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LENOWISCO and Cumberland Plateau
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Rural Health Leadership & Health Equity

LinkedIn Connect
DrPH Candidate

Health Services Management and Policy-making

College of Public Health. ETSU

Background

- Seven rural counties
- Hit hardest by the opioid crisis
- Transportation is the biggest barrier to care
- Low population density and expansive geographic area
- Limited community awareness about all the services and resources provided by the HD
- Equity is a major issue i.e what is funded vs what is needed

Major Activities

- Shadowed the district leadership
- Attended District Management meetings
- Contributed to harm-reduction grant, community health assessment, and press releases
- Outreach- BFF Festival, Mini Pride event
- Coalitions- Tazewell Health Collaborative, CAOC, ASAC
- Maternal and child health- Title V, WIC
- CADCA Virginia Mini-Academy
- Baby Care Home Visits

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Key Takeaways

- The barriers are upstream. Transportation, housing, septic system, and access
- Trust is the main factor to improve community health
- Leadership is built on trust and relationships with staff and the community
- The unhoused and PWID still need access to primary care
- To achieve equity for the rural population, programs and funding must account for implementation challenges in rural communities
- Coalitions and partnerships are central to leveraging scarce resources
- Partnerships enhance reach and referral completion
- Adapting health response to the changing community needs.

Recommendations

STATE LEVEL

- Invest in mobile health infrastructure to reduce transportation challenges
- Include a core rural county in the EHR pilot to account for the uniqueness of rural challenges
- Organizational and population level policies should account for the uniqueness of rural areas
- Consider primary care access tailored for the unstably housed and PWID.

DISTRICT LEVEL

- Structured strategic planning at the district level that involves both staff and managers across programs
- Balance between fiscal discipline and expanding access to services to the unreached
- Document processes to maintain institutional knowledge
- Consider weekly extended clinic hours
- Extend feedback downward
- Consolidate overlapping coalitions
- Plan every outreach around one clear behavior-change goal, not just an information handout.
- Incorporate patient exist/satisfaction survey across all services to better understand what is working well and not