



Summary: NOSORH Health Equity Learning Community – Session 3 Get in Relationship with People and Places Experiencing Inequities

Thursday, April 6, 2023; 2:00-3:30pm ET

Slides: [4.6.23 Health Equity Learning Community - Session 3.pdf](#)

Session Learning Objectives:

1. Come together as a community to advance rural health equity.
2. Build a common understanding of core population health concepts and terms in a rural context.
3. Identify ways to get in relationship with those who might be experiencing health inequities and begin to create change.

Time (ET)	Agenda Item
2:00-2:05 pm	Welcome / Check-in
2:05-2:35pm	<p>Reflections & Breakouts</p> <p>Self-assessed using compass assessment questions (See slides 6-7)</p> <p>In breakouts:</p> <ul style="list-style-type: none"> • Who has started to develop their health equity team? • What are the top reasons you see for developing a health equity team? <p>Key Takeaways:</p> <ul style="list-style-type: none"> • Helps to have more than one person designated as the “minority health person” and to have multiple individuals to integrate learnings and relationships with partners you are trying to reach. • Health equity team or division can support and collaborate with communities in need and serve as a hub for access to services. • Need to figure out how to integrate health equity into all aspects of work. • Health equity work requires continuous improvement.
2:35-3:00pm	<p>Deep Dive: Get in relationship with people and places experiencing inequities</p> <p>Resource: Equity Team Engagement Plan</p> <p>Summary Notes:</p> <p>Reviewed process for risk stratifying your population by people and places</p> <ul style="list-style-type: none"> • Option I (simpler)

	<ul style="list-style-type: none"> ○ Well-being of people: <ul style="list-style-type: none"> ▪ Cantril’s ladder (self-reported well-being) <ul style="list-style-type: none"> • simple tool for use with community members • use to identify proportion of the population that is thriving, struggling or suffering • data can be stratified by age, sex, race, etc. ▪ Medically or socially at risk ○ Well-being of places <ul style="list-style-type: none"> ▪ Social Vulnerability Index or Area deprivation index ▪ Child poverty ○ Equity - Race, Education, etc. <ul style="list-style-type: none"> • Questions to consider: <ul style="list-style-type: none"> ○ Who isn’t thriving? ○ What would it take for that to change? ○ Responses shared: <ul style="list-style-type: none"> ▪ At-risk populations <ul style="list-style-type: none"> • Unhoused • Elderly • Individuals with disabilities or mobility issues • Children • Individuals facing multiple barriers or challenges. ▪ Need to consider intersectionality and the multiplier-effect of factors such as physical, mental, social, racial, income, distance, language, culture and/or more. • Next steps after identifying who is at risk of not thriving: <ul style="list-style-type: none"> ○ Get proximate using design thinking ○ Engage community residents on your health equity team ○ Ask the Five Why’s and use tools like 7 Stories to map the system and create the conditions for longer term change
G	<p>Community to Community</p> <p>Breakouts:</p> <ul style="list-style-type: none"> • <i>Where are you now in identifying people experiencing inequities?</i> • <i>How would you identify who is experiencing health inequities?</i> • <i>Once identified, how would you reach out and begin to develop a relationship with them?</i> • <i>What is an area you could use help from others?</i> <p>Key Takeaways:</p> <ul style="list-style-type: none"> • The power of collaboration, partnerships, learning from others and sharing ideas

	<ul style="list-style-type: none"> • We need to do a better job communicating and collaborating across departments. • Leverage existing data to identify inequities to address - Reach out to CBOs, health systems, FQHCs, rural health clinics, universities or health departments to get data in order to identify populations that are struggling and community health needs. • Survey patients on social determinants of health or conduct a statewide community health needs assessment. • Use social media to share information about where to go for help. • Work with faith-based groups.
<p>3:15 – 3:30pm</p>	<p>Appreciative reflections, and next steps</p> <ul style="list-style-type: none"> • Next steps: <ul style="list-style-type: none"> ○ Review P2PHE Roadmap and ○ Work on using your data to understand who and where people aren't thriving. What equity factors are represented? ○ Use Equity Team Engagement Plan to get in relationship • Next session: <ul style="list-style-type: none"> ○ Thursday, May 11, 2023; 2:00-3:30pm ET ○ Topic: Developing a balanced strategy