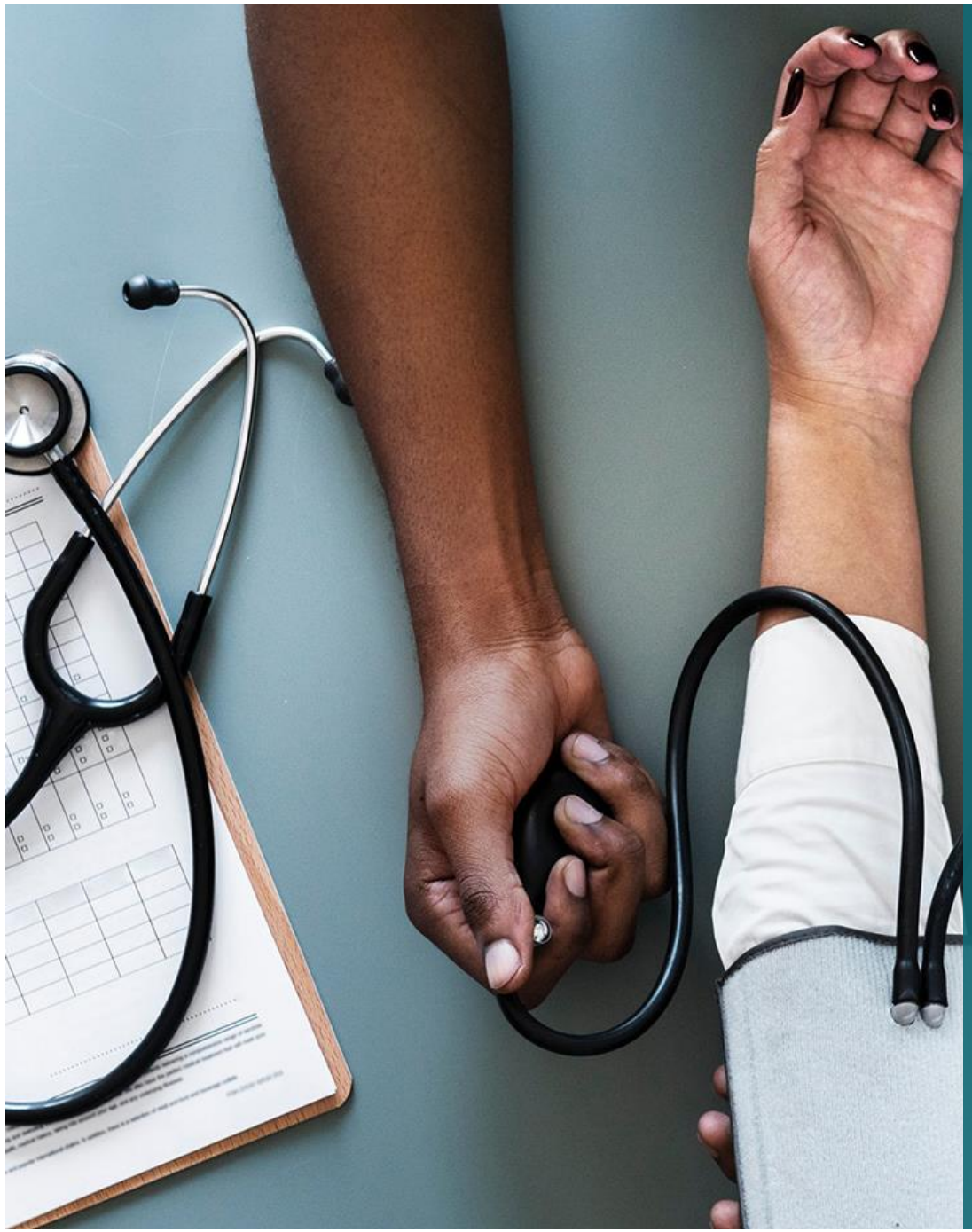


Developing Health Equity:

A Public Health Data Driven and Contextual Approach

Dr. Nate Horwitz-Willis, DrPH, MPH, MPA

Founder, Horwitz-Willis Advising and Consulting

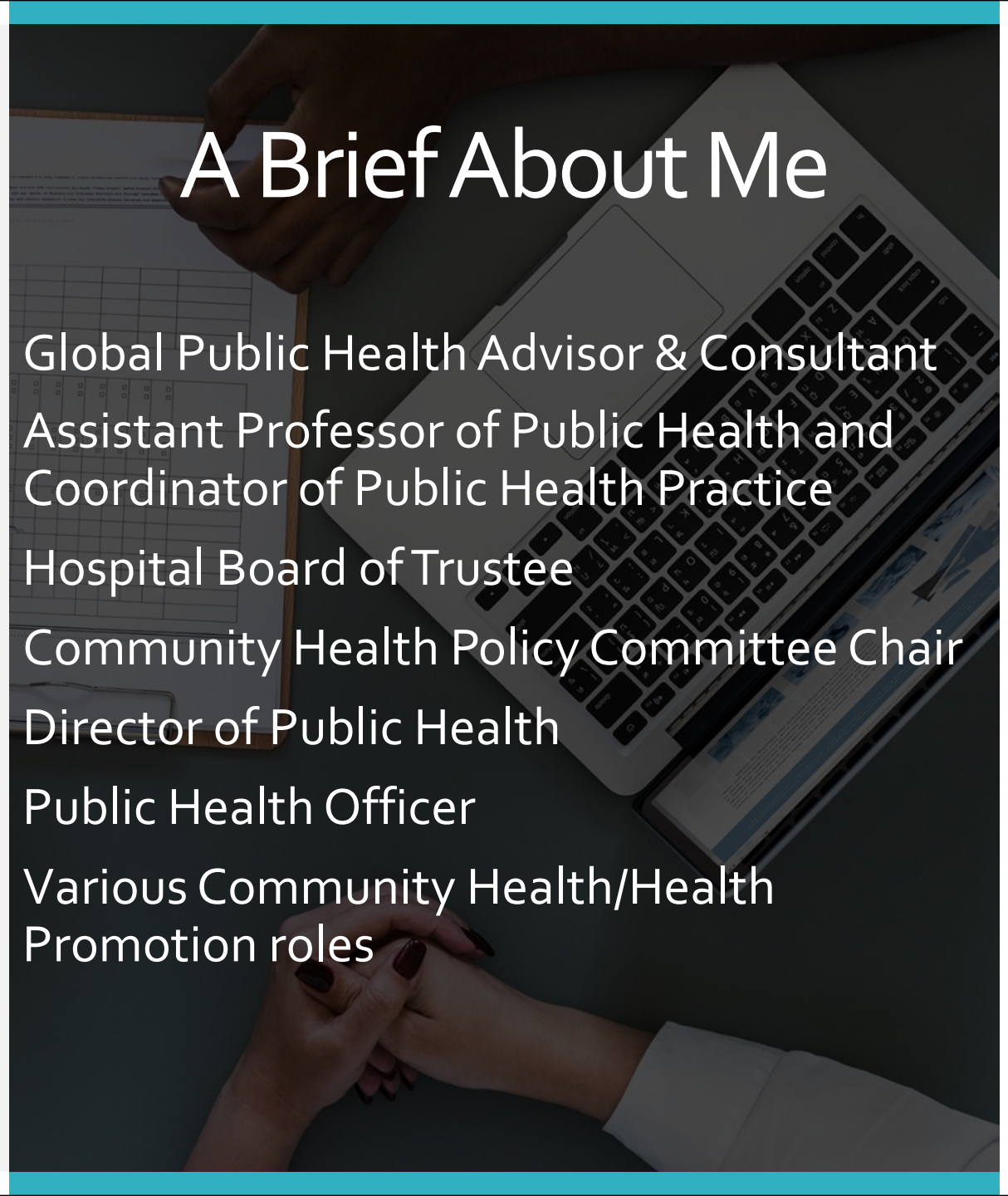
MCPHS University, Assistant Professor of Public Health and Coordinator of Public Health Practice

Workshop Goal

Add value to organizations seeking to improve and provide equitable health services in the communities they serve.

Workshop Objectives

- 1) Help healthcare leaders innovatively and effectively meet their ACA community benefits mandate.
- 2) Provide insightful evidence-based tools to bridge the gap between community health and patient centered care.



A Brief About Me

Global Public Health Advisor & Consultant

Assistant Professor of Public Health and Coordinator of Public Health Practice

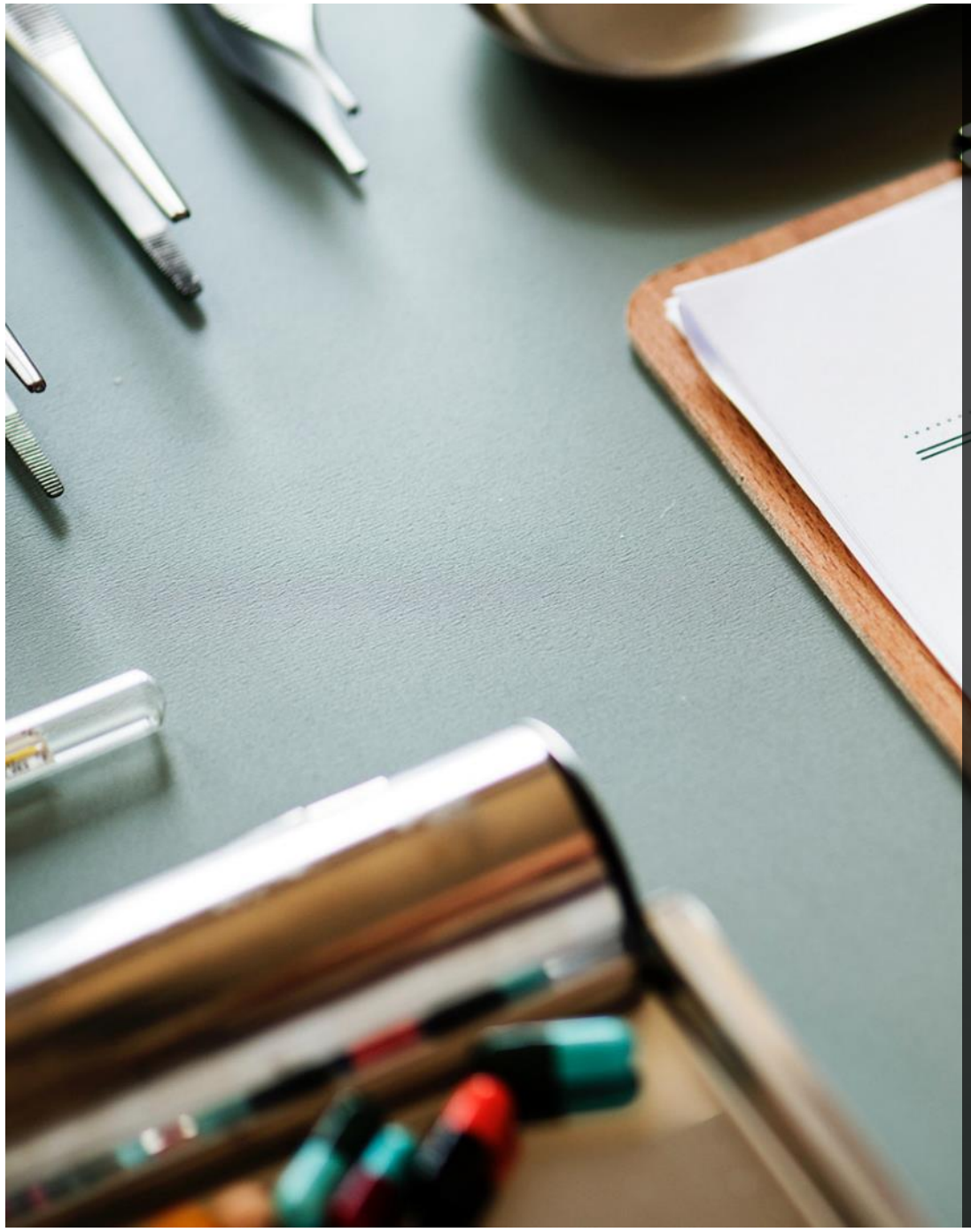
Hospital Board of Trustee

Community Health Policy Committee Chair

Director of Public Health

Public Health Officer

Various Community Health/Health Promotion roles



Audience

Individuals who who work for and/or with healthcare/public health entities.

Will learn how to contextually understand data related to the social determinants of health.

Will gain exposure for using technology to better implement methods of care and population/public health surveillance related to social determinants of health impacts.

This workshop will use your existing cell phone technology and/or your own laptop/tablet.

Incorporating Mindfulness and Thoughtful Participation

- Place cell phone or electronic devices on silent or vibrate.
- This is workshop encourages dialogue: Questions are welcome for clarity and understanding during the workshop.
- If a question starts to evolve into a complex/nuanced discussion, we can revisit it for discussion at the end of the workshop.
- An opportunity for additional questions will occur at the end of the workshop.
- Please try not to engage in side conversations during the workshop.
- Please consult with the presenter regarding permission to record audio or video. Taking photos is welcome.

Etiquette Notes

Bottom line: Let's have fun engaging in this experience!

Social Determinants of Health and Health Related Social Needs to drive Patient Centered Care

Culture

Incorporating cultural humility to address Gender inequities, racism, and genetic endowment.

Financial and Economic Mobility

Physical and Social Environment

Includes traumatic experiences and substance use, misuse, and abuse that impact behavioral health outcomes.

Education Achievement and Use

Access to Healthy Housing

Community Health Assessment

Organizational Patient Population Health Priority Assessment

Analyze and Evaluate

Assessing and Evaluating

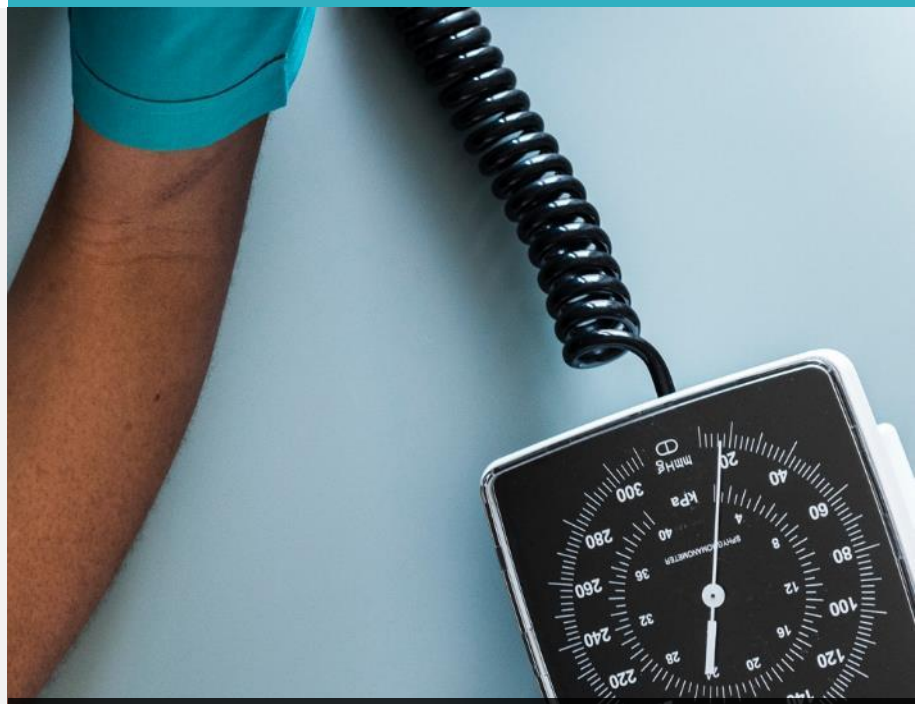
- Community Health Assessment
- Organizational Patient Population Health Priority Assessment
- Analyzing and Evaluating the Data

Target Key Community and Patient Health Concerns

Review the Organizations MVG and SWOT

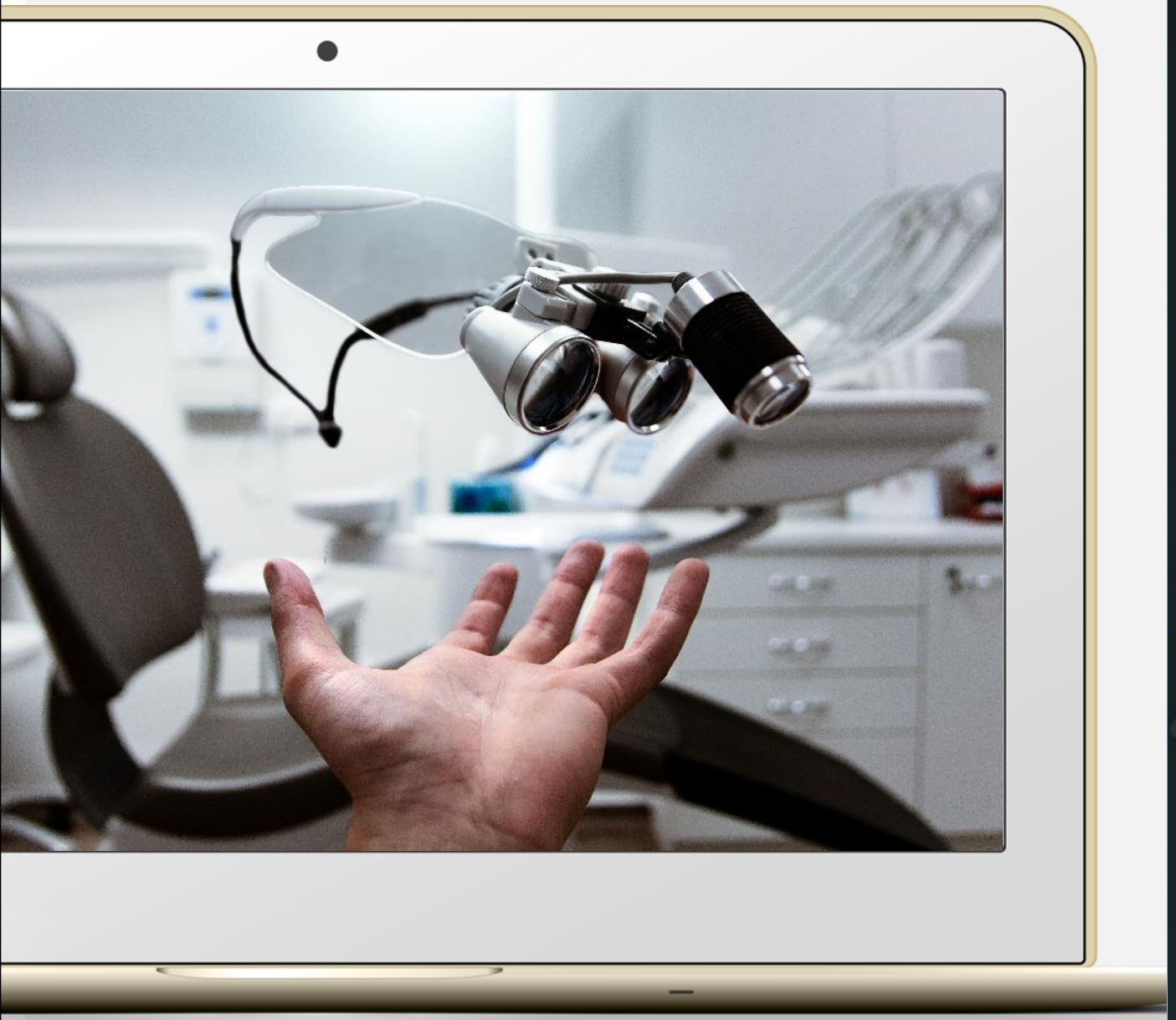
Rank Priorities

Deliberate and Revise



Patient Population Health Priority Assessment

Assemble health professionals and community champions that are engaged in the community.



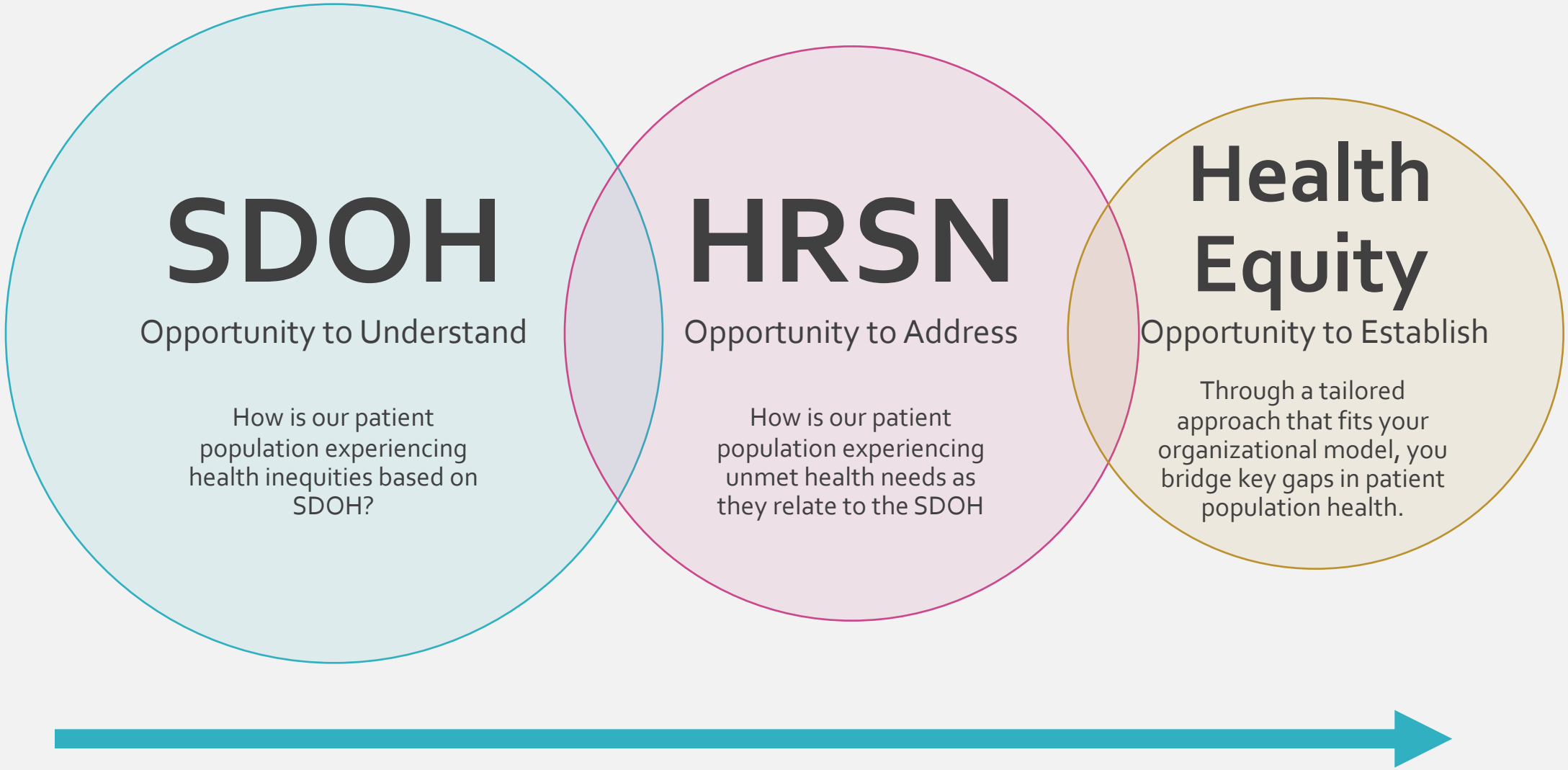
Justifying Implementation: Analysis and Evaluation

You have to dig in to the data to help you align clinical and ancillary health services to meet ACA mandates. It can be challenging and external consultation is recommended:

- Balancing bottom line with health outcomes.
- Determining where to make equitable investments to benefit community and thereby your patient population.
  - Capital Investment
  - Program Investment
  - Personnel/Services Investment

Some Justification: Developing and Establishing Health Equity

Understanding Social Determinants of Health (SDOH), Addressing Health Related Social Needs (HRSN), and Establishing Health Equity



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Health Equity

Once the patient population or community health screening is done, what are the areas (neighborhood) or types of treatment (hospital) need revision that is both inclusive and welcoming. Welcoming, in the sense of being proactively engaged with the intent to proactively reduce or eliminate health inequities across the region.

Patient-Population utilizes services and building a culture of health

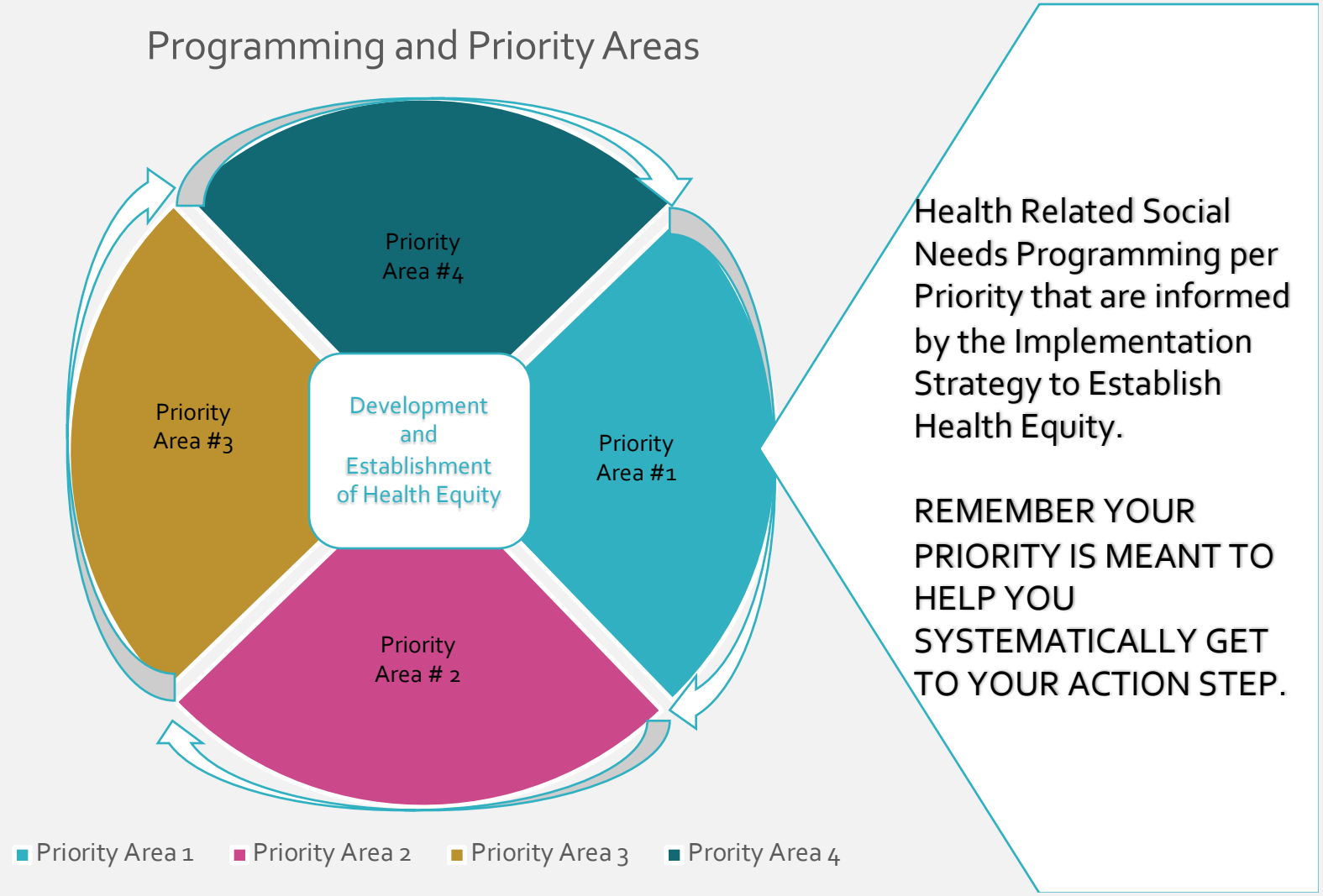
Furthering the Use of the Data: Sentiment Analysis and Evaluation

Putting this together through deliberation.

Data-Driven Implementation Strategy to Establish Health Equity

How will we scale in the future

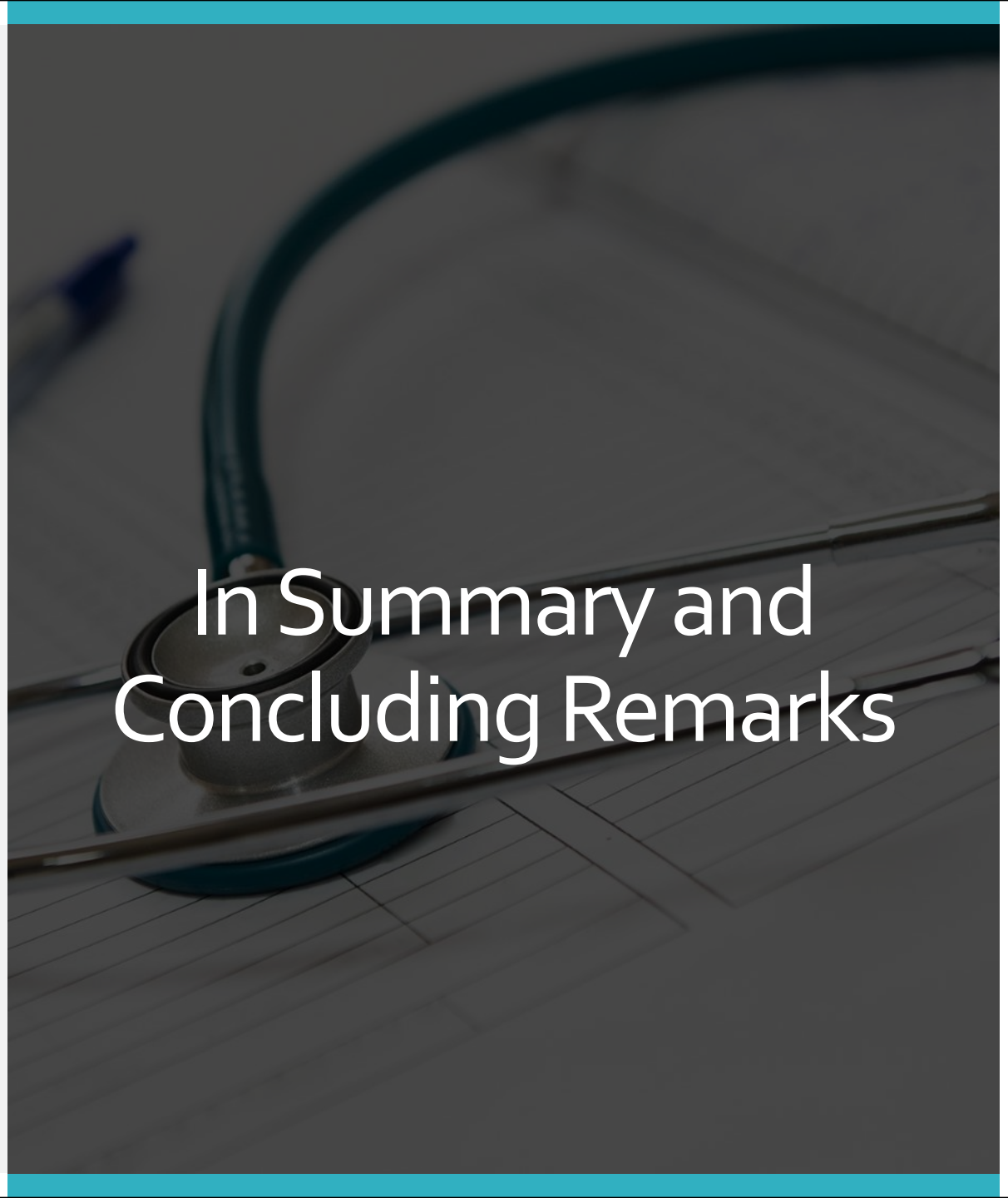
HRSN Programming/Services based on Priorities



Health Related Social Needs Programming per Priority that are informed by the Implementation Strategy to Establish Health Equity.

REMEMBER YOUR PRIORITY IS MEANT TO HELP YOU SYSTEMATICALLY GET TO YOUR ACTION STEP.

- The Social Determinants of Health are ubiquitous – But understanding them as they relate to your patient population is critical. They are not prioritized the same in every community. based on data, to your organization and patient population you are working with.
- When you understand the specific SDOH's your patient population is experiencing, then you can begin addressing the HRSN of your patient population.
- That community health assessment and patient population health priority assessment, when analyzed, provide specific understanding about their SDOH's and how to best address their HRSN.
- It is recommended to have an expert in-house that can conduct this work or to consult with an external expert to achieve health equity, better meet ACA mandates, and provide optimal patient centered care based on your patient population.



In Summary and Concluding Remarks

Questions, Comments, & Discussion

Thank You

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