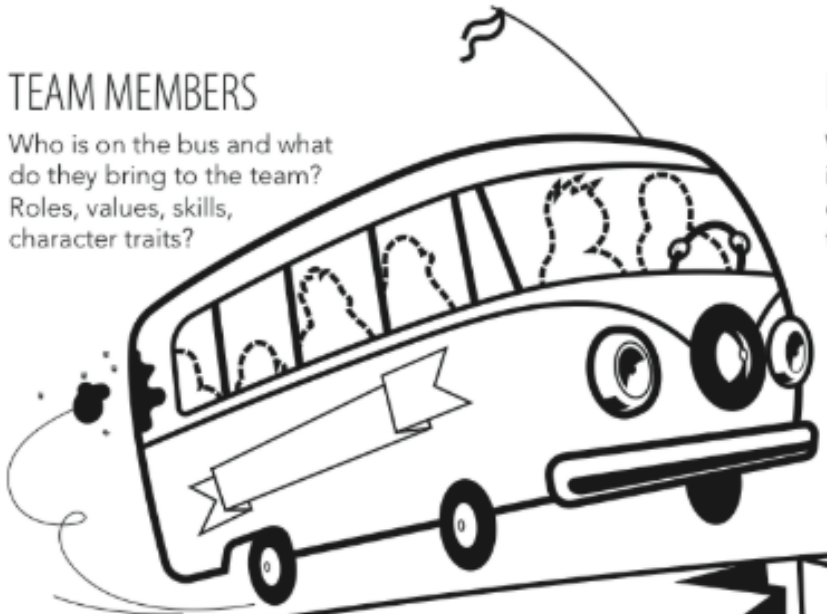
What do team members expect from eachother in order to be(come) a successful team?

TEAM VALUES

What are the values that are recognized by all team members that the team live by?

TEAM MEMBERS

Who is on the bus and what do they bring to the team? Roles, values, skills, character traits?



DRIVER

Who is behind the wheel? Who is the navigator? How will the team choose a direction? How will the team take decisions?

TEAM GOALS

What is the goal the team want to reach? When is the effort a success?

TROUBLE

What will you do when the shit hits the "van"?

OBSTACLES

What would prevent the team to reach their goal?

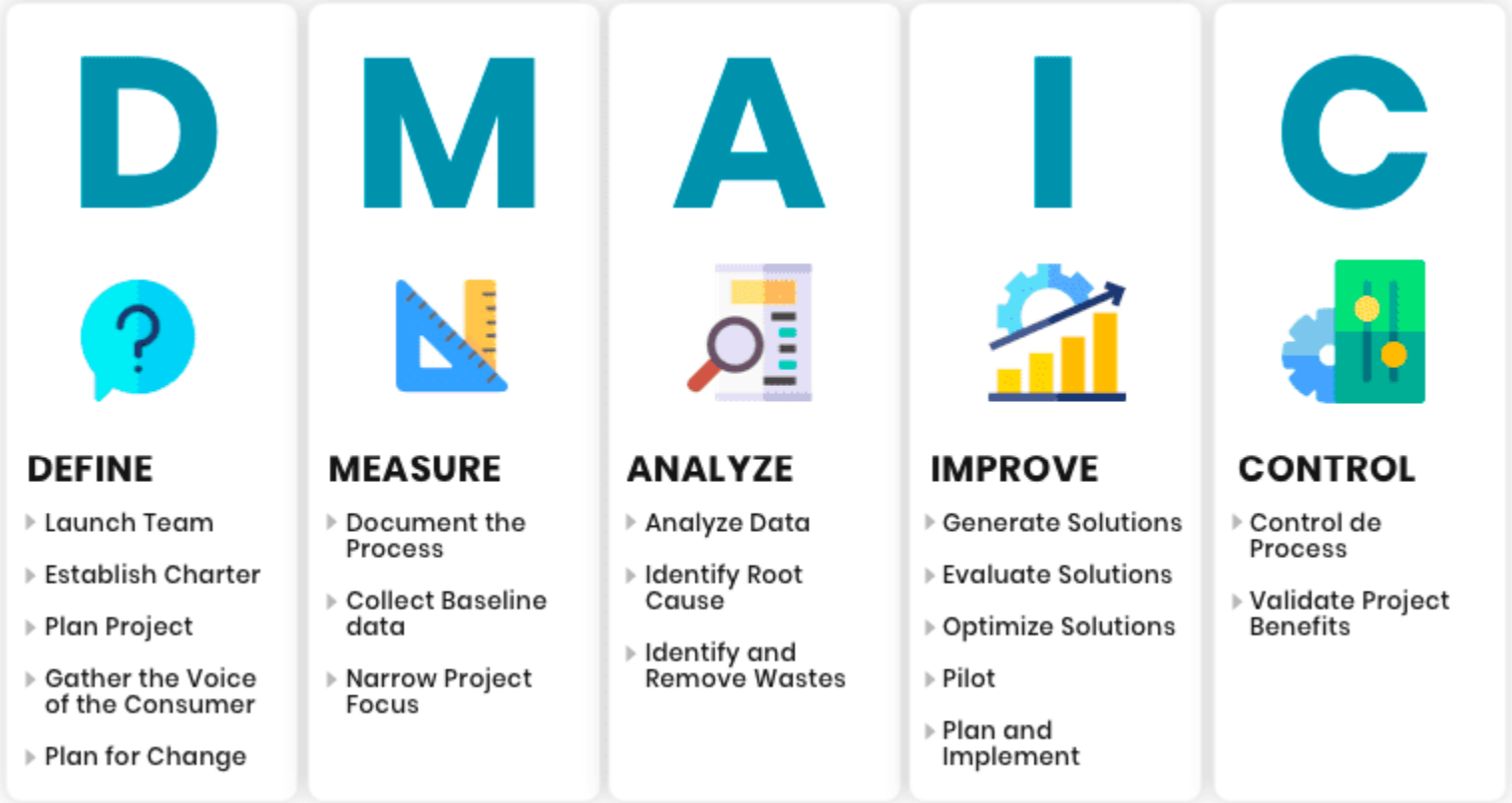
ENERGY SOURCE

What generates energy in the group? What gets every-one going?

DMAIC Framework

3.
IMPLEMENT AND EVALUATE

Data-driven, systematic approach to process improvement



DEFINE the problem

- Identify opportunities
- Identify key contributors/stakeholders
- Consider a charter with a community-based organization

EQUITY CONSIDERATIONS

- Consider the needs and issues faced by populations experiencing the worst health outcomes
- What populations are impacted most by the problem you have identified
- Does the team composition and structure promote inclusivity?
- How will the patient voice by incorporated into the program design?

How can you incorporate ‘community voice’ into your QI project?

MEASURE

- Document the current process
- Collect baseline data and define where you want to go
  - Develop a **SMARTIE Aim**
  - Define metrics and measures

EQUITY CONSIDERATIONS

- What inequities already exist?
- Examine the data by race, gender, economic status, geography, etc.
- Are the targeted populations clearly articulated in the aim statement?
- What strategies will help mitigate bias in data collection or analysis
- What is the local culture surrounding the issue?

Develop SMARTIE Goals

Goals are critical to success! To improve diversity, equity and inclusion, we must be intentional in our efforts. Use this worksheet to craft SMARTIE goals!

SMARTIE Framework by the Management Center
http://www.managementcenter.org/resources/smartie-goals-worksheet

SPECIFIC	MEASURABLE	ACTION-ORIENTED	RELEVANT	TIME-BOUND	INCLUSIVE	EQUITABLE
What is it you want to achieve? Consider including the 5Ws: what, why, who, where and when.	How will you know when you have achieved your goal? To be able to track progress and to measure the result of your goal, consider: how much or how many?	To keep you motivated toward attaining your goal, are there identifiable intermediate actions/milestones? *Variations: achievable, attainable, acceptable.*	What results can realistically be achieved given your available resources, including people, knowledge, money and time? *Variation: realistic*	What is an appropriate deadline for achieving your goal? How will you track progress?	How will you include traditionally marginalized people into processes, activities, and decision making in a way that shares power.	How will you include an element of fairness or justice that seeks to address systemic injustice, inequity, or oppression.

INCLUSIVE: How will you include traditionally marginalized people into processes, activities, and decision making in a way that shares power

EQUITABLE: How will you include an element of fairness or justice that seeks to address systemic injustice, inequity or oppression

Population Health Data Resources

SCOPE	Name	WEBSITE
National Level	Healthy People 2030	https://health.gov/healthypeople
State Level (NY)	NYS Prevention Agenda	https://apps.health.ny.gov/public/tabvis/PHIG_Public/pa/
County Level	County Health Rankings	https://www.countyhealthrankings.org/
County Level (NY)	NYS Prevention Agenda	https://apps.health.ny.gov/public/tabvis/PHIG_Public/pa/
Regional (Finger Lakes)	Common Ground Health	https://www.commongroundhealth.org/
Monroe County Specific	MC Dept of Public Health	https://www2.monroecounty.gov/health-index.php
City Level	City Health Dashboards	https://www.cityhealthdashboard.com/
Rochester Specific	RocHealthData	https://rochealthdata.org/
	ACT Rochester	https://www.actrochester.org/

Publish data from survey and EMR in a user-friendly reports

ANALYZE

- Get at the ROOT CAUSE of the problem
- Examine the problem and consider underlying drivers

EQUITY CONSIDERATIONS

- How can we address the root cause of the outcome and any disparity
- How can we ensure that those impacted by the intervention will have input into the process

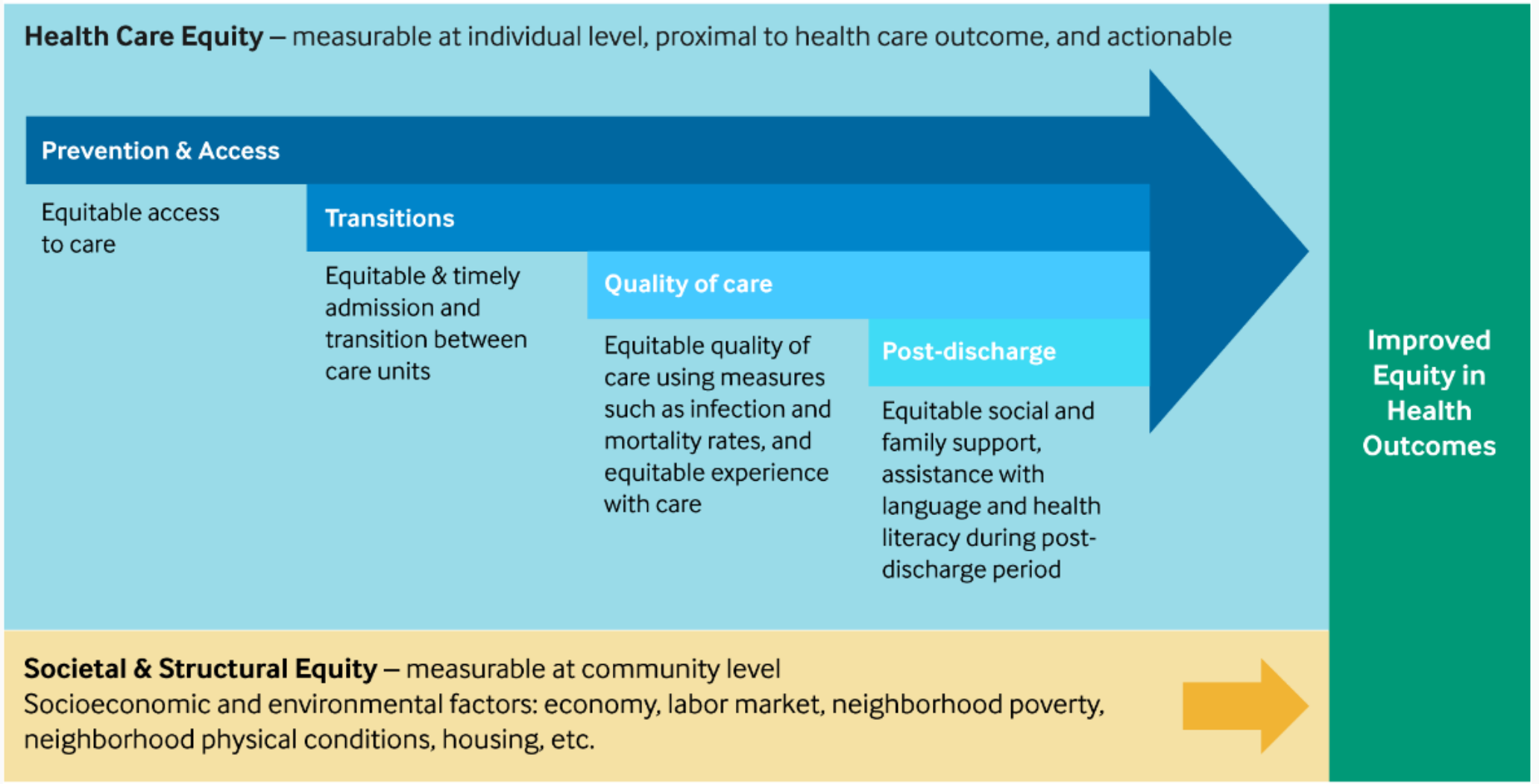
IMPROVE

- Have a clear vision of what your “ideal state” would be and work to get there
- Consider evidence-informed interventions that address each (or a specific) key driver/root cause
- Start with a pilot (PDSA cycles)

EQUITY CONSIDERATIONS

- Will the change impact those most vulnerable?
- Is the community voice considered when establishing the “ideal state”?
- Are materials readily available in the languages and formats necessary?

A Conceptual Model for Health and Health Care Equity



Sai Ma, PhD, et al. Distinguishing Health Equity and Health Care Equity: a Framework for Measurement. **NEJM Catalyst March 7, 2023**

CONTROL

- Monitor and stabilize the process improvement
- Find ways to replicate and disseminate findings

EQUITY CONSIDERATIONS

- Were there any inadvertent intervention-generated disparities created?
- Do the target populations believe the project outcomes?
- Are results shared with stratified data that shows gains were experienced equally by all?
- How can we share the results among all stakeholders?
- How do we sustain equitable change?

Improving health outcomes…

There are many approaches, but some of the most effective are:

- POLICY improvements
  - A law, regulation, procedure, administrative action, incentive, or voluntary practice of government and other institutions.

- SYSTEMS improvements
  - Change that impacts all elements, including social norms of an organization, institution, system or community

Sustainability

4.
SUSTAIN
PARTNERSHIP

Sustainability Factors to consider:

- Identify key internal experts and influencers to further your cause
- Find external “partners of the future”
- Discover new funding sources and recurring revenue
- Gain leadership and board support for the efforts

HOSPITAL COMMUNITY COLLABORATIVE
Empowering Partnerships for Health Equity

HOSPITAL COMMUNITY COLLABORATIVE

Empowering Partnerships for Health Equity

PARTNER PLEDGE

We, (organization names), are working together to (state your intervention goal) in (state your community) by (set a timeline and deadline).

To fulfill our goals within the timeline established and to ensure the sustainability of our intervention, we commit to the following:

1) **Meeting (frequency)**
2) **Bringing new partners to the table, including those from our respective organizations and communities who will help advance our goals**
3) **Defining, tracking and reporting metrics to our management, champions, funders, advocates and community (frequency)**
4) **Identifying ongoing sources of funding**
5) **Gaining management recognition and support from our respective organizations**
6) **Other**

Signature

Name, Organization 1

Signature

Name, Organization 2

Consider a formal commitment to sustain the partnership and the work ahead.

Sustainability

New York State Health Foundation Sustainability Toolkit

Suggests choosing 3-4 factors to sustain a project

APPENDIX A

SUSTAINABILITY FACTORS:
DEFINITIONS AND EXAMPLES

SUSTAINABILITY DEFINITION:

When new ways of working and improved outcomes become the norm.[1]

PERCEIVED VALUE – acknowledged value by those affected by the new ways of working and improved outcomes. Examples include project activities being considered potentially beneficial by clients, service providers, or community members.

MONITORING AND FEEDBACK – monitoring is conducted on a regular basis and feedback is shared in easy to understand formats. Examples include information-gathering calls to monitor the project, and feedback provided to key staff using easy-to-understand formats (e.g., graphs).

LEADERSHIP – the degree to which leaders (including decision-makers and champions) continue to be actively engaged beyond the implementation stage. Examples include ongoing attendance at meetings focused on the new ways of working and ongoing monitoring of outcomes.

STAFF – staff has the skills, confidence, and interest in continuing the new ways of working and improved outcomes. Examples include staff being able to use a new referral system capably or thinking that a new curriculum is more effective in achieving better outcomes.

SHARED MODELS – continued use of a shared model among those involved in the new ways of working. Examples include the Chronic Care Model, the 40 Developmental Assets, the 5As, or Plan-Do-Study-Act (PDSA).

ORGANIZATIONAL INFRASTRUCTURE – degree to which organizational operations support the new ways of working and improved outcomes. Examples include rewriting job descriptions to support the project activities and channeling resources to project activities through the organization's business plan.

ORGANIZATIONAL FIT – degree to which the new ways of working and improved outcomes match the organization's overall goal and operations. Examples include project activities becoming part of the organization's strategic plan.

COMMUNITY FIT – degree to which the new ways of working and improved outcomes match community interests, needs, and abilities. Examples include an expressed desire for new or improved services and outcomes.

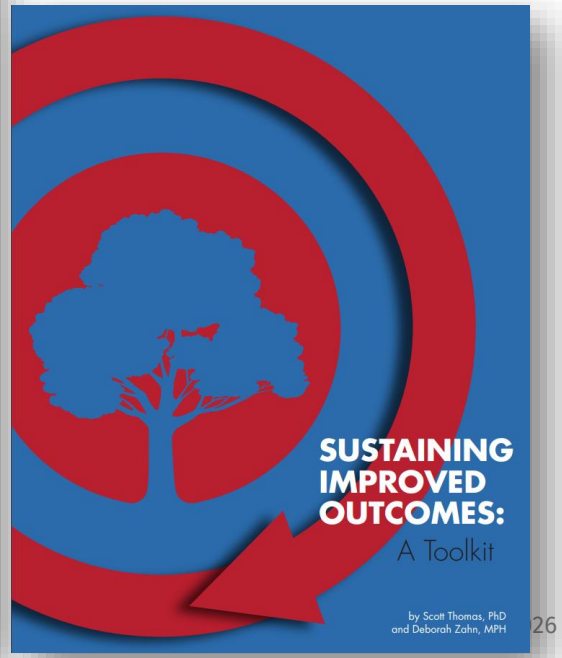
PARTNERS – involvement of partners who actively support new ways of working and improved outcomes. Examples include partners who continue to contribute staff or resources after the implementation phase.

SPREAD – expansion of new ways of working and improved outcomes to additional locations. Examples include expanding activities planned for one community agency or department to new agencies or departments.

FUNDING – funding beyond original project period. Examples include extensions of original grant funding or funding to expand project activities to additional populations or communities.

GOVERNMENT POLICIES – degree to which new ways of working and improved outcomes are supported by government policies. Examples include reimbursement for a new service or incorporating outcome measures into surveillance systems.

1 Sustainability: Model and Guide. National Health Service Institute for Innovation and Improvement. (2007). Note: When our work in sustainability began, the Sustainability: Model and Guide was publicly available online. Access is now limited to those working in the United Kingdom.



HANYS
Always There for Healthcare
SINCE 1925

Quality | Collaboratives | Clinical & Operational Oversight | Business Services | Advocacy & Analysis | Education

Care Connections:

- Care Connections Home
- Virtual Learning
- Faculty and Staff
- Partners
- CHW Scholarship
- Community Partner Stipend
- Resources
- Join Us

Care Connections Resources

- Care Connections Program One-pager
- Partnership Building Toolkit

Our Organization

About HANYS
Award Programs
Membership
Member Directory

Advocacy & Analysis

Analyses
Behavioral Health

Care Connections

Partnership building toolkit

This toolkit includes a step-by-step guide to coalition building, partnership building activities and advocacy information. Use these tools to help your team define your impact area, establish partnerships, set shared priorities and sustain your efforts.

Pulling it all together… an example

Community Health

Needs Assessment and Improvement Plan

Theresa Green, PhD, MBA
Associate Professor, Public Health Sciences
Associate Director, Center for Community Health & Prevention
Director Community Health Education and Policy

Community Health Improvement Workgroup of Monroe County, New York

Working collaboratively since 2000
4 Hospitals, 2 Health Systems
1 Health Department
10+ Community Advisory Organizations

Mission: To improve the health and wellness of individuals and families of Monroe County by addressing prioritized needs and inequities through sustainable systems change built on collaboration and supported by shared resources.

- Rochester General Hospital
- Unity Hospital

- Strong Memorial Hospital
- Highland Hospital

Monroe County Department of Public Health

Meet our team

CHIW Reporting CORE Member Organizations	Representatives	Leadership
Monroe County Department of Public Health	Kathy Carelock Melissa Schwartz	Marielena Vélez de Brown, Commissioner
University of Rochester Medical Center Strong Memorial Hospital	Mardy Sandler Kelly Luther	David Linehan, CEO URMC Kathy Parrinello, CEO
University of Rochester Medical Center Highland Hospital	Kara Halstead Kim Foster David Gafford Beth Ragsdale	Kathy Parrinello, CEO Maura Snyder, COO
Rochester Regional Health – Rochester General Hospital & Unity Hospital	Katie Sienk Dawn Davison LeKeyah Wilson	Mary Parlet, SVP CAO Ambulatory Care
Coordinated by the Center for Community Health & Prevention	Theresa Green Morgan McDonald	Edith Williams, Director

chiw
COMMUNITY HEALTH IMPROVEMENT WORKGROUP

Financial Support:

- Budget is determined annually
- Hospitals are invoiced for a split of the budget proportional to # of discharges

CHIW Partner Advising Member Organizations

- Monroe County Office of Mental Health
- Monroe County Medical Society
- Common Ground Health
- Rochester RHIO
- FLPPS
- ABC
- Jordan Health
- City of Rochester
- United Way
- AA and Latino Health Coalitions
- Trillium Health
- Ronald McDonald House
- RMAPI

Create Community Health Assessment and Community Health Improvement Plan (CHA/CHIP) for Monroe County

Create the Monroe County 2025 Collaborative **Community Health Needs Assessment**

Select 3 top priorities in line with the NYS Prevention Agenda Objectives

Create the Monroe County 2025-2027 Collaborative **Community Health Improvement Plan**

Commit to Evidence-informed interventions and metrics

Approved by hospital boards

then **IMPLEMENTATION!**

Community Engagement

- Self-Reported Health Concerns in the Finger Lake Region (2022) from Common Ground Health
- URMC Community Advisory Council (CAC) Meeting 7-23-2024
- URMC Patient and Family Advisory Council Groups (PFAC)
- African American Health Coalition, Latino Health Coalition and Indigenous Health Coalition meeting 9.26.24
- Rochester Flower City AmeriCorps Members 10.25.24
- Monroe County Dept of Public Health Board of Health 11.4.24
- Hospital leadership from Strong, Highland, Rochester General/Unity

What does the community want?

Priorities from Community Engagement with Data Support

2025-27 Monroe County Community Health Improvement Plan

26.5 of 100,000 births result in the death of the birthing person; This is 3x worse for Black women.

13.1% of Monroe County and 27% of Rochester residents live in poverty.

13.5% of residents experience frequent mental distress

PROBLEM:

How do we implement activities to address our improvement plan?

$15,000 CHIW Mini Grants!

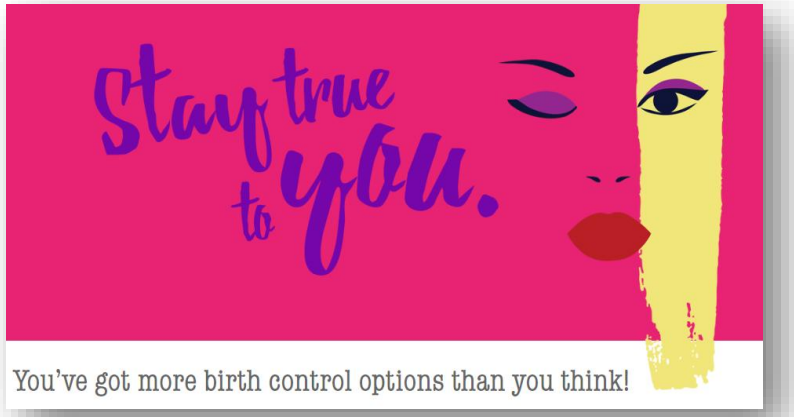
- Started in FY23 (July 1, 2022)
- GOALS:
  - Support content experts from community agencies in their efforts to address our CHIP goals
  - Help community agencies build infrastructure and benefit from the abundant resources within the CHIW membership
- The application process is simplified and advertised through our community partners (40 applicants for 2026 funding!)
- Mini grantees attend CHIW meetings quarterly to discuss progress and are highlighted in our newsletters and website

2022-24 Monroe County CHIP
2023 MiniGrant Projects

Focus 1: Addressing Disparities in Maternal and Child Health

Metro Council for Teen Potential addressed disparities in maternal and child health through relaunching a media campaign that supported the reproductive justice and autonomy of young women for the prevention of unintended pregnancy in the City of Rochester.

The campaign had 2 million impressions and more than 7,500 visits to the website in summer 2023!



Focus 2: Promoting Mental Health and Well-Being

Five courses were held, with 61 individuals attending full training; with 45 becoming certified in MHFA!

Wellness Associates of Greater Rochester Mental Health First Aid—an internationally recognized program designed to increase awareness of the signs and symptoms of mental illness and decrease negative stigmas associated with these conditions.

2022-24 Monroe County CHIP
2024 MiniGrant Project

Focus 2: Promoting Mental Health and Well-Being

Rochester Refugee Resettlement Services (RRRS) is a small community-based organization that helps New Americans become self-sufficient and successful community members.

They own 85 homes in the Rochester area, and house more than 500 people. The goal of this project is to screen refugee children for behavioral health conditions through a CDC Mental Health screening, developed specifically for pediatric patients.

RESULTS

- 206 Screenings, 176 RRRS residents
- 49% were 6-13 yo., 32% under 6 yo
- 27% Bantu, 24% Somali, 23% Afghan, 22% Syrian, 3% Burmese or Venezuelan

POSITIVE Screen = Behavioral Adjustment Issues

- 19% screened positive, very few >13 yo the rest split evenly in the age groups
- 58% positives were from Bantu children, particularly high in the younger group.

"Before age 6 this community needs structured services comparable to the Head Start program organized by Action for a Better Community. This grant project has prompted meetings to plan for a setting geared specifically for refugee children."

2025 Transition Year for CHIP

2025 MiniGrant Projects

Wisdom Seekers, Wisdom Keepers (Common Ground Health)

Black and Latina girls ages 9 to 17 from RCSD schools and their adult female mentors/caregivers engaged in a nine-month curriculum on topics to promote a healthy future.

RESULTS

- 59 Participants enrolled, including students and mentors
- Students were recruited from 2 RCSD schools, and 2 CBOs
- 16-25 participated in each session

Rochester Hope

Rochester Hope provides services to people in the inner city of Rochester, including food, links to resources, monthly clothing distribution, assistance with acquiring household goods and furniture, and immigration support. MiniGrant funding was used to cover general costs.

"In 2025 we averaged food for 1060 adults, 820 children, and 90 seniors each week. This means that over the course of the year, we provided food for people over 100,000 times. During 2025 we distributed more than 1.25 million pounds of food."

2025-27 Monroe County CHIP
2026 MiniGrant Projects

Healthy Births	Mental Well-Being	Financial Stability
Nurturing the Nurturer: A Maternal Wellness & Mindfulness Series	**I Sankofa Rest Hub: Healing Spaces for Fathers and Families**	**Bridges to Opportunity: Workforce Pathways for Newcomers & Migrants**
Rochester Black Nurses Association Dr. Celia McIntosh	FathaTorch, Inc. Mr. Rashakim Hudson	Enlace Services, Inc. Ms. Irene Sanchez
Maternal wellness and mindfulness initiative, designed to improve mental well-being and reduce maternal mortality through a trauma-informed, culturally responsive program. Program includes counseling, yoga, mindfulness, peer support, education, etc.	One year community wellness initiative designed to reduce stress, anxiety and emotional strain on fathers using restorative, culturally grounded spaces for men to rest, reflect, and rebuild. Set to strengthen mental health and family connections	Empower newcomers and migrants (recent arrivals, immigrants and US citizens relocating) to gain the language, skills and connections needed to enter and thrive in the workforce. Goal is self-sufficiency through fostering collaborations
2, 8-week cohorts of 12 mothers each from under resourced neighborhoods	40 fathers, from families impacted by stress, poverty or violence, low income	200 Newcomers, migrants, and farm workers

Brief report

Journal of Public Health Research

Hospital-community partnership to implement community-based health improvement

Journal of Public Health Research
2026, Vol. 15(1), 1–5

DOI: 10.1177/22799036251410256
journals.sagepub.com/home/phj
Sage

Theresa Green[1], Max Dargavel[2], Megan Clifford[3], Jennifer Quick[4] and Richard Millard[5]

Community Partners!

Abstract

Not-for-profit healthcare systems have a mission-driven obligation and federal mandate to address significant community health concerns through the Community Health Improvement Planning process. In this county, four hospitals, the county public health department and several community-based organizations collaborate to review data, prioritize needs, and identify evidence-based interventions every 3 years. Recently the partnership initiated a mini-grant process to fund community-based organizations that propose evidence-informed projects to address improvement goals. The mini-grant process funded three community-based projects in high-risk areas to address disparities in maternal and child health outcomes, including mental health. Results showed increased contraception education to adolescents, 45 new Mental Health First Aid providers for children and new families, and 176 refugee children screened for behavioral health concerns. By supporting community-based agencies to design, conduct and evaluate evidence-informed interventions, hospitals can build strong partnerships and trust among their patient community while improving health outcomes for those at greatest risk.

Keywords

disparities, community, partnership, planning, mental health

Received: 30 May 2025; accepted: 8 December 2025

Introduction

Disparities in health outcomes persist despite health system efforts to improve care.[1] Many of the drivers of health disparities are due to underlying variation in the upstream community-based social drivers of health.[2] Not-for-profit hospitals and health care systems have a moral obligation and federal mandate to address health beyond healthcare delivery and annually report on community benefits. The Affordable Care Act, section 9007, created additional inequities that drive health disparities. Health systems recognize the critical importance of improving social circumstance; however, the expertise and sustained implementation capability often lies with community-based organizations.

[1]Public Health Sciences, Center for Community Health & Prevention, University of Rochester Medical Center, NY, USA
[2]Center for Community Health & Prevention, University of Rochester Medical Center, NY, USA

thank you!

Theresa_Green@URMC.Rochester.edu

UNIVERSITY of ROCHESTER MEDICAL CENTER

Upcoming sessions

Wednesday, March 11 | 10 – 11 a.m.

Leveraging data to guide your work

In this session, panelists will identify helpful, publicly available data on topics such as chronic disease prevalence and healthcare utilization and describe how to analyze the data to inform decisions.

Remaining sessions in this series:

- March 18 | Finding and engaging community partners
- March 25 | How to launch projects with a community partner
- April 1| Ensuring that the project is worth the investment
- April 8| Centering community voices
- April 15| Extend your hospital's reach with community health workers

Care Connections

Questions?

Theresa Green, PhD, MBA
theresa_Green@URMC.rochester.edu

HANYS Always There for Healthcare SINCE 1925