



# Defining Rural Population Health and Health Equity

## Overview

As the terms “population health” and “health equity” become integrated into the rural health vocabulary, it is important to establish a unified understanding of what these terms mean. This issue brief aims to define population health and health equity, with particular attention to the nuances for rural clinical partners. It can be used to educate rural health and clinical care partners on their approaches to population health and health equity and engage rural health stakeholders in meaningful discussions that improve the health and well-being of rural residents.

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## Defining Population Health and Health Equity

**Population Health** — at a broad level, population health is **defined as** the health outcomes of a group of individuals, including the distribution of such outcomes in the group. The phrase “group of individuals” could apply to a geographic location or other groups stratified by their demographic characteristics, such as gender, race or ethnicity. Functional definitions of population health are applied to identified groups of interest, which may be a service catchment area for an organization or a targeted subpopulation of need.

For rural hospitals, population health often focuses on **Internal Revenue Service** (IRS) community-benefit requirements, outcomes-based quality improvement efforts, and reimbursable services (access to primary care, availability of maternal health services, care

### Common Elements

- recognizes a group of individuals sharing one or more attributes
- incorporates regular analysis of data to identify trends and needs.

coordination, etc.). These valuable efforts should be undertaken concurrently with local public health and other community

partners to simultaneously address social and environmental factors impacting health outcomes of the population.

**Health Equity** — A distinct difference exists between equality and equity — where equality provides everyone with the same opportunity and equity levels the playing field to provide everyone with the same opportunity. Though a commonly used term, the definition of health **lacks consensus**.

## Common Elements

- recognizes the population (i.e., demographic, geographic, etc.) *and* the individual
- incorporates the barriers (social, economic, racial, etc.) to achieving optimal health.

The [World Health Organization](#) recognizes health equity as the absence of avoidable, unfair or remediable differences among groups of people,

whether those are defined socially, economically, demographically, geographically or by other means of stratification. Health equity implies that everyone should have a fair opportunity to attain their full health potential, and no one should be disadvantaged from achieving this potential.

The Robert Wood Johnson Foundation offers a functional definition of health equity as “[having] a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”

## Population health in rural and frontier communities

Population health efforts come in a variety of forms, depending upon the audience. For instance, a hospital may focus on accessibility to primary care as a sustainable contribution toward broader population health efforts. However, there are many other efforts rural health stakeholders may be in a position to undertake.

- Through the [Hawaii Smiles](#) program, all 3rd graders are provided with a free, non-invasive dental screening during the school day. Children who are in need of dental care are referred to their dentist or a local clinic for follow up. This program ensures basic access to preventative oral health services, while removing barriers to transportation, affordability, and truancy.

- The [HEALing Seeds](#) program connects residents of several rural communities in Allen County, Indiana, to training and education that encourages healthy cooking and increased access to healthy foods. Addressing what people eat, and how making changes can have a significant impact on an individual’s health outcomes. The goal of HEALing Seeds is to improve the health outcomes of the population of their communities.
- The [South Carolina Rural Health Action Plan](#) is a comprehensive, statewide plan for addressing the health and well-being of rural South Carolinians over a 3-5 year period. The key to this project was the collaboration with local community stakeholders and engaging partners outside of the traditional health sector. Partners worked to develop strategies that addressed the unmet health and social needs of residents. The final report included five areas of focus, 15 recommendations, and over 50 action steps in the areas of physical activity, transportation, housing and more.
- Louisiana has gone beyond the collaborative spirit to [integrating](#) with its Chronic Disease Management and Health Promotion teams, creating a new [Well-Ahead LA](#) division. The joint division works to ensure rural community needs are addressed while expanding Centers for Disease Control and Prevention (CDC) programs that may disproportionately benefit urban communities otherwise.



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# Health equity in rural and frontier communities

Just as with the definitions of health equity, there are a variety of ways in which rural and frontier stakeholders are addressing inequities in their communities.

- **Alaska's Community Cafes** are an opportunity for residents to address underlying community issues, whether related to a health concern or some other topic. Cafes last an hour, with the first 25 minutes devoted to a presentation on a given topic. Participants are then divided into smaller groups for discussion.
- Having a connection to what matters is really what can make good, positive change in the community. **Hawaii's Rural THRIVE** is a long-term strategy to improve the health and well-being of vulnerable populations and communities. As part of the initial phase, 17 community forums were held on all six islands, including discussions and storytelling sessions from local community members.
- **Arizona SHARES** gives healthcare students a better understanding of social support services and how to connect individuals with those services — particularly health insurance coverage. By serving as something similar to a Community Health Worker, students earn volunteer credits, allowing them to graduate with distinction. Graduates of the program are better equipped to answer patients' questions about coverage on the spot.



- **Montana Healthy Communities** began as small seed grants for equitably transforming local rural communities. Seed grants helped to support a range of projects including a farmer's market, a community garden, and chemo care kits. Though funding has completed, the project still maintains a platform for sharing innovations and lessons learned with other rural communities. The website **showcases** local wellness initiatives, provides evidence-based program ideas, and offers monthly health and wellness webinars. In addition, it publishes a weekly online newsletter.



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# How can you get started?

Rural health partners should recognize that achieving health equity and addressing the needs of rural populations requires systematic, community-wide change. Key rural health organizations should be prepared to lead and/or support these efforts, acknowledging the long-term goal of achieving health equity. Rural clinical partners can have a positive impact on population health and health equity by:

- Organizing or participating in cross-sector discussions between health and human service organizations and community partners to identify common challenges and opportunities for collaboration. Consider leveraging a [HRSA Rural Community Programs](#) grant to fund these efforts.
- Creating an organizational culture that routinely examines health indicators and community data to address clinical and upstream patient needs. Consider developing a Community Health Improvement Plan (CHIP) from available community health needs assessment (CHNA) data. Find more information on conducting rural CHNAs and CHIPs [here](#).

- Adopting policies and strategies to improve accessibility and availability of primary care or specialty services (i.e. extended hours, childcare services, telemedicine, etc.) based on patient barriers.
- Leverage students and other academic partners in outreach efforts. This not only trains the next generation of public health and healthcare leaders concurrently, it integrates population health and health equity into the learned experiences of the students.
- Ensuring an inclusive environment for all patients by: recruiting leadership and providers that are representative of the patient populations, adding larger waiting room seats, offering a quiet waiting area option, requiring cultural competency training for all staff, ordering larger patient gowns, having language interpreters readily available, and implementing a screening and referral system for social determinants of health.

## Additional Rural Population Health Resources

TASC Population Health Toolkit

RHHub: Population Health

RHHub: Rural Health Disparities

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## Conclusion

As shifts in the evolving rural health landscape focus more attention on the non-clinical factors impacting health outcomes, rural health stakeholders should recognize the variations in approaches and priorities for community partners. By understanding how these approaches differ, conversations can begin to move communities toward improved health outcomes and health equity for rural populations.



**NOSORH is dedicated to building the capacity of State Offices of Rural Health and their stake holders to grow leadership for population health and health equity. For more information contact [Chris Salyers](#), DHSc Education and Services Director.**

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