Pathways to Population Health Equity Rural Health Roadmap

PATHWAYS TO POPULATION HEALTH EQUITY

Purpose: This Roadmap supports rural health organizations to deepen health equity efforts to create the conditions for everyone to thrive together using the Pathways to Population Health Equity framework. While it looks linear, rural health organizations and rural communities are encouraged to identify where they are on the journey and start there. This journey is an expanding spiral of transformation in which, with every turn, you expand and deepen the partnerships and work.

STEP 0: Get ready by building understanding, relationship, and trust

- Engage in your own journey of cultural humility and learning about the way rural areas have come to experience poverty, inequity and racial injustice through books, movies, and training courses.
- Learn about and get comfortable acknowledging the history that has shaped your rural community and, if relevant, your institution within that.
- Look at your data to understand who might be at greatest and rising risk of not thriving.
- Build authentic relationships and develop trust with community members experiencing inequities.
- Show up consistently in community forums in-person and virtually and engage in listening and dialogue. Meet people where they are and be in relationship with those experiencing inequities.
    - Listen to community residents' stories, concerns and acknowledge any underlying reasons for mistrust, even if you did not create them.
    - Advance solutions proposed by the community in a way that invites and resources them to lead.
    - Conduct a stories to systems change process to gain a deeper understanding of how the system is showing up in the lives of people experiencing inequities.
- Take time to build relationships, understand people's priorities, stories and interests, to build trust and understand who the formal and informal leaders of a community are. Consider mapping trust. Embrace differences and be receptive to learning.
- Build inclusive, bi-directional communication channels for sharing information with communities. Use ASL services for hearing impaired and translation services for people where English is not their first language.
- Think about and plan for how you will engage and integrate community residents with lived experience of inequity into your health equity team.
- Embrace differences and be receptive to learning and change.
- Think about how to build on existing rural community values like taking care of one's neighbors and creating a community where everyone belongs, autonomy, entrepreneurship, and indigenous pride.
- Take the P2PHE Compass assessment as a team for only the health department component if you don't yet have a community collaboration. If you have a community collaboration, take the community collaboration Compass or the Assessment for Advancing Community Transformation (AACT) Tool. Identify and act on three opportunities for improvement in readiness.

STEP 1: Form your health equity team

- Gain leadership buy-in from key community champions, groups, and public health practitioners (at smaller levels, not just county). Get clear about why you want a health equity team with the different voices you are gathering.
- Map where there is trust, power and assets in the community and who holds access to these. Identify who is doing similar work and determine whether it makes more sense to join that table rather than create another one.
- Identify and engage potential members of your health equity improvement team, include a balance of community residents with lived experience of inequities, facilitative leaders who can build a trustworthy equitable process, and multi-sector partners with access to resources and other expertise who are able to act as stewards (e.g., health care, business, housing, schools, agricultural extension and facilitative leaders who are good connectors).
    - Identify several community champions who are at risk of not thriving who are trusted and are seen as leaders by their community, whether they have a formal leadership role or not. An ideal champion is someone who is able to bring their lived experience forward but also invites that of others to the table, is solution-oriented, and effective at collaboration for a longer-term change process.
    - Identify those who have access to resources and expertise across sectors – for example, a member of agricultural extension if you are working with farmers could be helpful.
    - Identify those who are facilitative leaders – authentic, organized, able to bring all voices in and keep a process moving, a good listener and effective at engaging people where they are (this could be you, but doesn't have to be).
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STEP 1: Form your health equity team *(cont.)*

- Plan for how you will engage these groups by engaging in a process of understanding who they are, what their story is, what they care about, and where there is shared interest/value and capacity for them.
- For all three groups, assess their ability to engage well as part of a team – with cultural humility, patience for the process of change, the ability to see and draw in perspectives beyond their own and to support the process through learning and growth.
- TIP: It is essential that the support team for the health equity team includes someone who is a good process facilitator, comfortable with data, measurement and health literacy, and can be a good "accompanier" or "buddy" to community members. This doesn't all have to reside in one person but these base skills are very helpful.

- Prepare community residents with lived experience to engage in the process and develop and support them as leaders and visionaries.
- If you are starting from a team that exists already, prepare the team to be ready to bring in new partners and community members with lived experience of inequities.
- Re-form the table using a team launch process to set the tone for how your health equity team will work together and to ensure future success.

STEP 2: Understand why people and places are at greatest risk and rising risk of not thriving and what it could take to change that

- Conduct or review a community-driven asset and needs assessment
  - Grow cadre of community health advocates who can be trained in collecting data and using it to drive improvement.
  - *Engage the community to identify measures that matter to them.*
  - *Choose measures that are understandable and relevant to communities and can be easily collected if secondary data isn't available. For example, the Well-being In the Nation measures are often powerful, easy to understand and easy to collect in rural areas.*
  - *Use stories and data to understand the mental, physical, social, cultural, and spiritual well-being of different groups and places in your community, with a special focus on those with the greatest opportunity to thrive.*
  - *Identify vital community conditions and the root causes driving inequities.*
  - *Make sure data can be analyzed to understand how different groups of people and places might experience inequities.*
  - *Meet people where they are—for example on ranches and farms for migrant agricultural workers and ranchers.*
  - Use language interpretation and American Sign Language to create language justice.
  - *When you are collecting data, engage and pay trusted community residents to help decide what to collect and do the collection.*
- Use community sensemaking to identify and risk stratify which groups of people and places are at greatest and rising risk of not thriving.

  - *Understand the strengths, assets and resilience factors of your community.*
  - *Review existing population health data broken out by race, place, wealth, and other equity factors.*
  - *Use local data at the census tract or neighborhood level when available.*
  - *Use measures and resources like the Well-being In the Nation (WIN) measures, County and Health Rankings and Roadmaps or Mobilizing for Action through Planning and Partnerships (MAPP) assessments to identify and address upstream community conditions and root causes.*
  - *Build data sharing processes between public health departments, rural health agencies and community organizations and use data from across sectors to build the whole picture of community needs and assets.*
  - *Listen to people experiencing inequities to understand their priorities and solutions. Take action to implement as many immediate solutions as possible.*
- Build community to community bi-directions (multidirectional) knowledge sharing that includes public health. Give communities access to the data in a deidentified way with appropriate sensemaking.
- Invite community members and community residents who are experiencing inequities to join your health equity team (or join their team if a group already exists). Take the community collaboration portion of the P2PHE Compass assessment together with your expanded team and identify three areas of improvement.

STEP 3: Develop balanced strategies with community residents experiencing inequities and key partners across sectors in communities

- **Thriving health agency/community collaboration:** Develop and implement strategies in the areas you identified on the Compass to build your health equity readiness, processes, and capacity.
- **Thriving communities**: Based on your community assessment and improvement plan, develop holistic strategies across all four portfolios to create a balanced strategy. The key is to make sure it is balanced as a whole.

  - **Portfolio 1: Mental and physical health – Downstream/more urgent response**
    - *Plan for mental and physical health and well-being across the life course and over generations holistically, including the impact of generational trauma.*
    - *Identify and build relationships with non-traditional multi-sector partners (e.g., schools, community pharmacies, barbershops/beauty salons, faith communities, community health centers, ag extension, youth groups) to increase health information.*
    - *Increase utilization of community health workers and peer coaches.*
    - *Develop a population-based plan to invest in primary care and community health/resource centers in addition to working to make rural hospitals more robust and aligned to meet the priority needs of populations experiencing inequities, including physical, mental health and dental needs.*
    - *Utilize available technology platforms to make referrals or provide specialty care where there is limited access to transportation.*
    - *Invest in peer to peer in person and online networks to support population health around chronic physical and mental health conditions.*
    - *Destigmatize and provide supports to address mental health and addiction issues, family system issues, and cultural and generational trauma.*
    - *Work with state offices of rural health to support increased training of current and new preventive care providers and implement pilot programs.*
  - **Portfolio 2: Social and spiritual well-being – Midstream Prevention**
    - *Address priority social needs (food, housing, jobs, loneliness, cultural loss, language needs, family issues)*
    - *Connect partners to existing programs/activities at faith-based organizations, libraries, community centers, ag extension, and volunteer opportunities.*
    - *Support the implementation of clinical-community connection models of care to promote population health.*
    - *Promote family and community involvement in the planning and development of programs/activities to incorporate and build on existing rural community and cultural values.*
    - *Support initiatives that provide family support regardless of family structure (e.g., a grandmother requesting assistance to care for grandkids).*
    - *Invest in initiatives that build on peer-to-peer support (community health workers, peer to peer addiction supports, 12 step groups, youth groups, online forums)*
  - **Portfolio 3: Vital community conditions (Upstream Prevention)**
    - *Map your existing strategies against places experiencing inequities.*
    - *Develop a vital conditions map for your rural area at the subcounty level.*
    - *Identify where there are gaps and reallocate resources toward strategies that directly impact communities experiencing inequities.*
    - *Partner with other agencies (tribal leaders, housing, agricultural extension, employment, farmers, etc.) and community coalitions to address priority needs for the long-term. Break down silos at every level by taking on challenges that require collaboration.*
    - *Map community assets to potential strategies and realign resources to address underlying community conditions (e.g., conditions in factories/plants or for migrant farm workers, water/sanitation) that lead some populations to be more vulnerable.*
    - *Advocate for broadband and digital access as a precondition to community health (and meaningful work and wealth).*
    - *Support an equitable food economy, especially in farming and tribal areas.*
    - *Address economic and environmental issues specific to rural communities that impact health.*
  - **Portfolio 4: Root causes (Groundwater)**
    - *Grow community power.*
    - *Invest in long-term strategies for truth telling and reconciliation. Acknowledge past and present inequities openly with community members along with a commitment to walk together to identify a better path forward. Apologize even if you were not responsible.*
    - *Shift narratives through the arts, storytelling, media.*
    - *Invest in policy, systems and investment change to support real-time strategies around equitable recovery, resilience and renewal using tools like the Springboard for Equitable Recovery and Resilience and the Build Healthy Places Network Healthy Neighborhood Policy Scan.*

STEP 4: Take action to advance equity – evaluate, learn, change, and sustain

- Identify areas for immediate action (Impact/Effort grid) and areas for sustaining long-term strategic effect. Implement immediate "low permission" actions right away together with community residents.
- Develop and implement a series of 90-day equity action labs in each strategy area or portfolio guided by your health equity improvement team with weekly check-ins and review of data.
- Identify outcome, process, and balancing measures aligned with your strategies and overall objectives for national goals like Healthy People 2030 and the Public Health Accreditation Board (PHAB) standards for accreditation around equity.

- Together with community residents, evaluate your progress in real-time and adapt what works as you learn. Honor and abandon the things that didn't work.
- Build in time for joy, celebration, rest, and reflection with the whole community.
- Regularly engage additional community leaders as a stewardship group to assess and shift strategies as needed.
- As things emerge that work, ensure they are sustained and scaled by making them a new norm through policy and practice.