ARKANSAS
HEALTH EQUITY
COLLABORATION

WINTHROP
ROCKEFELLER
INSTITUTE

HEALTH EQUITY FOCUS GROUP

Community Feedback Report

The Winthrop Rockefeller Institute is a nonprofit conference and retreat center whose mission is to continue Winthrop Rockefeller's collaborative approach to creating transformational change.

We engage our resources and Winthrop Rockefeller's values to convene purposeful gatherings on his historic cattle farm. We do this work by employing the **Rockefeller Ethic**, which represents the belief that diversity of opinion, engaging in respectful dialogue, and practicing collaborative problem solving combine to create transformational change.

Our trained staff are available to assist groups with meeting design and facilitation, and we offer a variety of professional development workshops to provide unique learning and team building opportunities. The productive energy of our mountaintop location coupled with the highest levels of hospitality ensure all who come here are able to do their best work.

THE ROCKEFELLER ETHIC

COLLABORATIVE PROBLEM SOLVING

+

RESPECTFUL DIALOGUE

+

DIVERSITY OF OPINION

=

TRANSFORMATIONAL CHANGE

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about the institute

REPORT CONTENTS

HOW TO USE THIS REPORT

This report highlights the community feedback collected from focus groups conducted during the Arkansas Health Equity Collaboration, a Winthrop Rockefeller Institute program. The feedback represents the expressed barriers that Arkansans face in living healthy lives and proposed solutions for health inequities. Gov. Winthrop Rockefeller believed in the power of local people to address local concerns, which is precisely what this community feedback presents.

The feedback is grouped into five categories: **access to resources, cultural perspectives, community/economic development, and workforce**. This does not suggest that health equity only touches these five categories; in fact, we know health inequities touch every sector and every Arkansan. Instead, these categories represent five areas where health inequities are felt the strongest across Arkansas. They are five areas with the lowest hanging fruit, ripe for immediate addressing. The Institute believes any organization, community/municipality, or business can and should use the contents of this report to inform their own health equity programs.

CONTEXT

The Winthrop Rockefeller Institute (Institute) launched the Arkansas Health Equity Collaboration stemming from Dr. Brookshield Laurent, Chair of Clinical Medicine and Executive Director for the Delta Population Health Institute of the New York Institute of Technology College of Osteopathic Medicine, and Dr. Gloria Richard-Davis, Executive Director of the Division for Diversity, Equity and Inclusion at UAMS, and their experience with the COVID-19 Health Equity Response Team (HERT). HERT was a statewide stakeholder group commissioned by state legislators to recommend to the Arkansas Department of Health medical director and state leaders how to apply an equity framework to the COVID-19 response. At the end of their commission, team leaders felt it necessary to make a concerted effort to focus on the upstream factors that affect all health outcomes, requiring a collaborative, multi-sector approach. Doctors Laurent and Davis brought the need for such a group to the Institute in the summer of 2021, leading to a topic dinner in early November.

During this dinner, diverse representatives from various community sectors gathered to discuss improving health equity in Arkansas.

The 14 attendees spent 12 hours together discussing the different issues and ideas from their sectors around health equity, producing an initial list of ideas, and then selecting a few categories to focus our work.

The major outcomes from this dinner were several key themes to explore in health equity, initial stakeholders for further work, and an overarching definition of health equity to be used moving forward.

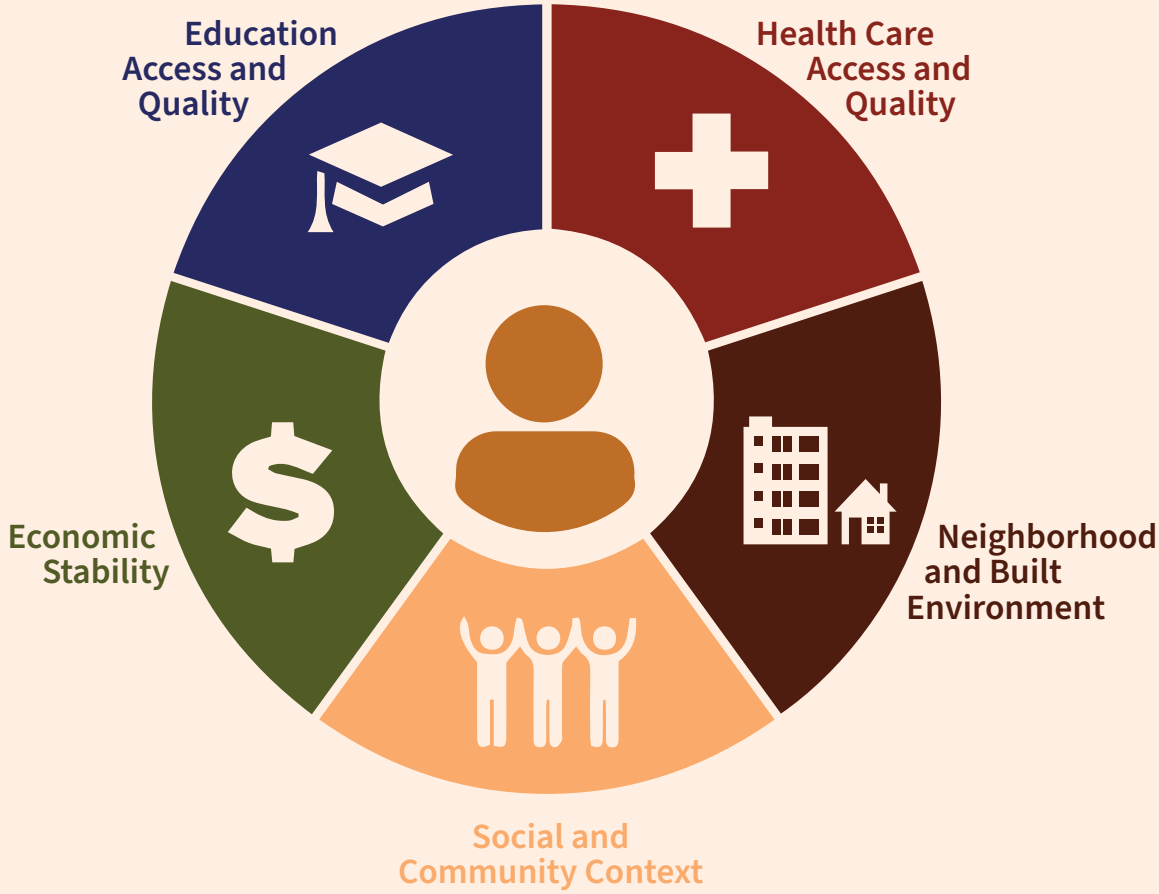
HEALTH EQUITY DEFINED

The Institute and the Arkansas Health Equity Collaboration used the 2017 Robert Wood Johnson Foundation's definition of health equity;

> ***"Health equity means that everyone has 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."***

The United States Department of Health and Human Services (HHS) anchors health equity in the social determinants of health (SDOH), which are "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." (Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (Retrieved from https://health.gov/healthypeople/objectives-and-data/social-determinants-health).

SOCIAL DETERMINANTS OF HEALTH



They are broken into five areas: **economic stability, educational access and quality, health care access and quality, neighborhood and built environment, and social and community context.** Some examples of social determinants of health are:

- **Safety in neighborhoods and safe/ reliable transportation**
- **Racism, discrimination, and violence**
- **Educational attainment, job opportunities, and steady income**
- **Access to healthy foods and physical activity opportunities**
- **Air and water quality**
- **Literacy levels**

For more information about HHS's objectives for health equity within the social determinants of health, please visit https://health.gov/healthypeople/priority-areas/social-determinants-health

health equity defined

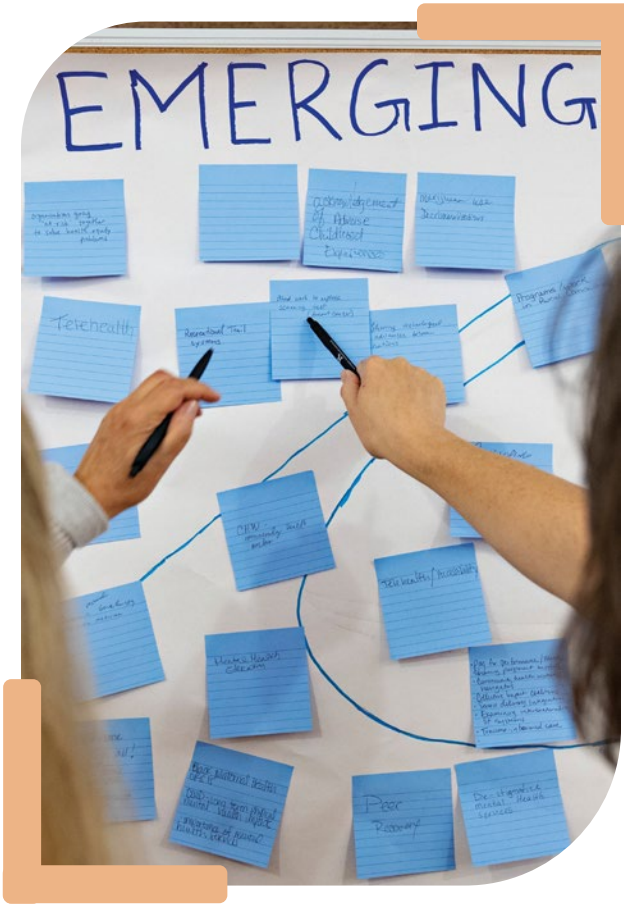
METHODOLOGY

FEEDBACK COLLECTION

Gov. Winthrop Rockefeller strongly believed local people were the best source of ideas for solving localized issues. With this in mind, the Institute and those who convened at the topic dinner elected to conduct focus groups to obtain more feedback from Arkansans about the barriers they felt to health equity. The goal was to hold up to ten focus groups, reaching a diverse group of 100 individuals across the state. The Institute began with a list of participants created by attendees at the topic dinner, then conducted specific outreach for focus group participants utilizing the focus group hosts to identify other individuals/ groups that should attend.

The approach was to hold at least one in-person session in every quadrant of the state, along with Central Arkansas. Sessions were held in Rogers (NW), West Memphis (NE), Camden (SW), Monticello (SE), Fort Smith (West), and Little Rock (Central). Locations were chosen by contacting partners in different areas and trying to cover various locations. In Fort Smith, we gathered at a local meeting spot with restaurants; the Northwest Arkansas Council hosted the Springdale session in their office and meeting space; in West Memphis, we met at the Civic Center; and in both Monticello and Camden, we gathered in a meeting space at the local hospitals.

The attendees at the topic dinner determined the initial themes. After analyzing responses, it was determined that the information fell into three themes: Access to Resources, Community/Economic Development, and Education.



PARTICIPANTS

The focus groups represented various participant groups. Participants were invited by either topic dinner attendees, the partners hosting the in-person sessions (since they had more personal contacts in the area), or our own internal outreach and research. The areas where participants came from also varied, with a large share coming from Central Arkansas and Northwest Arkansas cities and towns.

MEASURES

Questions

What is an underlying challenge to health equity that you have faced that surprised you or was unexpected?

What has been a known or personal frustration with equity work/efforts in access to resources, community/ economic development, and education?

What is an equity strategy that has worked in these three areas? What made it successful?

What could we do differently regarding health equity in communities, a roadblock you would remove, or a resource you wish existed?

Consider the areas of Access to Resources, Community & Economic Development, and Education. What new ideas would you add that are not already listed?

Now, what is not a major focus area relating to Health Equity at the community level list that you know should be?

What is the biggest thing we need to advocate for?

Who is not here but should be at the table?

ANALYSIS

Upon returning from each focus group, captured responses were transcribed into a Google Sheet and coded qualitatively. Four reviewers coded the responses with the predetermined themes of Access to Resources, Community/Economic Development, and Education. During transcribing and coding, two themes emerged in addition to the original three determined from the Topic Dinner. These themes were Cultural Perspectives and Workforce. Cultural Perspectives are responses about how access to health care and healthy lifestyles have been purposefully and inadvertently limited for minority populations, and because of this, these populations have varying degrees of mistrust of the health care system. Workforce responses speak to the need for better health care workforce development, including cultural competencies, and the need to make health equity in the workplace a priority for Arkansas's business sector.

RESULTS

Over 1,500 individual responses were collected during ten focus groups, yielding a large set of community feedback reflecting Arkansans' barriers to living healthy lifestyles and the potential solutions they feel would mitigate them. "See Appendix A:" on page 13. Access to Resources responses were broken down into responses about communication/ information, food, insurance, mental/behavioral health, transportation, and general concerns. Education responses addressed general educational concerns, insurance, K through postsecondary, nonprofits/ providers, and public information. Community/ Economic Development had subcodes addressing community development and economic development, collaboration, and community concerns. Cultural Perspectives were broken down into general concerns, stigmas, systemic, and trust. Workforce had no subcodes; all Workforce responses were coded as general concerns. **Additionally, 164 responses highlight programs and initiatives respondents felt work well and should be continued and duplicated where appropriate, as well as a list of resources and people.**

ACCESS TO RESOURCES	
SUBCODE	COUNT
Communication/Information	31
Food	13
General Concerns	67
Insurance	16
Mental Health/Behavioral Health	18
Transportation	24
TOTAL	**169**

COMMUNITY/ECONOMIC DEVELOPMENT	
SUBCODE	COUNT
Collaboration	27
Community Concerns	19
Community Development	30
Economic Development	20
TOTAL	**96**

CULTURAL PERSPECTIVES	
SUBCODE	COUNT
General Concerns	49
Stigma	11
Systemic	15
Trust	13
TOTAL	**88**

EDUCATION	
SUBCODE	COUNT
General Concerns	78
Insurance	16
K - postsecondary	25
Nonprofits/Providers	15
Public Information	24
TOTAL	**158**

DISCUSSION

The primary takeaways from access to resources responses are that Arkansans wish to maximize existing resources before creating new ones and invest in communication technology and databases in all communities to ensure people can access the latest information. Respondents wanted to expand access to health care and related services through insurance, namely dental, postpartum care, and culturally competent mental health. There is also a fervent desire for low-cost (or no-cost) transportation and corresponding infrastructure to facilitate access to basic needs such as health care visits and food. Regarding community/economic development, the focus groups illuminated the need for cross-sector collaboration, including shared values and information sharing. There was a desire for financial literacy to create independent and health-based infrastructures such as greenspaces and foodways. Respondents stressed the importance of informing policymakers about health equity and the need to consider health/well-being when making policies.

Cultural Perspectives responses underscore the importance of cultural and linguistic competence in health care communication, building trust with historically excluded populations, and combating misinformation. Education responses highlight the need for formal education and health literacy communication improvement. This includes health care pipeline programs introduced early to students, prioritizing educational/existing resources, school-based comprehensive wellness programs, and community investment in healthy lifestyles to support workforce opportunities. Finally, workforce response reiterates the importance of improving transportation options, having more workforce training, especially around benefits like insurance and mental health, and early exposure to health care-related careers for children in underserved populations.

APPLICATIONS AND RECOMMENDATIONS

PROJECTS OF THE ARKANSAS HEALTH EQUITY COLLABORATION

Between July 2022 and August 2024, the Arkansas Health Equity Collaboration used the focus group feedback to inform projects to advance health equity. The group started by culling through all the responses to determine three to five that illustrate the significant barriers within the five themes. They were encouraged to identify what responses illustrate obstacles that could be addressed with the people and resources represented by the 60 or so people in attendance, not necessarily longer-term projects.

Once the key responses were identified, a committee of 18 people researched areas within each theme where health equity could be advanced, looking at potential projects and resources that could be leveraged.

The committee brought this research to a second meeting with the Arkansas Health Equity Collaboration, where three working groups were created to develop the projects further and begin implementing them. These working groups were Access to Resources, Education, and Workforce – each agreeing to ensure that Community/Economic Development and Cultural Perspectives were threaded into their projects. From here, the working groups used an impact-effort matrix, where projects are placed on a matrix depicting the effort it would take and the impact it would have. "See Appendix B:" on page 13.

The three working groups researched their prospective projects, each settling on one to explore. Access to Resources developed a plan to create a toolkit for communities to create bespoke resource hubs that meet the specific needs of their members, centering the principle that communities should be the drivers of solutions to resource gaps. Education developed early childhood health literacy programming while also putting together a project that would better help community health workers to be health advocates for underserved populations. Workforce created a plan to survey employers and their employees on the current state of health equity in the workplace, with the goal of presenting the findings to Arkansas's businesses and the legislature to highlight major gaps. Through this process, especially concerning the Workforce's project, a fourth working group was created to create public policy guiding principles that could be used to advocate for health in all policies at the Arkansas State Capitol. When looking at the responses from our focus groups, all projects are rooted in at least one of the major barriers identified by Arkansans. Significant gaps in resources for healthy living, low levels of health literacy, varying degrees of emphasis on

health equity in the workplace, and a desire to see health in all policies.

Due to several factors, the Arkansas Health Equity Collaboration's projects could not get off the ground as initially hoped. Many people involved early on were required to step away when equity measures were under stricter scrutiny in the Spring of 2023. In addition to impacting those who could be in the room, the scrutiny also diminished the availability of funding sources to support the implementation of the projects. Because of this and a general sense of burnout felt by people who do equity work, the Arkansas Health Equity Collaboration experienced ongoing fits and starts that significantly impacted its ability to take the projects from the idea phase into the implementation phase within the time of Phase 1, which ended in August 2024. Regardless, the projects are primed for implementation upon procuring financial and logistical support.

CONCLUSION

The Arkansas Health Equity Collaboration began in 2021 as a response to the health inequities the COVID-19 pandemic illuminated. Many were familiar to those working in health equity spaces, and all were felt to one degree or another across the state. The Institute went to communities around the state to better understand how to serve Arkansans. We found that health equity is not being achieved across the state, and the barriers are varied. Meaningful health equity initiatives must be community-based and community-driven.

APPENDIX A:
FOCUS GROUP FEEDBACK BY TYPE

Focus Group Feedback by Type: Focus Group Data by Type.xlsx

APPENDIX B:
PROSPECTIVE WORKING GROUP PROJECTS

ACCESS TO RESOURCES

Major Projects

- Leverage resource advocacy training
- Leverage connections, political awareness
- Guidance to recognize individual powers
- Increase mental health education providers
- Connecticut NPO hub perfect example of state NPO relationship
- Logistics, transportation hours of operation cost
- Personalization, holistic, care, relationship
- Addressing gaps in services
- Leveraging connections, kids, and ports
- Hosted event for community members
- Affordable transportation
- Faith, the community, be in access to resources
- The targeted population needs SDOH health
- Solutions and services needs have
- Make the case to the public
- Executive sponsors
- Public account, utilities, celebration
- Aggregate data from hospital needs assessment, other HRSA government agencies, community voices
- Increase postpartum coverage and continued coverage for children's programs to increase the racial-ethnic representation of providers and funding
- Increased materials for infant initiatives
- Affordable Wi-Fi
- Paper communication, a unified message from either a sole source or multiple community-trusted sources
- Regional partners can access resources and access
- Training community people to meet the needs of the community
- Other resources Greek organizations
- 211 needs to have a deeper connection with community partners and state agendas
- Create an Omni channel to approach everyone
- Collaborate with Arkansas Connect to expand broadband
- Incentives/funding stream that focuses on her health
- Leveraging connections PTAS
- Awareness of resources in Programs breakdown silos that are already expandable across the state will not create a new one
- Ensuring these directly impacted by health equity barriers have a seat at the discussion table to make the decision
- Empower local gatekeepers to identify gatekeepers
- Follow up on referrals What works? What does it mean?

- Advocacy events for health equity were held in communities to share her experiences of what is needed
- Faith-based community
- Resource hubs
- Community hubs to make it easier to access multiple resources at once
- Resource hubs
- Community engagement outside medical workers
- Advocate for data, sharing, and transparency while maintaining the privacy of individuals
- Develop a relationship with multi-sector partners
- Partnership with churches
- Information centers, schools, churches, etc.

Quick Wins

- Community health care workers are calm, Arkansas, a coalition of Marshallese
- Address, SDOH, ie, homeownership food desert, transportation, and health care system
- Speed to market: how do people learn about resources?
- Language/culture-appropriate resources
- Gatekeepers and CHW more training
- Community-level needs assessment with community leaders at the table
- QR code on flyers website so list available resources
- Shared list of resources
- Awareness of available resources, general knowledge
- Increase/facilitate conversations with government groups to improve resource exes
- Divine nine
- Identify trusted community conveners, schools, libraries, and churches to understand local resources
- Understand in involving workforce navigators, school nurses, CHWS
- Nonprofit government programs buying
- Telehealth doctors for rural communities
- Partners foundations
- Incentive health care
- Figure out what resources we already have
- Study data from Resource Center
- Engaging individuals outside health care and incarcerated individuals and seeing what resources they need
- School-based health extended services to parents and community members
- Partners, DHS
- Applying for insurance supplements
- Telehealth for PCP, specialties, and mental health
- SDOH platform is necessary for the state preference for a platform everyone works on If not separated, platforms must communicate
- There needs to be a centralized hub for activity resources from across the state that everyone has access to It can relate to

Thankless Tasks

- Disaster resources versus institutional, consistent resources
- Current data and islands without Internet access
- Telehealth
- Community liaisons, partnerships, churches, gatekeepers
- Other partnership rehires
- Partnership with broadband
- Community involvement on local level
- Update resource list at least two times a year
- Access to language of choice
- Exercising outside health care churches
- Case planning discharge resource maintenance in the room

Filler

- Universal packet and more specific packets format website email paper phone 211
- Connection to specific resources
- Leverage installs to migrate awareness
- Other partnerships, local volunteer groups

EDUCATION

Major Projects

- Policy Recommendations Medium-high Effort, Medium-high Impact
- Social-emotional theory government recommendations
- Identity education curriculum changes needed (culturally appropriate learning)
- Community Assessments Low-Medium Effort, Medium-high Impact

Filler

- Resource Maps Medium Impact Medium Effort
- Identify interpreter services are statewide and what is offered (resource identification)

Quick Wins

- Identify Gaps Medium Impact, Medium Effort
- Identify social learning components (identify gaps across the state)
- Identify how/when/where the problem manifested Where did the mistrust start? (surveys, interviews, etc.)

Thankless tasks

- Toolkit Medium-high effort, Medium-high impact
- Make communities more knowledgeable with trust and cultural perspectives
- How to train and educate advocates
- Help the community understand how to direct them to SMEs and appropriate resources

WORKFORCE

Major Projects

- Q5 Develop/host career pathway workshops
- shadowing terms apprenticeships
- exploring emerging equity investment vehicles to fund public health projects (public health bonds, equity increment financials)
- Involve the hometown health department in contacting local communities regarding health equity promotion
- to expand broadband across the state
- Recruit more black Hispanic Asian Marshallese doctors If the pool is small, training physicians on how to care for participants from these backgrounds
- Creating curriculums for licensing professional development on adverse experiences and their efforts across sectors (health care, education, legal)

Filler

- Identify elements of healthy communities that attract a workforce
- Job boards within schools/ public schools
- Resources directory cellars
- System map- what are the current resources on all levels so that we can identify gaps and opportunities
- Connect home health workers to platforms (curecom) to find other jobs and organizations (National domestic workers that advocate for them)
- Train more youth in the community health workers field
- The nonprofit sector in AR -start with a survey that asks questions about their current state of health -build out a program that they could implement into chairs for their workforce
  -Ask AR funders foundations to support this deployment

Quick Wins

- An ongoing resource to clean up helps communities
- Utilize community health workers and local community volunteers to promote inclusion and diversity, addressing health equity barriers
- Workforce health equity wellness training and education internal and external
- Q2 centralize data hubs
- Making the business case to employees and policymakers of need health equity
- Creating a health equity graphic/world that could designed for workforce entities
- Health Equity tool kit for employers
- tool kit for communities to partner with employers in developing health/healthy resources
- Create a healthy community toolkit to distribute to employees
- engaging the financial sector to leverage capital and programs like new market tax credits to create investment in communities and workforce development
- Encourage more technical schools and representatives of licenses and careers without bachelor's degrees in high school never saw realtors or plumbers at job fairs
- Identify housing strategies that support workforce populations (eg, income, responsive)

For more information on how to get involved with the Arkansas Health Equity Collaboration, reach out to Dr. Brookshield Laurent at blaurent@nyit.edu.

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