



ADVANCING RURAL HEALTH EQUITY STAKEHOLDER REPORT

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[Abstract](#)

To pursue, advance and sustain rural health equity is a deeply complex and challenging effort. It takes the collective impact of multiple organizations, cross-sector coordination and the creation of a common shared purpose to address and overcome the magnitude and complexities of rural health inequities. This report reveals the current state of health equity efforts and recommends ways to advance equitable care, foster healing, create new levels of trustworthiness and pave the way to better health and well-being for rural constituents and communities.

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INTRODUCTION

Rural northern New England¹ is home to Dartmouth Health (DH), New Hampshire's only academic health system and the state's largest private employer with 1,800 providers serving a population of 1.9 million patients. It is a regional and globally recognized center of excellence renowned for its research, education and clinical practice, with a commitment to the delivery of effective and patient-centered care. Located in the same region are renewed centers of academic excellence including Dartmouth College, Geisel School of Medicine, The Dartmouth Institute, and Colby-Sawyer. Manufacturing and farming once drove the area's economy but have long since disappeared. Now these geographically dispersed rural communities face higher rates of poverty, and many suffer from the health impacts of non-clinical issues around food insecurity, limited housing, income insecurity, social and technological isolation, limited access to transportation and occupational safety.

The situation for these rural communities has worsened during the Covid-19 pandemic and exposed the region to a triple threat: its populations are older and sicker than many in urban areas; more communities experience significant poverty and social vulnerability, and its health systems are limited in their capacity to respond².

The glaring inequities over the last two years have brought health equity and social injustice to the consciousness of health and health care leaders in a way that has never been seen before. Conversations at the health delivery system-level to address the social determinants of health, to embed principles of equity into the delivery of care, and to improve community engagement have become more commonplace.

In September 2020, leaders from DH, Geisel School of Medicine and Dartmouth College committed to the 2022 launch of a Center for Advancing Rural Health Equity (CARHE) to address long-standing rural health disparities, eliminate unjust variations in health outcomes, and create greater alignment of effort across health delivery, education, research and community in the region.

Advancing rural health equity in rural northern New England requires the acquisition of new knowledge, new ways of collaborating, new skills and competencies, and significant outreach to create stronger community partnerships. For the CARHE to meet these demands, this report provides a summary of the current best practices for community outreach and engagement to advance rural health equity. It outlines how to leverage local assets, challenges to overcome and recommendations for successful and sustainable governance and operating structures. In addition, the report determines how to maximize and operationalize rural health equity collaborative activities in the region and how to design and implement programs and research which are equally responsive to community, regional and health delivery needs and priorities.

¹ In this report rural northern New England refers to the geographical area covering rural northern New Hampshire and southeastern Vermont and includes the Grafton, Sullivan, Windsor and Orange Counties.

² Village Versus Virus: Rural Ethos Protects Where Public Health Fails", Health Affairs Blog, July 27, 2020.
DOI: 10.1377/hblog20200722.490817

The report draws on the Institute for Healthcare Improvement’s (IHI) five-component framework for Achieving Health Equity: A Guide for Healthcare Organizations³, as its content theory and to structure recommendations to guide the CARHE in its efforts to advance rural health equity.

CARHE Design Work to Date

During the spring and fall of 2021, the DH Population Health team undertook a series of interviews and hosted stakeholder meetings with representatives from government, public health, research, education, clinical care, social services, state foundations and community partners. Early discussions centered on how to bring together the region’s health delivery partners, communities, education and research partners to advance health equity through a focus on rurality, equity, social justice and social determinants. A framework was created to realize the four distinct representations at CARHE of influence and voice. (See Figure 1.)

Figure 1. The Four Pillars for the Center for Advancing Rural Health Equity



The four pillars of community action, education, healthcare redesign, and research will provide an essential structure for capturing knowledge and catalyzing action across the region’s communities, health systems and academic institutions. These four inter-related areas of activity are described in further detail in the table below.

Community Action	Empower health systems and community leaders across sectors to understand and respond to local needs while relentlessly focusing on eliminating barriers to optimal and equitable health in rural populations.
Education and training	Contribute to the development of a pipeline of leaders committed to advancing health equity in rural northern New England through collaborative learning to improve clinical practice, research, and community leadership.
Healthcare Redesign	Translate community-engaged research into improvements in healthcare delivery in partnership with health systems and communities
Research	Generate evidence to inform implementation and redesign in clinical practice, regional action, and policy through action-oriented research.

³ Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. *Achieving Health Equity: A Guide for Health Care Organizations*. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. <http://www.ihl.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx>

Several attempts in the past to bring together clinicians, researchers, population and public health teams in response to an urgent challenge to tackle health inequities has resulted in rather fragmented, non-aligned efforts despite everyone's best interests. An example of this is the improving care for patients with diabetes in the DH Manchester clinic effort prior to the Covid-19 pandemic. Despite a meaningful collaborative effort to bring together various stakeholders, common challenges were experienced during shared improvement efforts across the multiple sectors (In this case population health teams, policymakers and researchers). It is hoped that the four-pillar framework will provide the necessary components and structures for successful cross-sector, multi-stakeholder collaborative efforts with shared data collection, common funding mechanisms, a shift to upstream determinants of health, community engagement and new learning and knowledge-sharing.

In addition, the wide-reaching scope of stakeholder involvement across the four pillars of health, academia, research and community, will position CARHE to better facilitate cross-sector collaboration not only across the region but potentially elsewhere in New England and beyond.

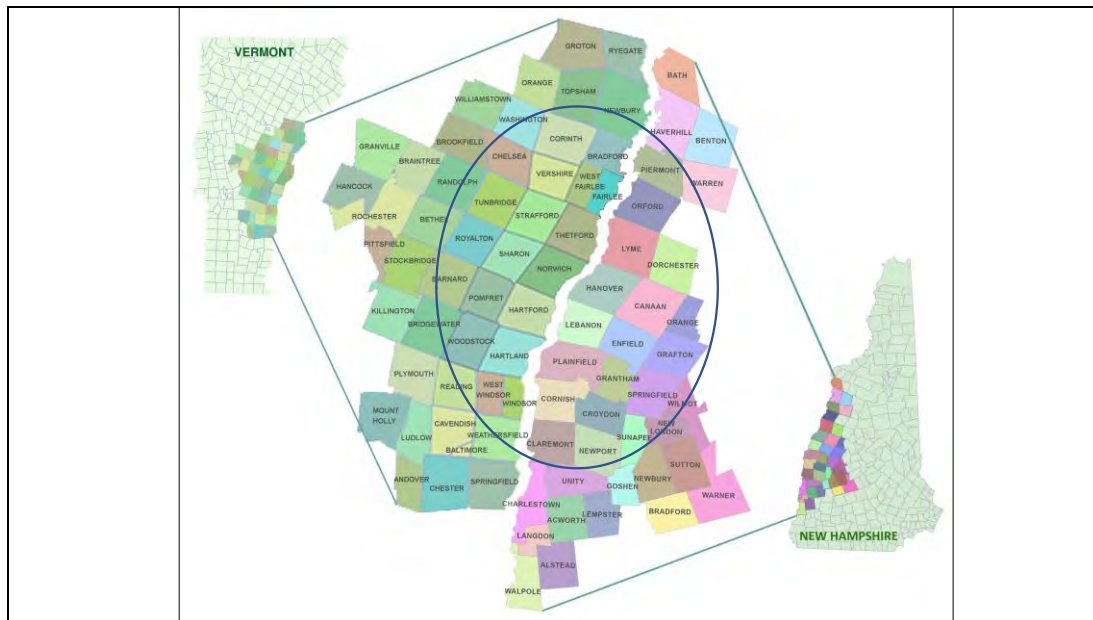
Data Collection

Core to the success of the CARHE is the ability to generate knowledge, build capacity of the region's academic health delivery and community leaders to address health equity, and work in partnership with community-based organizations and rural populations to support their residents to achieve full health potential. Consultant Yaël Gill, with support from consultant Kate Hilton, engaged in a diagnostic process to provide an informed view of the current state of health equity and provide a clear roadmap to achieve higher levels of performance and transformation. Ms. Gill conducted a series of interviews with thirteen key Rural Constituents⁴ who represent local health delivery, research, human service agencies and non-for-profits in New Hampshire (NH) and Vermont (VT). Conversations focused on uncovering ways in which rural constituents engage with the health delivery system, and with other local agencies and organizations who address the social determinants of health. (See Appendix A: Interview Questions for Rural Constituents)

To give a sense of the impact and reach of the Rural Constituents across rural northern New England, you will find an asset map below in figure 2 which conveys an approximate catchment area for the work that they do collectively to advance the health and well-being of the communities they serve.

⁴ In this context a 'Rural Constituent' is a rural resident of northern New England who represents one of the following: i) Those with lived experience as a rural resident, ii) Organizational representatives from service providers who contribute to rural health or iii) Those working to improve the health of the populations

Figure 2. Rural Constituent Asset Map



Below we outline the general themes from these conversations, highlighting the bright spots where community engagement is most successful; determining the pressing needs of the rural community, in particular among those experiencing significant health inequities; uncovering the daily challenges and roadblocks facing rural constituents; and identifying community assets which can be leveraged by the CARHE to advance rural health equity.

Bright Spots

- **Rural Advantages**

Rural northern New England has an abundance of natural resources which makes it an ideal place for people to live and work. Its bucolic rural flavor with plenty of green spaces, four distinct seasons and a natural environment provide for a simpler way of life, and there are numerous opportunities to pursue an active outdoor lifestyle. Despite the quieter rural lifestyle, there is a strong sense of community. Due to its more isolated geographic attributes, small-knit rural communities are more self-reliant and independent than their urban counterparts. To support rural constituents with health and human service needs, the region has a wealth of knowledge and support systems. Strong economic drivers with job opportunities and vacancies draw people to the area with good school systems, civil engagement, robust town meeting cultures, a buzzing arts and culture scene, and plentiful restaurants and other social activities.

- **Community Engagement**

Discussions with Rural Constituents revealed six drivers for engaging successfully with the community to create strong relationships, build trust and respond to their needs quickly and efficiently. These are valuable to the CARHE as it seeks to work collaboratively with others in the community in multistakeholder coalitions.

1. Firsthand Knowledge

The Rural Constituents highlighted several local human service agencies that are most trusted by rural residents and where they can find support they need. The Rural Constituents highlighted several local human service agencies. These agencies all shared a common attribute – the value of firsthand knowledge of how rural constituents cope with poverty, food insecurity, substance misuse, rising fuel costs, inadequate levels of affordable housing, in addition to increased levels of homelessness, anxiety, trauma and mental health needs. The value of having a physical presence is reflected by Meals on Wheels volunteers' in-home visits, which not only provide much-needed food delivery, but also include a welfare check on the resident, providing an opportunity for a quick evaluation of the home environment and resident's well-being (i.e., is there running water, do they have enough medication, etc.)

2. Assessments and Actionable Solutions

Hunger Free Vermont and Willing Hands, hunger relief and food recovery agencies, were highlighted for their expertise in how to feed and assess the support needed for the most vulnerable. Equally important is their knowledge and expertise in successfully bringing people and community partners together to take action collaboratively and swiftly.

Further examples of community engagement bright spots can be found at Twin Pines Housing, TLC Family Resource Center, The Family Place, Grafton Aging Resource Center, Southwestern Community Services (NH), Southeastern Vermont Community Action (SEVCA) and Service Link. These agencies were praised for providing local residents in need with a wealth of informational referrals and brokering services. They work with residents to complete needs assessments and then use the data to provide actionable solutions, increasing the levels of success and helping to build lasting and trusting relationships.

Several Rural Constituents felt that there is an urgent need in the region to create more incentives for people to work together and to actively create solutions in a timely manner. They felt that sometimes people come together and talk too much about the problem and do not push enough to go out and create and undertake the solutions.

3. Value of Cross-Organizational Networking in Crisis Situations

Mentioned many times over during our conversations with the Rural Constituents was the power and success of Upper Valley Strong, the coalition of non-profit agencies, churches, schools, towns and local branches of State government who came together in 2011 as the Long-Term Recovery Committee in response to Tropical Storm Irene. Since then, they have continued to create, strengthen, expand and coordinate disaster recovery efforts as needed throughout the region. Many feel that Upper Valley Strong has some of the most robust examples of community engagement – their ability to conduct initial assessments to determine the fair distribution of resources; to find solutions; to coordinate volunteers and professionals for rebuild projects; and to communicate with those in need. The success of this multisectoral collaboration has

resulted in many positive outcomes for residents, increasing the trust built across involve communities.

4. The Power of Direct Care

An additional driver for effective community engagement is the power of smaller organizations such as Baby Steps Family Assistance and the Soup Kitchen in Claremont that provide direct care to residents and have a strong understanding of their most pressing needs. On a more personal level, several Rural Constituents spoke of the staff in general or thrift stores whose daily or weekly interactions with the most vulnerable provides a reliable source of care needs and community engagement.

Other positive examples of providing direct care and understanding the necessary needs and support can be found with the State agencies of the Division for Children, Youth and Families, (DCYF) and The Vermont Department for Children and Families (DCF) in addition to the county Family Court in Newport, NH.

5. Creating Strong Relationships and Building Trust

Aging rural residents often struggle with higher rates of poverty and are more isolated than those living in urban centers. Rural Constituents listed a number of agencies that have successfully engaged isolated rural residents who contend with limited access to transport and technology. The resource centers such as Support Services at Home (SASH), Aging and Disability Resource Centers, Aging in Hartland and Community Cares of Lyme have strong relationships with their beneficiaries and are able to connect the dots and help residents to navigate resources such as sourcing fuel assistance and food stamps in an otherwise hard to find or insecure environment.

Various health and health care organizations were noted for their success in engaging with rural residents and building trusted relationships. The Visiting Nurse and Hospice for VT and NH provides effective and compassionate nursing care for all community residents post hospital care and is one of the few health care organizations who get to see patients in their home residences – seeing firsthand the impoverished living conditions such as lack of heat or running water. Other trusted and well sought-after regional health care organizations that offer services for lower income patients and provide free clinics to those most in need include Mascoma Community Health Center, Alice Peck Day, Good Neighbor Health Clinic, Red Lion Dental Clinic and West Central Behavioral Health in Lebanon and Claremont.

6. Convening for Action

The most frequent example of effective engagement of rural residents given by the Rural Constituents was the Public Health Council of the Upper Valley. Many highlighted how previous flu vaccination clinics and more recent Covid-19 vaccine clinics showed how health delivery systems can work exceptionally well with the community through the design of a comprehensive and easily accessible approach. They demonstrated the health benefits of the vaccines, built goodwill in the community and created an implementation process which could be successfully scaled up. In addition, the council was applauded for its exceptional work over the last few years on substance misuse, its

ability to convene, and to share its wealth of knowledge and expertise across the community.

- **Shared Decision-Making Protocols**

According to the Rural Constituents, several human service agencies have created models of shared decision-making protocols and have incorporated collaborative and equitable partnership norms into their work. Frequently mentioned was the HAVEN, selected for its ability to solve problems for people in need of housing, food and other social services and addressing pressing concerns. Many spoke of the importance of creating collaborative and inclusive interactions and including the beneficiaries in the decision-making and solution-design. Vital Communities and the DCF and DCYF also show similar levels of collaboration and solution co-design with beneficiaries.

Diversity in voice was observed by several Rural Constituents as an important component to equitable shared decision-making protocols. To create diverse leadership, Listen Community Services includes individuals with varying perspectives and experiences on its board. Other organizations in the region have found this a more difficult aspiration to achieve as many of those with lived experience do not have many opportunities to build wider networks and connections and therefore are less likely to be asked to contribute.

Examples of effective shared decision-making with families can be found at New Hampshire's Family Resource Center; the Children's Trust communicates in a family-centric way. Spark! Community Center, Zack's Place Enrichment Center and Stepping Stone and Next Step were also mentioned as examples of strong peer support and shared decision-making protocols.

In health and health care settings, several examples of successful shared decision-making protocols and higher levels of collaboration between residents and providers are also evident. As a Federally Qualified Health Center, just over half of board members at Mascoma Community Health Center have to include patients. The decision-making process for the Visiting Nurse and Hospice for VT and NH has in its core design a triad of cooperation expected between the patient, the Visiting Nurse and the Provider and is well-trusted by residents. In addition, the Purple Pod at Children's Hospital at Dartmouth Hitchcock (CHaD) was mentioned as a place where strong parent-leadership competencies are encouraged, with robust examples of shared decision-making protocols and the ability to help residents overcome feelings of mistrust.

- **Advancing the Well-Being of All Community Members**

In addition to successful engagement of rural residents, we discovered plenty of encouraging examples where health care providers have contributed to advancing the well-being of all community members. We believe that these operating and governing structures should be leveraged by the CARHE.

Mt. Ascutney Hospital and Health Center, Valley Regional Hospital, Alice Day Peck Memorial, and the DH Population Health Team each have successful action-oriented

community outreach programs and know how to create the right conditions to convene and support group efforts.

Other positive examples of child and family engagement in services include the work of the Partners to Promote (P2P) (a program for the safety, permanency and well-being of families affected by substance misuse) and the robust, collaborative work of the Wraparound Coordinators and Community Health Workers. Project DULCE (Developmental Understanding and Legal Collaboration for Everyone) in VT was highlighted as a bright spot for its transformational improvement efforts for how families experience health care.

Lastly, several Community Stakeholders encouraged the CARHE to leverage the success of the Windsor HAS Community Collaborative. Using the Community Health Needs Assessment (CHNA) as its driver, the collaborative is determined by a defined unifying purpose using collective community impact. Each working group is focused on creating best practice strategies and is made up of community partners, residents, human service agencies, businesses and health care delivery partners. Notably residents with lived experience must be involved in the planning, implementation and measurement design. The collaborative brings people together twice a year for intentional learning opportunities and results-based accountability.

Challenges

- Rural Gaps

Despite the idyllic setting of rural northern New England, there are many challenges and gaps that make life harder for rural people living and working here than in other more urban parts of NH and VT. Cycles of deprivation and generational poverty have been in existence since manufacturing left the area fifty years ago. (See Figure 3 for key drivers of health). In the 2022 Community Health Needs Assessment⁵, the highest median household income community in Hanover, NH is nearly three times higher than the lowest income communities of Fairlee, VT and Dorchester, NH. The cost of living is high with little affordable housing, an increasing lack of inventory and the gentrification of poorer towns pushing people further from accessible resources. The region's economic diversity has expanded the stratification of residents, with winners and losers for services and funding for schools. Although there are low unemployment levels, some Rural Constituents feel that some employers do not offer a livable wage and affordable childcare options. A high percentage of families continue to struggle on a daily basis.

⁵ <https://www.dartmouth-hitchcock.org/sites/default/files/2022-02/2022-dhapdvnh-community-health-needs-assessment.pdf>

Figure 3. Key Drivers of Health in four counties in rural northern New England (VT and NH only)



As you drive across rural northern New England, there are pockets of wealth where tourism and the employment base are well developed. Examples include Woodstock (VT), where the proximity to Dartmouth College, the US Army Corps of Engineers Cold Regions Research and Engineering Laboratory (CRREL), and the Hanover-Lebanon-White river Junction urban area provide a wide range of employment along with almost year-round tourism, creating a strong economic base. However just a few miles away are some of the old manufacturing towns such as Newport and Claremont (NH), where mill buildings and retail storefronts stand empty, and town centers have been hollowed out from relocation of production outside the USA, business failures due to inability to compete with cheaper imports, and the loss of associated support services.⁶

Access to resources is difficult, especially for those on a fixed income, who may need to pay out of pocket or who may not have health insurance. In addition, resources are not present in more rural parts of the state where retail choices and broadband connections are very limited.

As the population ages, there are concerns that there will not be enough carers and many senior residents will be forced to age in place. Whilst many in the region have focused on improving care and well-being for older adults, there are still residents who

⁶ A snapshot of rural issues across northern New England, blog by John Powell, Countryside and Community Research Institute (CCRI), University of Gloucestershire, England. Published online November 2019 <http://www.ccri.ac.uk/usarural/>

live behind closed doors and may only interact once a week through a Meals on Wheels delivery.

One of the biggest challenges mentioned repeatedly by Rural Constituents, and which impact health outcomes for residents, is the lack of transportation options. For those living in the most rural parts of the region, residents may be at least 30 minutes away from the nearest hospital, job or resources for clothing and food. As public transport options are limited or non-existent in rural areas, shift workers cannot rely on the transit system to take them to and from work. Whilst there may be transport options offered by voluntary human service agencies to take residents to hospital appointments, there is nothing to fill the gap when these residents need to get groceries or other necessities. For rural residents with access to a vehicle, the variable and currently high cost of gasoline is another burden.

Nearly 190,000 residents of rural northern New England (including NH, VT and Maine) live farther than 15 miles from a hospital.⁷ Closures of hospitals or other health-care facilities would certainly intensify the problem and could result in large numbers of residents having to travel greater distances from the care provided in hospitals and health centers.

Lastly, there has been a shift in the nursing workforce, exacerbated during the Covid-19 pandemic. Like elsewhere in the country, older adults in rural northern New England are finding it harder than ever to get paid help amid acute staff shortages, as home health nurses are leaving their jobs to be employed by health systems with signing bonuses and higher wages. Furthermore, nurses are increasingly burned out after working during the pandemic in difficult and anxiety-provoking circumstances. The implications for older adults are grim with delayed discharge times from hospitals or rehabilitation centers, less than optimal services when they eventually get home due to cutbacks in services or simply unable to find care.⁸

Leveraging the Community Needs Health Assessment (CHNA)

Many Rural Constituents welcomed the efforts of the regional CHNA as a comprehensive, thoughtful and intentional true assessment of the community health needs, validated through its metrics, and the augmentation of the community's voice. They greatly appreciated how the CHNA intentionally brings together networks and

⁷ Regional Brief | 2019-01 | Declining Access to Health Care in Northern New England, New England Public Policy Center, Riley Sullivan, April 10, 2019 <https://www.bostonfed.org/publications/new-england-public-policy-center-regional-briefs/2019/declining-access-to-health-care-in-northern-new-england.aspx#:~:text=Declining%20admissions%20can%20be%20driven,New%20Hampshire's%2010%20lost%20population>

⁸ Pandemic-Fueled Shortages of Home Health Workers Strand Patients Without Necessary Care. Judith Graham, Kaiser Health News. Published online February 3, 2022, <https://khn.org/news/article/pandemic-fueled-home-health-care-shortages-strand-patients/>

multisector agencies to address the issues of substance misuse, housing, food insecurity, health, dental and mental health care.

Many were not surprised by the 2022 CHNA findings but felt disheartened that the same things reappear year after year. They possess a sense of urgency to mobilize many of the region's resources to address the social determinants of health, especially after the last two years of further hardships brought on by the Covid-19 pandemic. This question was frequently asked: *“What can be done across all sectors to make things better for people?”*

Many identified with the report's top priorities: access to mental health services, cost of health care services and health insurance, and preventing misuse and addiction to alcohol and drugs.

Many acknowledged seeing similarities in daily care coordination such as the high costs and difficulty in accessing mental, health and dental care services, the lack of affordable housing, exacerbated by the pandemic and for seniors aging in place, and the difficulties faced by those seeking recovery services. As one Rural Constituent noted: *“A whole generation is going to suffer regardless of wealth or privilege.”*

In addition to identifying the CHNA's most pressing priorities, the Rural Constituents shared several ways in which local communities, organizational leaders, health delivery and researchers could improve rural health and well-being:

1. Access and Workforce Demands

Several Rural Constituents referenced the need for an immediate focus on access to social services, in particular around mental health. For example, care assistants could help tackle ways to meet the increasing workforce demands for services. In addition, they highlighted the need for better marketing around human service agencies and an acknowledgement that people do not know how to access a ride or get counseling. *“People who are poor, isolated and hungry don't always know how to navigate the system....we need more ‘navigators’” to help these people.”*

2. Data Exploration

Several Rural Constituents felt that many voices and parts of the community are not featured in the CHNA report, and their lives and hardships are therefore not captured. They believed that food insecurities and access to and from health services are even more acute in Grafton and Sullivan Counties than the smaller hub of towns addressed in the report. They suggest drilling deeper into the data at the town-level in order to get a more precise understanding of the severity of health inequities such as infant mortality, substance misuse and poverty in the aging manufactured homes.

3. Storytelling

Many Rural Constituents agree that each time the CHNA is created, it produces a wealth of knowledge and data around the current health needs of the community. However, some felt that there might be a better way of sharing the stories behind the

data and using experiences and storytelling to advocate for change. For example, rather than stating “ % better”, the data could be crafted into a story which shows what improvements to care or to access look like in residents’ lives. In addition, they wanted to know more about the target audience and who reads the report. *“If we want to make it more useful, we should take the data and make it much more accessible through different mediums through a much wider, more inclusive community outreach effort.”*

Lastly, one Rural Constituent reflected that there should be a process to review and evaluate the recent opioid prevention work in the area over the last three years. She described how so much effort and energy had been expended by DH and its partners in NH and VT but noted the difficulty of scale-up efforts. As a result, mental health services are acutely pressed. She suggested conducting a deep dive into the opioid prevention work, to review why scale-up efforts were not as successful as planned and what changes could be made to avoid these difficulties in future efforts in the region.

Missed Opportunities

We asked the Rural Constituents to consider times when health care providers and other human service agencies in the region have not meet the needs of the rural communities. For some, missed opportunities are due to how organizations and systems are set up and noted that there will always be a perverse financial incentive between the priorities of the health delivery system and community needs.

One Rural Constituent felt that there was a disconnect with the health delivery system and providers trying to do the right thing; she was not sure that providers fully understood the term “community” – and who it really involves. *“They want to be supportive of community care but perhaps they don’t realize that some residents simply don’t have running water.”*

Another went on to describe how he thought that parts of the system were simply broken or misaligned. For example, providers focus on a patient’s BMI and do not take into consideration an individual’s activity level. He felt that clinicians may not be trained in nutrition counseling, that they tend to be look at patients through a clinical lens and do not take the whole person and environment into consideration. *“Perhaps the incentives are wrong even if the clinicians are passionate about better health for patients?”*

For others, the lack of equitable funding often led to missed opportunities. *“What can we do to spread out the philanthropic contributions of foundations such as the Jake and Dorothy Byrne Foundation? Is it fair that there are areas in the region which don’t get as much money or support as the communities in and around White River Junction?”*

Some considered that those living in more rural towns such as Claremont will always be at a disadvantage if the funds and services are concentrated in one part of the state. Similarly, Welfare Officers in larger towns are often better funded and work full-time, in comparison to smaller, more rural towns who have part-time welfare officers, and are not well-represented in the wider regional meetings and networks.

For others, the social safety net at the state level is already considered weak in NH. They felt strongly that the state and providers need to invest further in population health. *“We need to get out into rural communities to improve access to resources and reduce the volume of acute care needs.”*

Some of the missed opportunities were attributed to people working in silos across public health. An example of how to remedy this was described. As part of the terms of the Partners to Promote (P2P) regional partnership grant, a cross-sector governance structure should be created – this level of accountability required by the grant is forcing them to create a multi-stakeholder coalition from the start. The Rural Constituents suggested that this level of accountability should be considered and replicated at the CARHE.

Despite the advantages of DH as an academic institution with a large presence in the region, it has created challenges for those living in the more rural parts of community. *“When you have a system which is based less in the community and instead everything is funneled through Hanover, it creates disparities.”* Whilst this gap has and continues to be addressed, it needs to be acknowledged that it takes a lot of effort and will building. *“We need to create greater lines of communication with the health system and the more rural parts of the community. We need real leadership and commitment from the top to make significant changes.”*

Others wondered if the move to improving clinical outcomes over the last twenty years has redirected energy away from a rural population health focus. *“We need to reconstruct a public health model with increased community nursing models and meet the needs of the rural community where they are. We need to reverse the sense of disenfranchisement from the health system from those who feel left out and cut off from local services.”*

Many acknowledged how much DH has done to be more inclusive and welcoming of all residents, although there continues to be missed opportunities in provider/patient clinical interactions. *“We have good intent, but we need to show and implement new language, more use of trauma-informed care and embrace motivational interviewing techniques.”*

Both health delivery providers and human service agencies need to be more aware and sensitive to the needs of the illiterate population and to those living with addiction. For those seeking pain medications, Rural Constituents felt that more is needed to educate staff to be more empathetic and to remove stigma. They stressed the unintended harm when providers ask how people identify without the appropriate equity training and when providers label residents as ‘non-compliant’ if they do not attend an appointment, instead of using equity-based language that recognizes patient choice. *“We desperately need to be more patient-centered.”*

Several Rural Constituents reflected on past collaboratives and missed opportunities and stressed the need to learn from the 2012 ReThink Health, a Rippel initiative⁹. Built around the IHI Triple Aim Framework¹⁰, the collaborative aimed to accelerate change and enhance health system performance. Its goal was to improve the health of the population, enhance the experience and outcomes of the patient, and reduce per capita cost of care for the benefit of communities. Through this initiative, DH and its partners sought to create an ongoing structure which would help mobilize the community. The initiative showed what was possible, and several local assets enabled its success: being a small enough region to make culture change feasible; having a community with many content experts, leaders, talented retirees; and being a manageable group of stakeholders. It also provided an opportunity to repair broken relationships among DH and other provider institutions. However, missed opportunities for this initiative were also highlighted. The initiative was at times an elite-based, academic and theoretical model which did not engage sufficiently with the community and was not based on operations in the field. Even if the aspirations were community-centered, many did not feel like the initiative belonged to the community. *“Next time perhaps we can bring something to the community when it is further on in its design, and we should not assume that the community will comfortably engage in theoretical modelling alongside academics and researchers.”*

For some, the CHNA process has missed opportunities for the health delivery providers to meet the needs of the rural residents. One Rural Constituent questioned how the data from these reports is used to implement changes. *“Are we sure that the CHNA priorities are the same priorities of the health system leadership? Often the creation of an action plan involves many, but the action plans sometimes fall short, as they don’t involve everyone in the rollout and execution. We need to leverage those doing the work.”*

Whilst the majority of the Rural Constituents acknowledged that there will always be some level of missed opportunities between providers and residents, they encouraged those looking to advance the rural health and well-being of residents to look to existing coalitions and to avoid creating new networks and new meetings. There needs to be a real sense of a leader or a decision-making authority. *“We need a convener and a sense of purpose for us all being there.”*

Recommendations

The CARHE leadership may consider these findings and recommendations to leverage existing strengths and determine actionable next steps to create a stronger collaboration between members of rural communities, organizational leaders, health delivery, academic partners and researchers. The strategy and execution plan laid out in this section should be considered for the short-term launch of the CARHE strategic

⁹ <https://rethinkhealth.org/about/>

¹⁰ <http://www.ihl.org/Topics/TripleAim/Pages/default.aspx>

aims and its long-term success and sustainability, as a local, regional and even national hub for advancing rural health equity.

Using the IHI theory of change for pursuing equity as a guide, we present our recommendations for how the CARHE can advance rural health equity, assess where inequities are produced and where equity can be created, and learn from lessons from other organizations in the process of achieving health equity transformation.

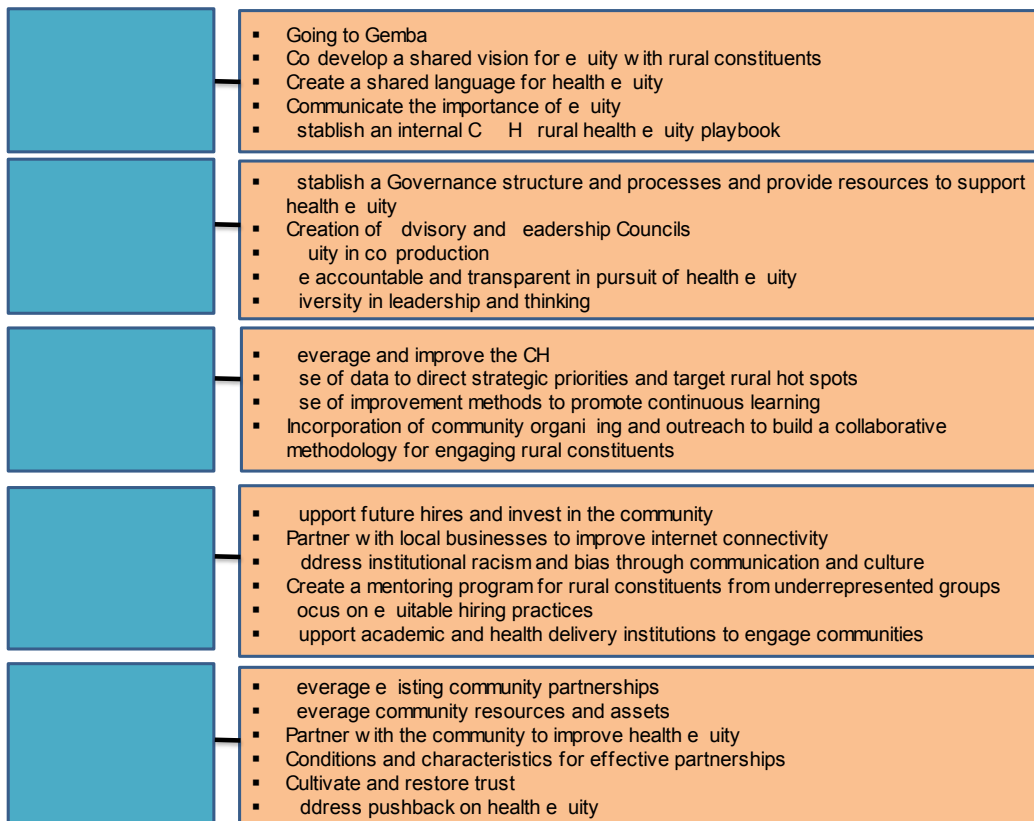
Figure 4. The Path to Pursuing Equity¹¹



Below is an overview of the strategy based on the IHI five-component framework, for the CARHE to chart its journey to advancing rural health equity. (See Figure 5 overleaf)

¹¹ *Achieving Health Equity: A Guide for Health Care Organizations*. IHI White Paper

Figure 5. Pursuing Rural Health Equity



1. Making Health Equity a Strategic Priority

By launching the CARHE, the executive leaders from DH, Dartmouth College and Geisel School of Medicine have demonstrated a system-level leadership commitment to improving rural health equity for the communities that they serve by building interdisciplinary teams and coalitions.

The leadership and trustees must now follow up with the concept of practicing rural health equity in word and deed. This means in addition to making statements and creating strategic priorities related to advancing health equity, senior leaders must translate the message across their organizations that building the capacity to advance rural health equity will take commitment over time, involve hard work and will not always be pleasant. Words can be impactful, but they are not sufficient. True accountability means words with actions, through transparent processes, building trust through relationships, co-production with rural communities, in particular with the most vulnerable and supporting a culture of continuous improvement.

- ‘Going to Gemba’

The leadership and trustees will need to work shoulder to shoulder with the rural communities and actively uncover common ground to cultivate and restore trust. In

Lean and Kaizen methodology, this is described as 'Going to Gemba'; this is the act of visiting the shop floor. Literally translated as 'The Real Place', it pushes the importance of leadership understanding what is happening at every level. In the CARHE context, this would mean finding ways to physically observe and understand the challenges and hardships of the rural communities – and meet them where they are, not on campus or in the hospital setting.

At the same time, coalition building does not always work out as planned. It is important for the CARHE to consider how to put rural health equity commitments into practice. Here are our recommendations.

- **Co-develop a Shared Vision for Equity with Rural Constituents**

To ensure that the Center reaches its goals and provides a sustainable and equitable model of cross-sector support and collaboration, the launch of the CARHE will need to demonstrate its unique value to the rural community and establish a welcoming, inclusive and practical look, feel, and way of being. This means ensuring rural health equity is core to the Center's mission, vision and values; that the Center includes a community-based approach to governance and is supported by principles, practice and policies that ensure that its work is executed with a relentless focus on health equity. All of these elements for success will need to be co-created and co-produced with the perspectives and ideas of rural constituents, including rural resident voices who are not currently represented in the CARHE Initial Planning Team. Any new effort to partner effectively with the community will need to show greater inclusivity, a clear vision, and leverage trusted partners from across all four pillars, in particular including more diverse voices.

- **Create a Shared Language for Health Equity**

As the CARHE Initial Planning Team designs the strategic and operational structures for the Center during the spring, it will be important that a shared language for health equity is created with input from rural constituents. This should include the following three components:

1. A rural health equity definition.
2. A set of health equity, health inequity and other terms to communicate effectively with the community.
3. Principles, practices and policies to foster equitable cross-sector collaboration.

To support health equity as a strategic priority, we recommend the use of a CARHE health equity shared language to be used across the community with providers, academic institutions and community stakeholders and residents. (See Appendix B: The CARHE Glossary of Equity Terms). We also recommend taking the first draft of a rural health definition, as determined by the CARHE Planning Team, to rural constituents for input and guidance. (See Appendix C: CARHE Rural Health Equity Definition)

With each phase of the CARHE design, implementation and rollout, and during challenging moments, we recommend creating a process to return to the three components (rural health equity definition, glossary of terms and principles, practices and policies) and build an iterative and continuous learning evaluation process to assess their relevance and ensure that rural constituent voices are considered.

- **Communicate the Importance of Equity**

In addition to the commitment for a shared language for health equity, the Center will need to create a robust communications strategy, provide frequent examples of data and resident stories about rural health equity, and examples of how the Center is providing support to tackle the biggest community needs.

Whilst we acknowledge separate activity by other stakeholders during the CARHE planning phase¹² to produce a series of events to increase community awareness of health equity and CH's work, we recommend that any work focused on a CARHE communication strategy include full transparency with the rural constituents of NH and VT of its goals, initiatives, progress and results.

We recommend the DH Population Health Team create a quarterly CARHE newsletter to keep the CARHE Initial Planning Team members and interested constituents abreast of what is happening to date. We recommend the development of a wider communication effort with extended outreach across health, research and academic networks in addition to finding new ways to reach the community. We heard from many of the Rural Constituents that more needs to be done to meet rural residents where they are and where they frequent. We suggest creating a communication effort which moves beyond the comforts of an email distribution list to hard copy newsletters distributed at local laundromats, thrift and general stores, resource centers, clinical settings, and through organizations and agencies that provide at-home care. One further consideration is the need for the use of plain language when communicating around health equity in the community. *"It's everyone's issue and we need to communicate more effectively."*

In determining the communication strategy for the CARHE, we encourage undertaking an exercise to assess what assets might already be in use in the community to address multiple social determinants of health and how to compliment other community health efforts such as the CHNA distribution and the Upper Valley Public Health Network forums.

In order to communicate clearly, effectively and often, the CARHE will need to assign resources dedicated to these efforts and strive to show how the community and its health are changing. Several Rural Constituents shared their concerns that sometimes initiatives are launched with much fanfare but often the progress is not shared widely.

¹² As noted in the Facilitated Planning Activities and Implementation Plan sections of the CARHE Grant Proposal, October 6, 2021, pages 3-6

For example, much was made of the launch of the Incubator¹³ work at The Dartmouth Institute (TDI) and DH but communications of how the process has unfolded and sharing of results once something “*comes out of the incubator*” is lacking.

- **Establish an Internal CARHE Rural Health Equity Playbook**

To compliment the leadership’s role in ‘doing health equity in word and deed’, resources within the CARHE structure will need to be set aside to ensure that staff and project partners will be held accountable to incorporating relationship building and health equity principles, practices and policies in their day-to-day work.

Structures and policies will also need to be put in place during the onboarding phase to ensure that the hiring of staff and community members for projects includes underrepresented residents from marginalized groups and there are processes in place to identify areas where the CARHE actions might be out of step with its values.

This will require significant staff training and clear expectation setting during the CARHE launch. Ongoing outreach and maintenance of these health equity principles, practices and policies must be incorporated into the daily operations and processes.

2. Develop Structures and Processes to Support Health Equity

- **Establish a Governance Structure and Processes and Provide Resources to Support Health Equity**

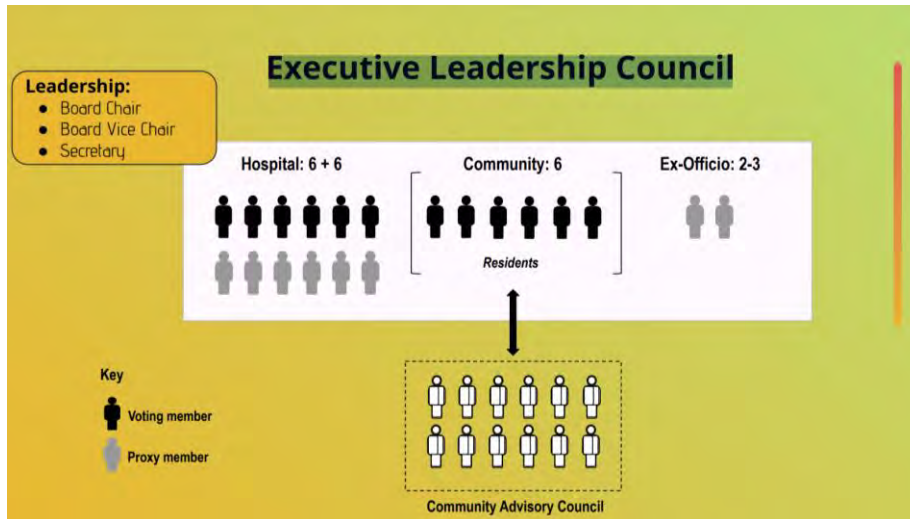
To successfully create a community-based approach to governance with equity at its core, rural constituents must be meaningfully engaged – determining, planning and executing governance priorities. In the CARHE context, this means engaging during the design and planning stages, with participants who represent the four pillars – the health care delivery system, educators, researchers, policy makers and rural constituents through a distinctly collaborative and equitable process. This takes time and financial resources, and expectations about pace must be workable for those involved.

With rural health equity at its core, the CARHE governance structure must be different to the hierarchical, traditional, command and control leadership of many of its supporting anchor organizations across the four pillars. This means an acknowledgment of all varying power dynamics and the CARHE Planning Team Governance Workgroup will need to assess where and how to share power amongst these four distinct but equally important pillars. The implementation of a distributed leadership structure is recommended.

¹³ <https://sites.dartmouth.edu/levyincubator/>

In the governing structure designs of [All Children Thrive](#) (Cincinnati, OH) and [West Side United](#) (WSU) (Chicago, IL), they have created a systematic approach by which patients and families, providers, partners, and community members are assigned to work together as equal contributors. At WSU, the Executive Leadership Council is made up of six voting members from six anchor institutions (the health delivery partners) and six residents from the 12-member Community Advisory Council (CAC). (See Figure 6)

Figure 6. Executive Leadership Council, West Wide United



We recommend that the CARHE governing structure include in its design, a responsible power-sharing process and consider whether the current design of including three members from each of the four pillars will allow an equal rural constituent voice in comparison to the wider WSU community-focused approach.

It was acknowledged during the initial CARHE design process and the Rural Constituent interviews, that a legacy of health system and community divides exist. Sometimes trust amongst the community lies at the individual not the institutional level. To rebuild trust and overcome the significant distrust of legacy institutional decisions and past initiatives, we recommend that the CARHE carry out more deliberate rural constituent outreach and engagement efforts and dedicate staff time to it accordingly.

When shared decision-making powers are given to community members from the beginning, the increased likelihood of sustainable and trusting engagements with the community is possible. The CARHE governance and leadership structures therefore require different competencies essential to engage the community and its different voices such as collaborative history, empathy, ability to manage uncertainty and complexity, strong communication skills, a welcoming and relational manner, etc.

In our interviews with the Rural Constituents, we identified a number of local organizations who have instituted successful shared decision-making protocols with rural residents. We recommend that the CARHE leverage learning from agencies such

as Health, Listen Community Services, the Children's Trust and others and include the different voices and experiences of these multisectoral partnerships to improve health equity and impact the multi social determinants and non-social determinants of health.

- **Creation of Advisory or Leadership Councils**

We acknowledge that the launch of the CARHE is an iterative process and at the start, the leaders of the CARHE may wish to invite institutional and organizational leaders who have previously engaged in efforts to be part of a smaller executive leadership council. Yet we encourage the development of a longer-term community advisory strategy whereby well-informed and knowledgeable rural constituents, including residents, are invited to participate in transparent, inclusive and honest conversations. During the Rural Constituent interviews, many reflected on the strong sense of self-reliance amongst rural residents, that simply the geographic and physical isolation forces this to be part their culture. *“They have a fierce independence and pride. They know how they want to take care of themselves, and they don't need someone to come in and tell them what to do.”*

To enable people to make decisions about issues that affect them, we need to engage people most impacted with the issues we are trying to address. We recommend the CARHE Governance Workgroup consider creating various governing committees to ensure that rural constituents have equal representation and voice in decisions. In addition to involving the experiences of multisectoral partnerships, the CARHE should identify which voices have not been part of previous community initiatives and invite them to participate in the governing structure.

These rural constituents should be invited to be join a community advisory council or to co-produce at the project-level for specific community health improvement strategies and objectives. Over time WSU has determined that often the community voice is more powerful and active at the workspace level (project level) where more decisions tend to occur and where the impact on residents is greater.

Lastly, we recommend that the CARHE launch an annual assessment of its governing performance. In this review, it should focus on the role of the governing structure and its practices, identify strengths and weaknesses, and create opportunities for development and performance improvement.

- **Equity in Co-Production**

Co-production is a crucial strategy to achieving equitable health outcomes. For the CARHE context, co-production involves the collaboration of different groups coming together – rural constituents and leaders from local health delivery, academic institutions and researchers – to share their strengths, experiences and to influence together to learn, solve and make decisions to improve rural health equity.

We recommend that in addition to putting health equity at the core of the CARHE mission and vision, the Center should put equity at the core of its operational work – through principles, practices and policies that will ensure the focus at the CARHE will

look and feel different to other past initiatives and programs. We recommend that the those designing the CARHE governing and operating structures ensure the following key equity principles are created and upheld as the Center launches and evolves:

1. Community-Identified Priorities

Commit to using the CHNA and community voices to set the agenda for improvements and strategies alongside the needs of the health system and providers to reduce rural health inequities.

During this process, we recommend that the CARHE include voices from rural marginalized groups and take full advantage of the desire in the community to collaborate. For example, consider holding open conversations with rural seniors aging in place or rural families supporting a loved one in recovery. Together identify examples of their physical, emotional and well-being needs to help inform the CARHE strategic aims and any future improvement or research efforts.

2. Solution-Based Resources

Commit to identifying and using community-based assets and strengths and partnering with organizations who are trusted and sought after by people in rural areas, as identified during the Rural Constituent interviews such as Upper Valley Strong, HAVEN and Resource Centers.

Look for those small communities where great grassroots efforts around workforce, housing and early education are already taking place such as Baby Steps Family Assistance, Twin Pines Housing and the Family Place.

Also consider how the CARHE can influence workforce development by bringing together some of the region's biggest employers such as Hypotherm, King Arthur Flour and DH.

3. Equitable Partnering

Commit to sharing power and center community partner expertise during co-production to remove barriers to access and participate. For example, provide transport to meetings or a solid internet connection to attend virtually. Pay people to show up – both residents and local not-for-profit leaders who are taking time away from important fundraising duties to take part.

Create the intention and space for psychological safety for all participants to exercise their participation freely without stigma, and leverage those in the community who are trauma-informed to train others and equip providers and residents with better ways to interact and behave with each other using principles of inclusivity and equity.

We recommend that the CARHE consider including the ‘Principles of Trauma-Informed care¹⁴’ and create a similar version specifically designed to meet the CARHE context. (See page 6 of Appendix D: *All Children Thrive*, Equity in Co-Production: A Guidebook for Learning, Reflection and Action,¹⁵)

By infusing equity principles of co-production throughout the strategic and operational components of the CARHE, we envisage that the education, research and healthcare pillars will form new connections and develop stronger relationships with rural constituents, creating a deeper understanding of the local assets, strengths, challenges and suffering, to solve the most critical problems.

- **Be Accountable and Transparent in Pursuit of Health Equity**

In IHI’s work over the last six years to improve health equity, it has urged organizations to acknowledge the tensions between interactions amongst anchor organizations (health systems and academic institutions) and the communities they serve. To change community perceptions and build lasting trust of the health delivery and academic institutions in the region, we recommend that the CARHE bring together leaders and staff from these institutions to understand the history of mistrust and their relationships with the community. This will not be a comfortable journey but will be necessary to fully determine what those misperceptions might be so that the CARHE is equipped to avoid making similar mistakes in the future.

We believe that by engaging with accountability and understanding the history of mistrust and its relationship with rural constituents, the CARHE will be laying the foundation for increased value and long-term sustainability in the community.

During IHI’s two-year Pursuing Equity Initiative¹⁶, it became apparent that a key strategy for anchor organizations to work successfully in the communities that they serve, was their commitment to direct benefits to historically underserved populations. In the Rural Constituent interviews, concerns were raised that there continues to be a lack of trust of DH for certain members of the community such as those who suffer from substance misuse and the older adult population who suffer from ageism and other forms of discrimination. *“Their experience of health care is much harsher and negative.”*

We recommend that the CARHE focus efforts on the most vulnerable and underserved residents in future CARHE program or research initiatives. We heard from Rural Constituents that a center focused on reducing health inequities in northern rural NH

¹⁴ Adapted from Center for Trauma Informed Innovation at Truman Medical Centers. The five principles were initially based on Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol; Community Connections; Washington, D.C. Roger D. Fallot, Ph.D. and Maxine Harris, Ph.D. April 2009. The revised Missouri Model Principles of Trauma Informed Care were approved October 2018 by the Missouri State Trauma Roundtable

¹⁵ Developed, tested and used by the Well-being with Community improvement team within the All Children Thrive Learning Network Cincinnati (ACT). See Appendix for full version.

¹⁶ <http://www.ihl.org/Engage/Initiatives/Pursuing-Equity/Pages/participants.aspx>

and VT would be of greater value if its focus included those suffering from substance misuse, tackling stigma around addiction and recovery, and being open-minded regarding the challenges facing these individuals and families. One bright spot to leverage is the work of the DH Moms in Recovery Program. Advantages of their approach include being located offsite, staff are trauma informed and stigma wary and where accountability to the community and consistency of purpose is highly evident.

- **Diversity in Leadership and Thinking**

We strongly encourage the inclusion of diverse voices with representation from rural constituents on the leadership and community advisory councils and as staff at the CARHE to help to advance equity and well-being and to support CARHE as an inclusive space to influence and effect change.

These individuals should bring lived experience into the day-to-day operations and strategic planning in all areas, including governance, leadership and workforce. We recommend the inclusion of peer liaisons, and people who can influence at the project level with like-minded or lived experiences. Many Rural Constituent praised the work of the Community Engagement Coordinators and suggested their close proximity to residents as an asset and considered as future participants on community advisory councils or projects.

3. Deploy Specific Strategies to Address Multiple Determinants of Health

To support the extension of health equity as a strategic priority, IHI recommends that health care organizations develop specific activities to address the determinants of health on which they have a direct impact, including health care services, socioeconomic status, physical environment and healthy behaviors¹⁷.

- **Leverage and Improve the CHNA**

For the CARHE context, the most recent CHNA report shows exactly where rural health disparities exist and thus, any improvement efforts taken on by the CARHE to meet the needs of the most marginalized populations will need to be informed by this report. The CARHE already has access to the data; its role in the next few months should be to create a set of strategic aims to help coordinate assessment activity within the community and create opportunities to further listen to and respond to community needs.

Whilst not surprising, many Rural Constituents asked if there was a plan to take what was learned about the needs of the community and improve the way this information is

¹⁷ P13 Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. <http://www.ihl.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx>

utilized to better inform decision-making, strategize and shape efforts to advance health equity.

They want to see changes to the current health infrastructure to provide improved access to health, dental and mental health services and see new ways to address the acute need for affordable housing and transportation with multistakeholder community partnerships. They felt that the parts of the CHNA data was based on the perceptions of community leaders rather than residents and that the pressures on certain towns was more intense than the report indicates. For future CHNA efforts, they recommend that the CARHE help to create a more balanced perspective with input from those who experience rural health disparities. *“We need voices from the agricultural workers, new Americans and immigrants, how do we reach these parts of the community and areas which have a distrust of wealthier areas?”*

Whilst the results of the CHNA priorities will inform the CARHE strategic aims, we suggest that it leads with flexibility and agility and commit to continuously listen, adapt and respond to the community and be prepared to change plans and strategies to address the rural residents’ most pressing needs.

- **Use of Data to Direct Strategic Priorities and Target Rural Hot Spots**

We recommend that the CARHE involve the community in planning for and setting priorities. Sometimes health systems inadvertently impose their “healthcare-ness” on others. By using the CHNA data as a starting point, the CARHE should take the lead on expanding community outreach to include marginalized voices and engage further with the wider rural communities. By sponsoring further exploration and stratification of the data, the CARHE and other multisectoral partners should create space for user-centered design and take the CHNA findings out to the communities via town hall meetings or listening forums and pay particular attention to the more isolated towns. In addition to focusing on meeting rural health needs, we recommend a structure to focus on tracking the results of these efforts.

We suggest that the CARHE create and own a community dashboard to continuously inform decision-making – to regularly identify community members disproportionately affected by health inequities. The dashboard should also review the CARHE initiatives to ensure that they continue to positively affect these populations. As part of the data collection for the dashboard, we recommend incorporating real time feedback loops with residents to determine if and how the CARHE is making a difference.

HealthPartners, an integrated, nonprofit health care provider and health insurance company (Bloomington, Minnesota) and Kaiser Permanente (Oakland CA) an integrated managed care and nonprofit health plan provider have spent more than 10 years acquiring, validating and applying REaL data to inform care of patients and members. To learn more about creating a data infrastructure and using data dashboards and analytic reports to improve health equity, we suggest reviewing the experiences from

these two organizations and others who have participated in the IHI Pursuing Equity initiative.¹⁸

For further considerations around measuring for equity and leveraging tools and resources to advance health equity, we suggest that the CARHE review the Cincinnati Children's structures and processes which have been put into practice across their organization¹⁹ and determine what similarities in scope and context could be leveraged.

- **Use of Improvement Methods to Promote Continuous Learning**

A health equity improvement strategy requires data collection and stratification to identify inequities, help set priorities, and drive improvement activities.²⁰ To create a data infrastructure, the CARHE will need provide staff with quality improvement training and support to accelerate improvements. All staff and rural constituents who will be participating in projects and initiatives should be trained in the basics of understanding the Model for Improvement and testing changes on a small-scale using Plan-Do-Study-Act (PDSA) cycles.²¹ By creating a culture of continuous improvement and learning, internally and in the wider community, the CARHE will have the opportunity to create a vibrant and sustainable learning network to accelerate implementation, spread, and scale-up of innovative approaches to improving health outcomes.

For over 30 years, the healthcare workforce, operational leaders, professional and community groups and individuals have proven that improvement capability is foundational and crucial to their success. We recommend learning from other organizations such as East London NHS Foundation Trust (ELFT), who provide mental health and community services to a diverse and largely low-income population. ELFT has made a concerted effort to successfully entrench a culture of continuous improvement across their organization, with local partners and stakeholders in the community, in addition to the service users²² themselves.

In the *Building a Culture of Improvement paper*²³ (See Appendix E), leaders and staff members speak of how they have fully integrated quality improvement (QI) into their methodology and thinking, creating a broader transformation that has seeped into every part of the Trust. Furthermore, the transformation extends to a new level of

¹⁸ Improving Health Equity: Address the Multiple Determinants of Health. Guidance for Health Care Organizations. Boston, Massachusetts: Institute for Healthcare Improvement; 2019. (Available at www.ihl.org)

¹⁹ Parson AA, Unaka NI, Stewart C, Foster J, Perez V, Jones NHY, Kahn R, Beck AF, Riley C. Seven practices for pursuing equity through learning health systems: Notes from the field. Learn Health Syst. 2021 Jul; 5(3): e10279. 22 June 2021 <https://doi.org/10.1002/lrh2.10279> pages 3-4

²⁰ Improving Health Equity: Address the Multiple Determinants of Health.

²¹ Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009

²² A 'service user' is a generic term in the UK for a person who uses health and/or social care services from service providers

²³ *Building a Culture of Improvement at East London NHS Foundation Trust*. Cambridge, Massachusetts: Institute for Healthcare Improvement; November 2016. (Available at www.ihl.org)

communication and transparency with service users and community members, many of whom are marginalized individuals who suffer heavily from stigma and significant poverty.

- **Incorporation of Community Organizing and Outreach to Build a Collaborative Methodology for Engaging Rural Constituents**

Alongside the culture of improvement methodology, we recommend engaging and incorporating in community organizing methods to create unity and solidarity to accelerate the C H 's work with the rural residents to solve problems and reach shared goals. A simple snapshot how to incorporate community organizing²⁴ for the CARHE context would include the following:

- Identifying and understanding a vulnerable community, its root problem(s), and how the existing social system has created the problem(s)
- Developing a shared solution (and narrative) for how to solve the community's problem(s)
- Creating an action plan to achieve the desired solution by winning collective power
- Building relationships, bringing people together, and educating them on how they can help carry out the plan
- Keeping the plan moving forward toward its intended goal through trainings, actions, media relations, regenerative support, building solidarity and coalitions, and other movement strategies

We recommend further reading around community organizing and social movement and exploring future training opportunities for the CARHE staff from Kate Hilton or her colleagues at The Leading Change Network²⁵ who develop leadership and support organizers around the world through a community of practice, ongoing learning and coaching.

In conclusion, the community organizing methods and tools should be utilized alongside continuous improvement methodology and the principles of co-production with equity. This will provide a comprehensive and complimentary collaborative methodology for CARHE to support the stakeholders and partners from across the four pillars to reduce rural health inequities.

²⁴ <https://www.brightest.io/community-organizing>

²⁵ <https://www.leadingchangenetwork.org/>

4. Reduce Implicit Bias with Organizational Policies, Structures, and Norms

The fourth component of the IHI Achieving Health Equity Framework is a significant part of our focus on health disparities. As the CARHE gathers data, it will almost certainly uncover some difficult truths. In this section we will set out recommendations as a starting point for a deeper engagement by the CARHE on addressing implicit bias, racism and stigma.

Whilst people of color represent a smaller percentage of the region's population than other parts of New England, we nonetheless urge the CARHE to commit to reducing structural or institutional racism in health care, education, research and in the community, as part of its core focus on reducing rural health inequities.

We believe that to advance rural health equity, the CARHE should create a specific bias and antiracist strategy and focus on the following:

- Diversify the local clinician workforce
- Encourage the review of admission data to the regions' academic institutions
- Analyze data on health outcomes and mortality by race, ethnicity, language and country of origin
- Study other health care institutions who have committed to becoming antiracist medical centers.²⁶
- Provide antiracist and implicit bias training for staff and rural constituents

Below we have listed several ways to operationalize this strategy.

• Support Future Hires and Invest in the Community

An example of this is to look at ways in which the CARHE can create an internship for young people of color or other marginalized communities (e.g., low income or LGBTQ). The CARHE could also set-up a formal learning opportunity for local schools and community colleges in specific towns or counties. It will be important to examine the demographics of the internship cohorts, to establish diversity goals and to keep track of the data, as part of the wider mission of advancing rural health equity.

• Partner with Local Businesses to Improve Internet Connectivity

As we discussed in the Equity in Co-Production section, equitable partnering requires the means to providing rural participants with a solid internet connection. We know that low-income and rural communities in particular often lack access to high-speed internet and effective access to technology. During the early days of the Covid-19 pandemic, the sudden move to online learning exacerbated the problems many rural communities face

²⁶ Academic Medicine's Journey Toward Racial Equity Must Be Grounded in History: Recommendations for Becoming an Antiracist Academic Medical Center. *Acad Med.* 2021 Nov; 96(11): 1507–1512. Published online 2021 Aug 24.

https://journals.lww.com/academicmedicine/Fulltext/2021/11000/Academic_Medicine_s_Journey_Toward_Racial_Equity.11.aspx

with their student populations' lack of access to the connectivity and the infrastructure needed to effectively participate in online learning.

We suggest the CARHE work with local businesses and corporations to create a program to donate laptops help with internet connectivity to students and communities in need and serve as examples for other organizations looking to make a positive impact.

- **Address Institutional Racism and Bias Through Communication and Culture**

To establish an organizational culture that enables conversations about stigma and race, we know that organizations need to first identify the ways in which racism and bias are embedded in the organization's systems and work to eradicate them. Whilst we acknowledge the DEIB initiatives at DH and other institutions and stakeholders within the four-pillars, we encourage the CARHE to set-up its own implicit bias training for staff and host "brown bag" lunches to encourage conversations on rural health equity topics relevant to the community.

Communicating about racism and bias should be centered around the common definitions for terms which we discussed in the previous section under a *Shared Language for Health Equity* (See Recommendation 1, Making Health Equity a Strategic Priority). The culture at CARHE should be one which deeply listens and responds to the needs, norms and preferences of the community. To further this notion, we suggest the CARHE create a strategy for holding meetings with rural constituents and find a space for CARHE meetings outside the DH medical campus that would better reflect the culture and communities of those who are most impacted by inequities.

- **Create a Mentoring Program for Rural Constituents from Underrepresented Groups**

Using the four-pillar framework of stakeholders, in particular across health care delivery, research and education, we recommend bridging the gap between the undergraduate/graduate experience and the professional workforce. By targeting those who often feel disconnected from campus, we suggest the CARHE explore ways to bring together students of color and other marginalized populations, and first-generation college students, with a network of supporters to build a sense of belonging and foster a generation of diverse leaders. This infrastructure could also support future recruitment events for local businesses, academic, and clinical institutions.

- **Focus on Equitable Hiring Practices**

As a new entity, the CARHE will have the opportunity to create and implement specific health equity principles, practices and policies. A key component of this will be the CARHE's ability to execute on actual hiring practices to ensure that graduates of color or other marginalized populations (e.g., low-income, individuals who suffer from substance misuse or LBGTQ) can thrive in the future at the CARHE. We recommend

that as the CARHE launches and the hiring process begins, that a commitment to interviewing ‘X’ percent of candidates from underrepresented backgrounds for its job openings, and to bring in ‘Y’ number of new hires. This will be hard work – and it’s important.

- **Support Academic and Health Delivery Institutions to Engage Communities and Improve Rural Health Equity**

To support the efforts mentioned above, we recommend gaining a deeper understanding of how medical students, clinicians and researchers should respond to health inequities, social injustice and the social determinants of health. There are several toolkit resources on the AAMC website which may be helpful and will be a valuable guide to how communities, academic health systems and academic institutions can improve community health and close health and health care gaps together²⁷.

As the CHNA details, there are several communities in rural NH and VT who suffer from devastating levels of substance misuse and stigma, who find themselves excluded or marginalized, and consequently mistrust the health delivery system. According to the 2022 CHNA²⁸, 57% of service area respondents listed the ability to get mental health services as their number one most pressing health need in their community with 29% of respondents listing the prevention of misuse and addiction to alcohol and drugs. The CHNA also details the significant relationship between the likelihood that respondents reported having difficulty accessing services and household income. While a high proportion of respondents in all income categories reported difficulty accessing at least one type of service, respondents with annual household income less than \$50,000 were most likely to report access difficulties. Using the CHNA and other forms of data collection to target rural hotspots will help the CARHE and its partners to direct their strategic priorities.

In the CHNA for respondents indicating their race or ethnicity as Black, Indigenous People, or People of Color (BIPOC), 15.3 % of respondents were more likely to indicate that they or someone in their household had “sometimes” missed getting health care or social services because of unfair treatment.²⁹

Improving rural health equity will mean engaging these marginalized groups, identifying and addressing their health equity goals and optimizing their existing strengths and assets. In addition, we recommend that the CARHE support health delivery providers, human service agencies and community residents to create projects and research initiatives focused on decreasing forms of structural or institutional racism, reducing stigma and developing everyone’s ability to be more trauma aware.

²⁷ <https://www.aamchealthjustice.org/resources/community-engagement-toolkits/communities-social-justice-teaching-hospitals>

²⁸ Page 14, 2022 CHNA

²⁹ Page 23, 2022 CHNA

5. Develop Partnerships with Community Organizations

As the fifth and final component of the IHI Achieving Health Equity Framework details, it is important to partner with community organizations to help address the short-term needs and the long-term health of the rural community. We acknowledge the hard work and success of the DH Population Health team to bridge the gap between the health delivery system and multisectoral partnerships to improve health and health equity in the region. We suggest building on the strengths of the DH Population Health team whose relevant work can be integrated into the CARHE structure. With long-standing relationships across the region, they are already engaged in related work.

Many of the Rural Constituents praised the work of the DH Population Health team, including the most recent efforts of DH and the Public Health Council Covid-19 vaccine clinics which brought together clinical knowledge and support for the shared goal of community health.

- **Leverage Existing Community Partnerships**

In this report we have listed many organizations who are currently working across the region with rural residents in need of further support and care. For the CARHE context, we recommend taking the lessons from the robust community partnerships formed and leveraging their infrastructures, processes and resources.

For example, the CARHE could pursue a partnership with Upper Valley Strong, which brings a collaborative track record and shared mission and the common understanding of key partnership priorities and initiatives to create a healthier community. Upper Valley Strong is a trusted convener with incredible breadth and depth of networking and the proven ability to meet community needs with creative thinking and provision of services.

During the pandemic Upper Valley Everyone Eats³⁰ also successfully demonstrated a collaborative and inclusive community partnership model by leveraging existing networks and creating new collaborative spaces. Not only did it raise awareness among health care center staff about the level of food insecurity in the communities they serve, but it also provided more actual facetime for seniors living alone without transportation. A sense of community care was spurred by the local proximity of meal distribution, some distributed directly within towns rather than mass distribution hubs, engendering a sense of localized support.

We encourage the CARHE to seek new partnerships to expand its reach and to further explore the regional landscape. For every new and existing partnership, the CARHE may seek out those who have not been engaged in the past and look to include them in meaningful ways, to determine what other related community partnerships or existing

³⁰ <https://vitalcommunities.org/upper-valley-everyone-eats-the-common-good-not-so-common-meals/>

coalitions could be integrated, and what efforts may already exist that can be of mutual benefit.

To foster effective engagement across the community, the CARHE can create an engagement assessment tool, to determine how to build and develop community partnerships. Here is an example of the questions which could be asked to develop such a tool.

- **Mission** - Are the missions and purposes well aligned? Are all partners engaged in ways that are meaningful to them, and their mission and purpose?
- **Shared Goals** – Do we have common goals and structures that enable and empower our efforts?
- **Trust** - Is the level of trust sufficient to put aside competitive interests and collaborate for the good of the partnership and community?
- **Inclusive Partnership** - Do we share an inclusive mindset? Who is working together, at what level and what are their roles? Are we looking to engage new members to advance the work? Who and why?
- **Value** - What mutual benefit will we see? What value is generated for whom and at what cost?
- **Resources and Capacity Building** - What support in terms of resources and what types of capacity building are viable and desirable across the partnership?

To further develop the tool, we recommend reviewing the IHI Improving Health Equity: Assessment Tool for Health Care Organizations³¹, in particular on page 10 under the 'Partner with the Community' section.

Lastly, we recommend continuously evaluating the community partnerships' progress to ensure that they are meeting the CARHE, and community needs effectively and efficiently.

- **Leverage Community Resources and Assets**

The success of community partnerships often lies with their ability to leverage resources to achieve collective outcomes beyond what they can achieve themselves.

To set up for success we recommend that the CARHE apply an assets-based approach as a fundamental working principle. This approach should include individual, organizational, community and cultural assets to highlight the strengths of communities in its engagements. As Rural Constituents recommended, town government, volunteer organizations, community action, those working with victims of domestic violence,

³¹ http://www.ihl.org/resources/Pages/Publications/Improving-Health-Equity-Guidance-for-Health-Care-Organizations.aspx?PostAuthRed=/resources/_layouts/download.aspx?SourceURL=/resources/Knowledge%20Center%20Assets/Publications%20-%20ImprovingHealthEquityGuidanceforHealthCareOrganizations_1e8ab818-4255-44cd-8c33-b72279ec7f0b/IHI_ImprovingHealthEquity_AssessmentTool.pdf

senior care, mental health, food shelters and maternal health groups could all be leveraged for their expertise and similar missions.

The CARHE should continue to build links with others in the community and co-create practices and solutions rooted in community ownership, such as how Community Health Workers at DH partnered with Ollie's Place to donate helmets and life jackets. When asked what assets contributed to the success of this partnership, a Rural Constituent highlighted three key components:

1. There was a common goal – safety for children
2. Everyone knew and respected each other's role in the process (i.e., role clarity and trusting relationships)
3. Everyone knew why they were there and the job that needed to get done (i.e., clear collaborative action)

By identifying strengths and helping others build skills, we allow people to share their gifts and create opportunities to activate them – an inclusive way to bring in those who are excluded or marginalized. One example is the Sugar River Region campaign in Sullivan County. As the second smallest and poorest county in New Hampshire, Sullivan County has long suffered from rural health inequities in comparison to wealthier and larger parts of the state. Rather than continue to focus on “who they are not,” they embarked on a community-led destination development pride campaign to determine “who they are.” After three years of extensive study of its regional assets, Sullivan County is now looking to integrate its findings into a long-term regional marketing plan to attract visitors, new residents, developers and businesses³².

We recommend that the CARHE leverage the knowledge of how the Sugar River Region pride campaign successfully engaged with rural and disadvantaged residents, determine how they created a sense of ownership and pride, and apply learning to CH's reducing health inequity efforts.

Lastly, leverage the local culture of compassion coupled with pragmatism that weaves its way through daily life in rural northern New England. As Anne N. Sosin, and Elizabeth R. Carpenter-Song noted in their Health Affairs blog in July 2020, many outsiders may view rural communities and the village mentality that permeates them as a vestige of the past, in their study, they found a rural ethos—a constellation of compassion, pragmatism, and solidarity—that was translated into practical action to offer protection against a virus [Covid-19] that has resisted the most aggressive public health strategies and a vision of a more equitable future.³³

³² https://www.eagletimes.com/community/whats-happening-in-the-sugar-river-region-county-to-launch-regional-marketing-plan/article_71b28ccf-171e-591f-ba68-c6513a83333e.html

³³ Village Versus Virus: Rural Ethos Protects Where Public Health Fails

- **Partner with the Community to Improve Health Equity**

The CARHE can learn from other academic health centers on how to reallocate power and leadership across systems and build relationships and trust with their community. As suggested, we recommend referencing the Seven Practices for Pursuing Equity³⁴ paper from Cincinnati Children’s Hospital and consider how they have effectively partnered with community partners as a major health care provider.

As the sole academic health center in the region, DH is highly regarded and well-trusted, although there are pockets of the community where perceptions of DH represent a barrier to engagement and progress. The CARHE should determine the best attributes for community and health delivery partnerships, especially with the most vulnerable.

With health equity at its center and with community involvement as an essential operational principle, the CARHE leadership should commit to ensuring people with lived experience are leading the work and are key decision makers throughout the change process.

In addition, the CARHE should look to partner with community-focused assets to avoid duplication of efforts and services. Examples of these assets could be school nurses, school counsellors, home based providers (social services and welfare officers), thrift store employees, childcare providers and trusted and sought-after agencies such as HAVEN, New Futures, The Family Place and Service Link – all of whom have built trust with families in the community and are intimately aware of their circumstances. We also encourage the CARHE to leverage community and health focused efforts at APD, the Windsor HSA Community Collaborative, and the Upper Valley Public Health Network. The CARHE may wish to support the future success of these efforts through the application of the AAMC Center for Health Justice Appreciative Inquiry Model³⁵. Using this tool will determine what is working in a community partnership – rather than what is not working – and create a process to build genuine and honest relationships and address problem solving through a more equitable and trustworthy means.

- **Conditions and Characteristics for Effective Partnerships**

To effectively work across the community in multisectoral partnerships, the values of mutual respect, inclusiveness, humility and flexibility are vital. Having a common understanding of the shared impact and creating continuous communication loops are also important. When we asked Rural Constituents what would make it possible for residents and community leaders to meaningfully partner with researchers and health

³⁴ Seven practices for pursuing equity through learning health systems: Notes from the field.
<https://doi.org/10.1002/lrh2.10279>

³⁵ Appreciative Inquiry Model. The AAMC Center for Health Justice
<https://www.aamchealthjustice.org/media/276/download>

care partners to address health inequities, they shared a number of conditions to ensure the implementation of effective partnerships:

1. The CARHE will need to build trusting relationships on the ground, and senior leadership sponsors will need to give time and space to accomplish this.
2. The CARHE will need a clear vision and will need to leverage partners who can act honestly and remove some of the NIMBY (i.e., “not in my backyard”) thinking which has dogged conversations around removing health inequities in the past.
3. The CARHE will need to change how researchers, students and faculty work with rural constituents and partners and encourage the adoption of the co-production with equity principles, practices and policies.
4. The CARHE will need to address the funding and research process to create a more agile funding mechanism which has historically been one of the biggest barriers for community-based research in smaller rural populations.
5. The CARHE will need to work with researchers to practice a growth mindset and cultivate an environment where some of their predisposed ideas will need to be addressed and residents will need to have the space to be heard.
6. The CARHE will need to work with health delivery partners to implement changes to clinical delivery models based on partnerships and learning, leveraging community resources and assets and existing community partnerships.

- **Cultivate and Restore Trust**

Deserving trust is crucial to equitably partner with the communities you engage and to achieve health justice³⁶. According to the AAMC Center For Health Justice, the process of engagement is as important as the product. As we have learned during the Rural Constituent discussions, there are pockets of mistrust with clinical and academic institutions in the region – all of which is a rational response to actual injustice. The CARHE will need to acknowledge and address the history of mistrust of health delivery and academic institutions by the community, determine the internal biases at these institutions and determine where and how explicit and implicit power can be affected to foster the development of new, trusting relationships with the community.

Recent examples from Harvard University and Milbank Memorial Fund show how institutions are willing to reckon with their role in perpetuating racism and racial inequities. There are lessons here for CARHE with regard to DH and Dartmouth's role in perpetuating rural health inequities. We encourage the CARHE and the institutions

³⁶AAMC Center For Health Justice 10 Principles of Trustworthiness
<https://www.aamchealthjustice.org/resources/trustworthiness-toolkit#principles>

within the four-pillars to consider exploring their own history as they seek to advance rural health equity and transform the lives of their rural constituents.

“We cannot dismantle what we do not understand, and we cannot understand the contemporary injustice we face unless we reckon honestly with our history”, quotes Tomiko Brown-Nagin, Dean of the Radcliffe Institute for Advanced Study and Chair of the Committee on Harvard and the Legacy of Slavery.³⁷

“Only when the harm is acknowledged is healing even a possibility”, these are words of Chris Koller, President of Milbank Memorial Fund in his blog³⁸ detailing the fund’s journey in realizing and grappling with its legacy and role in the United States Public Health Service Study of Untreated Syphilis in Tuskegee and Macon County Alabama. As they carefully examined their history, what they found was deeply disturbing and counter to their mission and values. To authentically fulfil their mission, and chart a path forward to advance health equity, they needed to take this moment to acknowledge their complicity and stop perpetuating systemic racism. Koller goes on to write that injustice harms not only the victim but also the perpetrator, who lives isolated from the wholeness of a full and inclusive community. The work of admitting harm and of pursuing healing, of building a more just society — where the fundamental dignity and relationality of every human being is affirmed and where love in all its forms can grow — calls us all.³⁹

In the CHNA, 44% of respondents said that stigma is a problem. Many residents are not engaging with the health delivery system; and with challenges around affordability, access to healthy food, and substance misuse, it is difficult to understand the full needs of these residents. The CARHE response should be to address this trauma with empathy and create space for vulnerability, growth and honest dialogues. It can establish new practices and working agreements to change this culture. We recommend that either the CARHE Initial Planning Team (or those that follow in the next iteration of design and implementation) review the AAMC Principles of Trustworthiness⁴⁰ and create a local version, adjusted to the uniqueness of rural NH and VT. They can be designed by and with residents from a more inclusive group of incomes, disparities and socio-economic status. Furthermore, these principles should not just live at the CARHE but should become a community-wide effort for multi-sectorial engagement in schools, human service agencies, with first responders and others.

In terms of where the physical ‘building’ of CARHE will live in the region or where CARHE meetings will take place, we invite the CARHE to reflect on where and how the community will feel most comfortable coming together. As noted in the example given with the DH Moms in Recovery Program, consider thinking about locations outside the walls of a health delivery or academic institution and creating a neutral space to build trust and connection.

³⁷ <https://legacyofslavery.harvard.edu/report>

³⁸ <https://www.milbank.org/2022/04/harms-and-healing/>

³⁹ Harms and Healing, Milbank blog

⁴⁰ The Principles of Trustworthiness

- **Address Pushback on Health Equity**

In a recent article⁴¹ by Dr. Kedar Mate, President and CEO of IHI, he encouraged leaders to harness curiosity as an antidote to fear and resistance. As we learned from the beginnings of the patient safety movement over twenty-five years ago, all change prompts some form of pushback and effectively addressing that pushback will be a key concern and responsibility of the CARHE. Pushback against efforts to close equity gaps take many forms and we recommend that the CARHE prepare for this by taking the three steps that Dr. Mate outlines:

1. **Expect and Prepare for Pushback**

Creating a center for advancing rural health equity reflects a shift in priorities and drawing a public focus on the health inequities in the region will not be easy. However, it is important to not fear the resistance that may be encountered and instead prepare for it.

2. **Address Pushback with Data and Stories**

The CHNA data and the stories that the CARHE will collect from its work will help to create a wider understanding of the scale of the problem in the region especially if the voices of the disadvantaged and marginalized are included.

3. **Gain a Deeper Understanding of What is Driving Pushback**

What drives the resistance to seeing and eliminating inequities is often fear. Built upon the four pillars of health delivery, research, education and community, the CARHE design reflects the assumption that health inequities are not the fault of individuals but produced by an inequitable system.

Courage, curiosity, data, stories, and overcoming fear all are essential to patient safety⁴². We encourage the CARHE to seek out champions of the patient safety movement in the region and discover what worked in the past to overcome the fear of transformation. There may well be lessons from this movement in how they overcame resistance in a similar landscape and region, and which can be applied to the rural health equity efforts.

Armed with data and stories, we encourage the CARHE to bring the voices of the disadvantaged and marginalized to those who may be resisting the efforts to close equity gaps or disagree with the business case for equity. By bringing together partners around a shared purpose through trusting relationships, CARHE can build a solid foundation for transformational work that is led locally and more broadly in the future.

⁴¹ Mate K. Addressing pushback on health equity. Healthcare Executive. 2022 Jan;38(1):44-45

⁴² Mate K. Addressing pushback

NEXT STEPS

To pursue, advance and sustain rural health equity is a complex and challenging effort. It takes the collective impact of multiple organizations, cross sector coordination and creation of a common shared purpose to successfully address and overcome the magnitude and complexities of health inequities in rural northern New England. By launching the CARHE and undertaking the recommendations outlined in this report through IHI's theory of change for pursuing equity, the residents and workforce in this region possess an opportunity to advance more equitable care, foster healing, create new levels of trustworthiness and pave the way to better health and well-being for rural individuals and communities.

The programs and research that supports the CH's strategic aims will require a constant and devoted effort to close the gaps and achieving health equity. The energy and commitment to rural health equity shown by the Rural Constituents, the DH Population Health Team and the CARHE Initial Planning Team is genuine and palpable.

In terms of next steps, Yaël Gill and Kate Hilton will submit a complementary brief synopsis of the work of the CARHE Planning Team from January to June 2022. We have compiled a summary of seven key recommendations for the next phase – the launch of the CARHE – with actionable next steps to create a stronger collaboration between members of rural communities, organizational leaders, health delivery, academic partners and researchers. (Figure 7)

Figure 7. Seven Key Recommendations for the CARHE Launch

1. Leverage the CH's data and improve rural data sources. Use the CH's community-based data as a strategic guide, while going beyond its limitations to ask the most vulnerable rural constituents for feedback and to identify priorities and solutions.
2. Commit dedicated outreach from organizational staff members to build project teams' capability to work in a different way. Outreach personnel should be skilled in community organizing practices and ideally be a rural constituent(s).
3. To make the CH's work transparent and accessible, commit dedicated communications personnel and resources to lift up the stories of rural health inequities and CARHE partnerships and transformation, including a targeted communications strategy to acknowledge harms of the past and restore trust.
4. In addition to including rural constituents on Rural Leadership and Community Advisory Councils, hire rural constituents and social influencers as project team members, organizational staff and consultants to diversify leadership.
5. Make this report and all the CARHE work accessible on a website to demonstrate transparency and accountability, serve as a model for others and invite feedback.
6. All CARHE leaders and staff should learn and commit to using improvement skills to design the CARHE work for continuous learning. CARHE staff and

project teams should also develop intentional feedback loops to make changes to clinical delivery models based on upstream work and learning.

7. Build collaborative 'coproduction' muscle through staff and project team training and use of standard community organizing methods in its projects and activities.