

UNDERSTANDING YOUR MARKET THROUGH A HEALTH EQUITY LENSE

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Today's Webinar

- Rural America faces disproportionate social and economic disparities compared to urban settings, often leading to poor health outcomes for rural patients and their communities. Now is the time to leverage data at the local level to begin to reduce healthcare disparities and develop interventions to improve health. Today's webinar will address the following:
 - Understand the importance of health data equity and social determinants of health data
 - Identifying what the data tells us about health disparities and priorities within a specific service area or county
 - Appreciating how this data can support health equity strategy and recognizing your Circle of Influence



Health Equity and Social Determinants of Health

Why Health Equity Data Matters

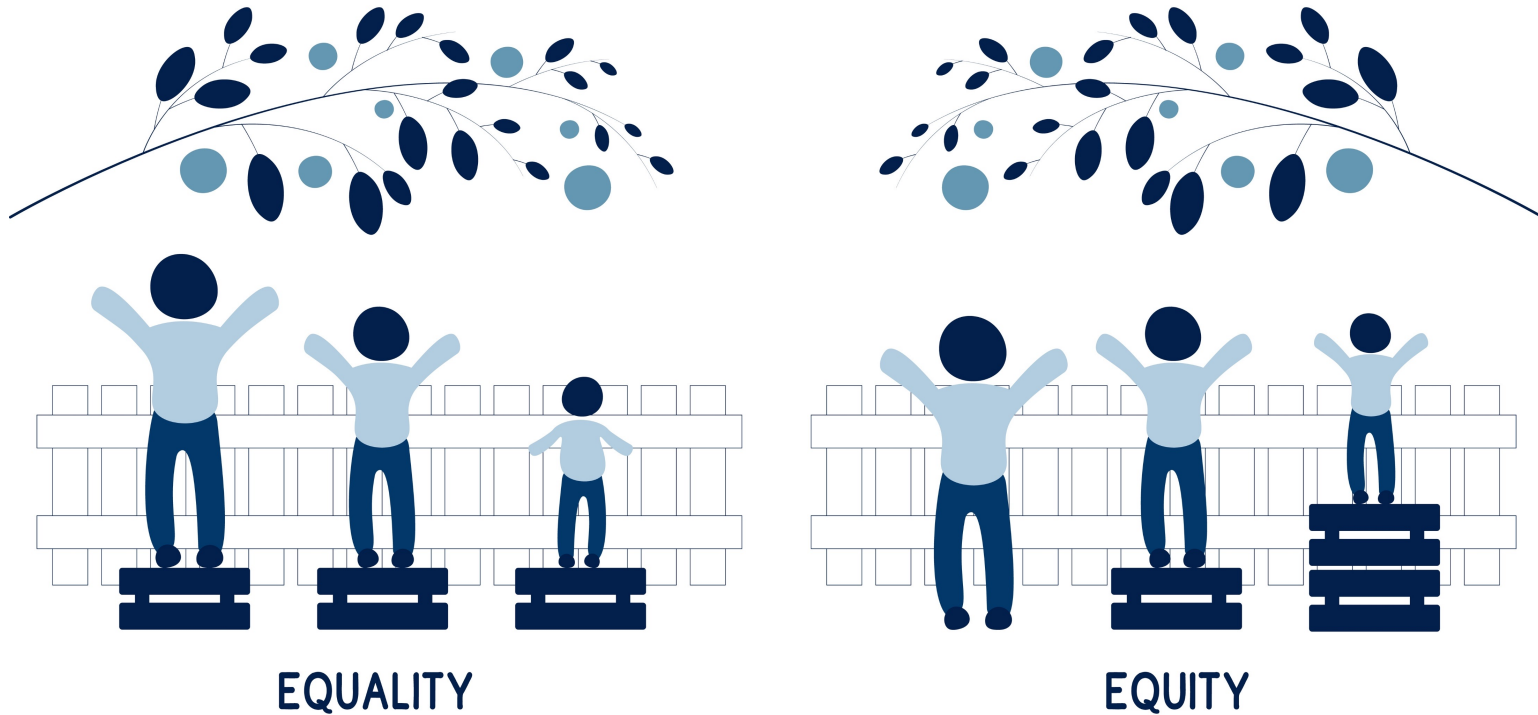
Unless specifically measured, **disparities in health and healthcare can go unnoticed** even as stakeholders seek to improve healthcare

Stratifying healthcare data by race, ethnicity, language and other demographic factors such as age, sex, health literacy, sexual orientation, gender identity, socioeconomic status and geography is **vital for understanding and addressing health disparities**

Healthcare organizations often **underestimate the magnitude of disparities** in their own patient populations, and they may be unaware of barriers patients face

Closely examining stratified quality and health outcome data is the **most reliable way to reveal the type and magnitude of disparity** and then **allocate or reallocate resources accordingly**

Equity vs. Equality



HEALTH EQUITY GENERALLY REFERS TO INDIVIDUALS ACHIEVING THEIR HIGHEST LEVEL OF HEALTH THROUGH THE ELIMINATION OF DISPARITIES IN HEALTH AND HEALTH CARE. (KFF.ORG)

Health Inequity

- Health inequities are unjust differences in health status due to things like **discrimination, exclusion of certain groups of people, and lack of power and financial mobility**
- The ability of people to access health services and to meet their basic needs (food, housing, etc.) are affected by:
 - **Income level**
 - **Educational attainment**
 - **Race/ethnicity**
 - **Health literacy**

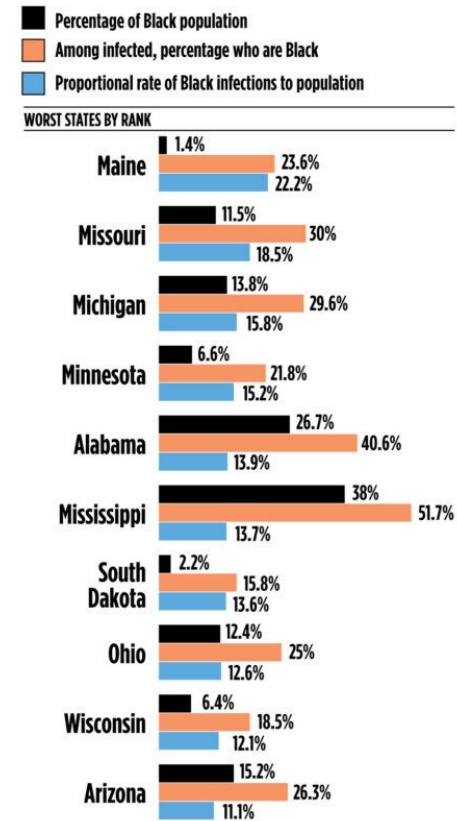


Health Disparities Today in Rural America

- A Native American child is twice as likely as a white child to die in infancy
- **Lack of health care and healthy food** make Black and Indigenous children in the nation's most disadvantaged counties five times as likely to die as children in other areas of the country
- The share of **uninsured** Hispanic Americans is 2.5 times higher than the share of uninsured white Americans, and Black Americans' lifespans, on average, are six years shorter than white Americans
- Asian Americans are 50% more likely to **develop end-stage renal disease** than non-Hispanic whites
- In June 2021, Maine reported the nation's largest racial disparity in coronavirus cases, with statistics showing that members of the state's small but growing Black communities are **contracting COVID-19 at a rate more than 20 times** that of white residents
- Black residents accounted for at least 713 of the 2,578 COVID-19 cases in Maine where the race of the individual is known – a staggering 27.7 percent of cases – even though Black residents represent just 1.4 percent of the state's population

COVID-19: The racial disparity

Black Mainers account for 1.4 percent of the state's population but make up 23.6 percent of its COVID-19 cases, the highest racial disparity in the nation.



SOURCE: The COVID Tracking Project
STAFF GRAPHIC | MICHAEL FISHER

What Are the Social Determinants of Health? (“SDOH”)

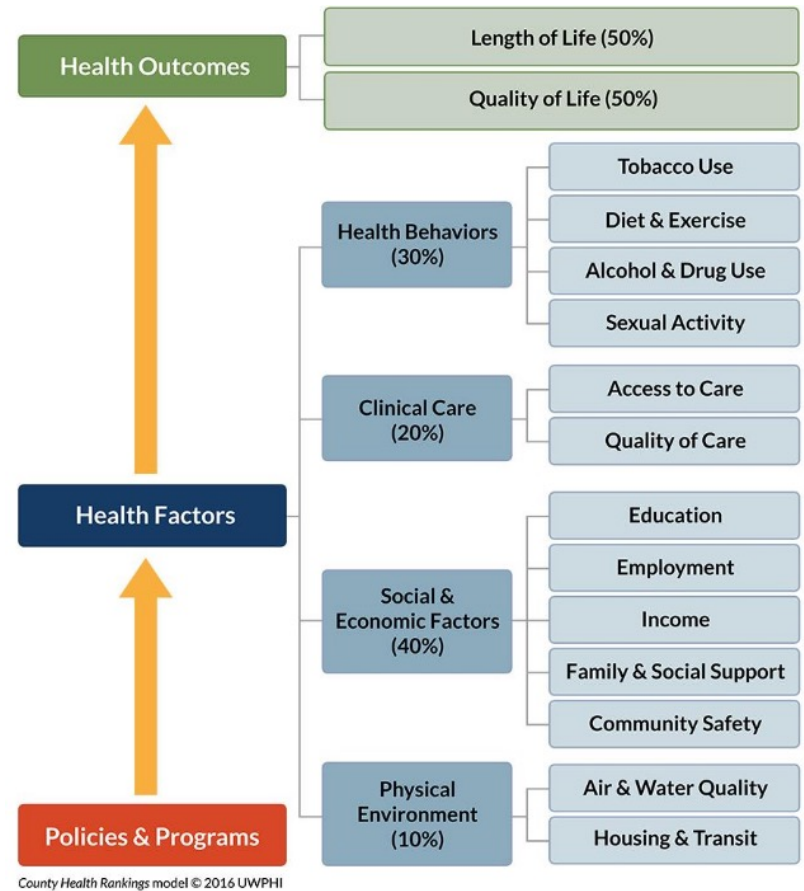
- The social determinants of health exemplify how multiple factors in a community can impact overall health including general well-being and health outcomes



- Social determinants of health (SDOH) are, according to [Healthy People 2030](#), “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”

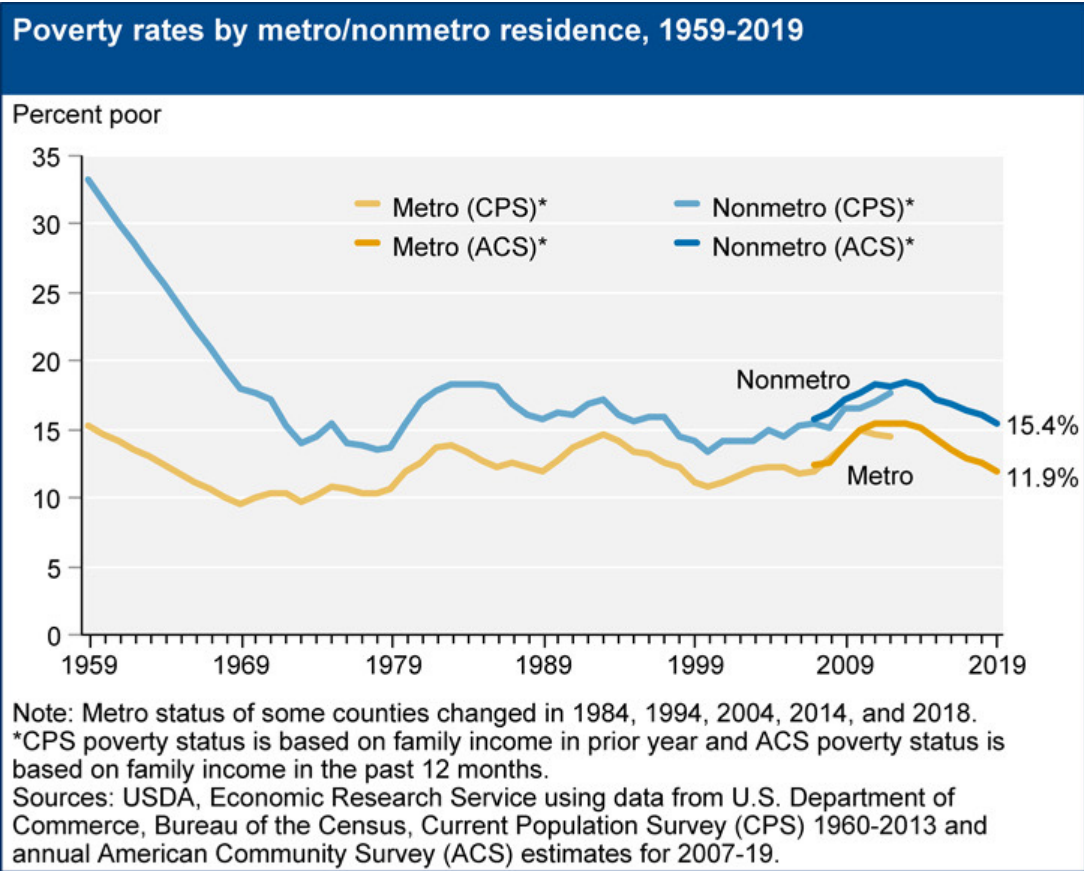
County Health Rankings

- The health of a community depends on many factors, including environment, education and jobs, access to and quality of healthcare, and individual behaviors
- As we know, much of what influences our health happens outside of the doctor’s office—in our schools, workplaces, and neighborhoods
- For some the elements for the greatest health outcomes are readily available; for others, the opportunities for healthy choices are significantly limited.
 - These limitations are directly related to the imbalance of policies, programs, and resource allocation.
- Where do your state’s counties rank?



SDOH in Rural America

- Rural residents are more likely to experience some of the contributing social factors that impact health, such as poverty
- The impact of these challenges can be compounded by the barriers already present in rural areas, such as limited public transportation options and fewer choices to acquire healthy food



SDOH in Rural America and Access to Healthcare

Social determinants that impact access to healthcare include:

- **Poverty, income, and employment status**, all of which contribute to whether an individual has:
 - Health insurance coverage, whether through an employer, a public program, or their own purchase
 - The ability to pay out-of-pocket costs such as co-pays and prescription drug costs
 - Access to dental care, either through dental insurance or the ability to pay for treatment
 - Time off work to go to an appointment
 - A means of transportation to visit a healthcare provider
 - Resources to afford retirement and pay for healthcare and health-related expenses in retirement, including costs related to aging in place
- The skills to **effectively communicate** with healthcare providers and self-manage their care
- An expectation that they will receive quality care, whatever their race/ethnicity or income level

A large, light blue silhouette of a lighthouse is positioned on the left side of the slide, extending from the top to the bottom. The lighthouse has a multi-tiered lantern room with a grid pattern and a small spire on top.

Using Health Data to Understand Community Health

Importance of Health Data

- › Understanding the effects of health disparities in our communities is essential to fulfilling the mission and supports the IHI's Triple Aim:
 - › Improving the patient experience of care (including quality and satisfaction);
 - › Improving the health of populations; and
 - › Reducing the per capita cost of healthcare
- › Hospitals and health systems can identify health disparities by querying data sets to see how processes or outcomes differ by demographics or geography
- › One of the most basic inquiries a health care organization can make is to stratify a process or outcome by race, ethnicity and language, sexual orientation and gender identity, religion, age, gender, disability, employment, education, socioeconomic status, insurance status, geographic location, ZIP code or another demographic or socioeconomic variable
- › Mapping data shows inequities at the community level by overlaying health data onto maps and seeing which neighborhoods have a higher prevalence of certain diseases to figure out what populations may be at additional risk

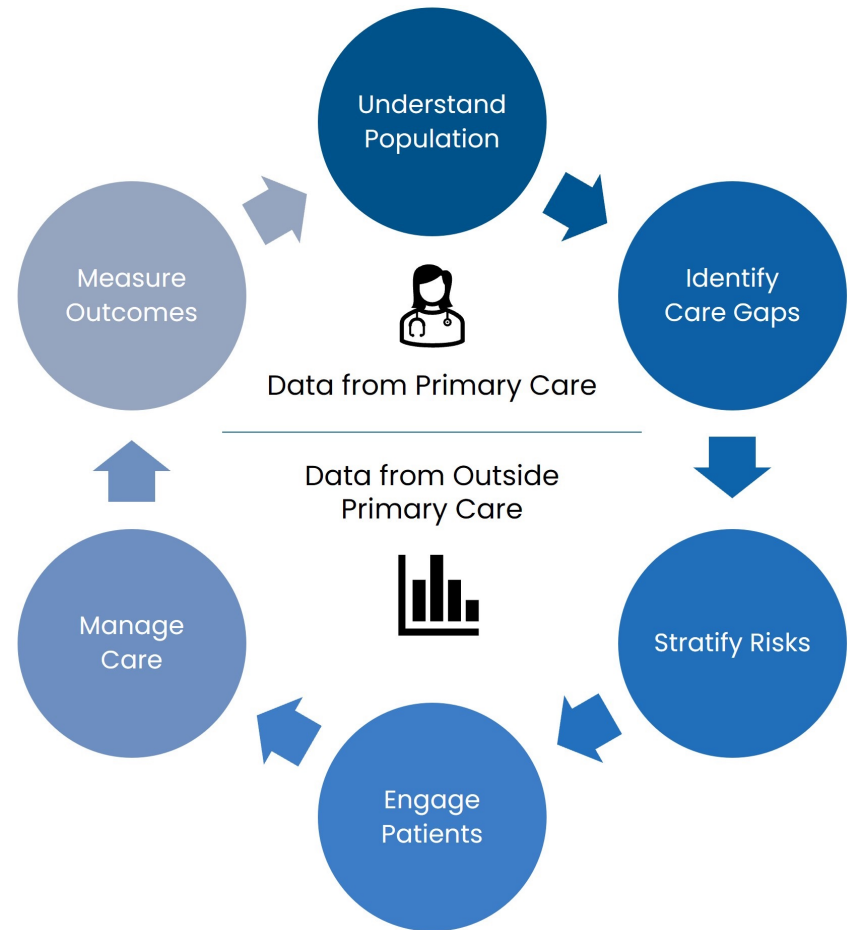
Data Sets

Internal Data

- Primary care utilization
- Ancillary (labs, testing)
- Pharmacy
- Dental
- Mental health dx
- Substance abuse dx
- SDOH (food security, housing, employment)

External Data

- Specialty utilization and referrals
- Hospital utilization
- ED utilization
- IP mental health utilization
- LTC utilization
- Substance abuse utilization
- Neighborhood SDOH data
- Claims data



Using ICD-10 Data to Identify Community Needs

- › Every hospital/healthcare provider has access to their community's health data through the medical coding system ICD-10, which they must use to submit claims to payers
- › In ICD-10, Social Determinants of Health (SDOH codes) are found in categories Z55-Z65:
 - › Z55, Problems related to education and literacy
 - › Z56, Problems related to employment and unemployment
 - › Z57, Occupational exposure to risk factors
 - › Z58, Problems related to physical environment
 - › Z59, Problems related to housing and economic circumstances
 - › Z60, Problems related to social environment
 - › Z62, Problems related to upbringing
 - › Z63, Other problems related to primary support group, including family circumstances
 - › Z64, Problems related to certain psychosocial circumstances
 - › Z65, Problems related to other psychosocial circumstances

Understand how SDOH data can be gathered and tracked using ICD-10 Z codes

Identify and Understand Health Inequities



Do not rely on assumptions about what health inequities exist in your community



Gain a comprehensive understanding of the identified health inequities

Examine multiple aspects of health in your community to get a clearer picture of health inequities



Use appropriate tools to identify health inequities



Engage community members and partners in data collection and interpretation



“What gets measured gets improved” – Peter Drucker

Using Data To Identify Inequities: Query Examples

PROCESS query examples (treatment, procedure, encounter)

- Percentage breakdown by race of female patients who were screened for breast cancer
- Percentage of male patients who had a colonoscopy, by ethnicity
- Percentage of patients with chronic health conditions who filled prescriptions, by ZIP code

OUTCOME query examples

- Breakdown of readmitted patients by insurance status
- Ethnicity breakdown of patients who suffered a fall during an inpatient stay
- Breakdown of Hispanic patients hospitalized for COVID-19, by English-speaking and non-English-speaking

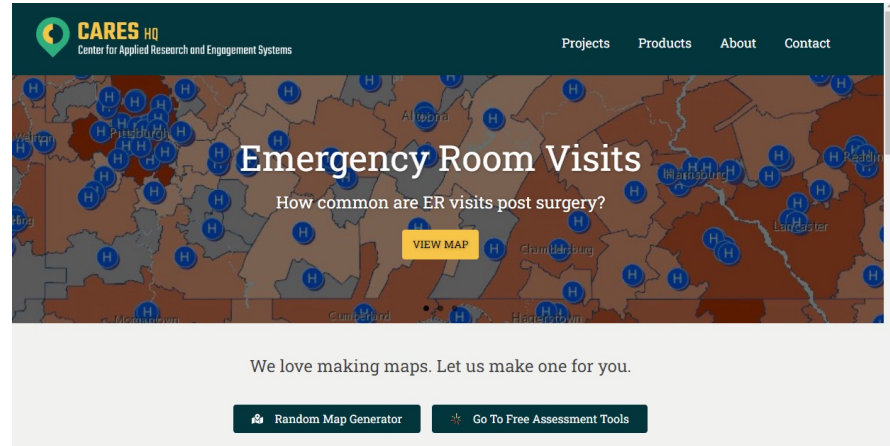


What Does the Data Tell Us About Our Community?

Center for Applied Research and Engagement (CARES)

➤ The Center for Applied Research and Engagement Systems (CARES) is affiliated with the University of Missouri system. CARES helps organizations and planners learn more about their community by providing access to data from the US Census Bureau, American Community Survey (ACS), Centers for Disease Control and Prevention (CDC), United States Department of Agriculture (USDA), Department of Transportation, Federal Bureau of Investigation, and more. These data focus on health, the environment, the economy, education, agriculture, and safety.

- Data geographies range from national, state, county, city, census tract, school district, and ZIP code levels
- The data supplied by CARES are timely and reliable. Where applicable, the data allow for breakouts of information and incidences by detailed racial, ethnic, and socioeconomic categories.



CARES Dashboard Components/Elements

CARES data include nearly 650 individual indicators, organized by the following categories: Clinical Care and Prevention, Demographics, Education, Health Behaviors, Health Outcomes, Healthcare Workforce, Housing and Families, Income and Economics, Other Social and Economic Factors, Physical Environment, and Special Topics (currently focused on COVID-19 metrics).

Stroudwater's dashboard dropdown menus and radio buttons allow the user to quickly focus on each individual indicator under these categories

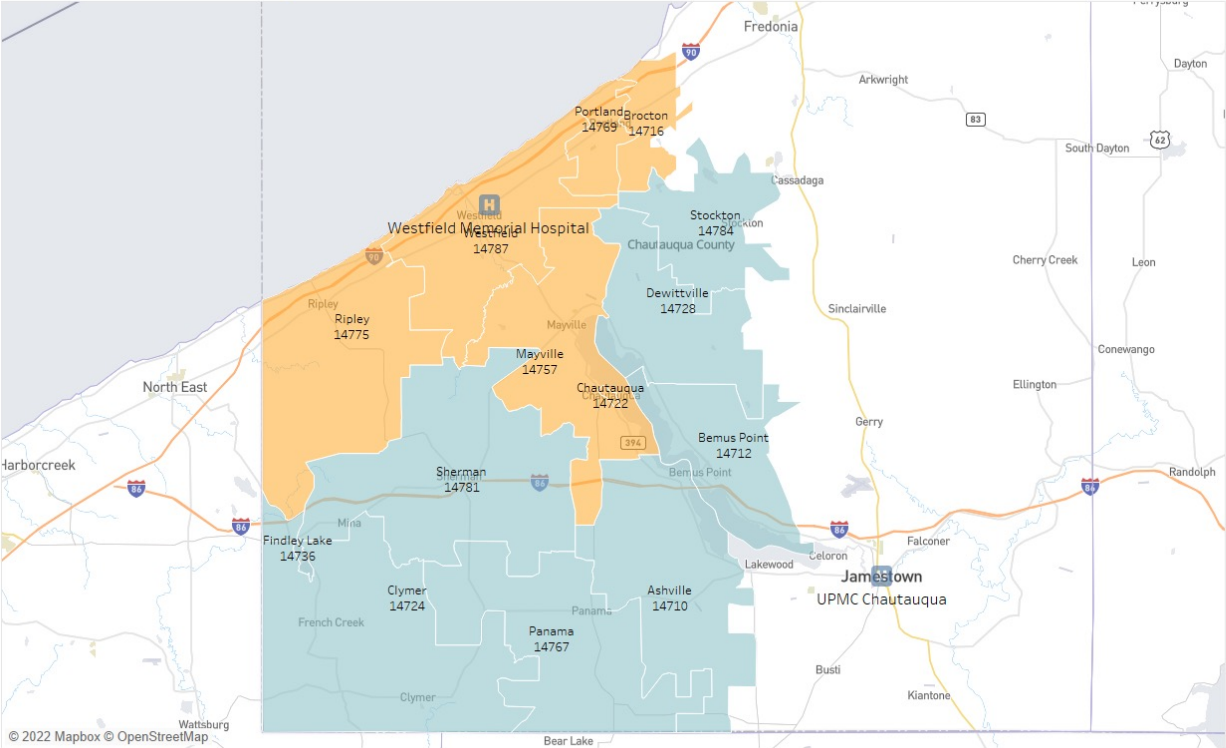
The dashboard includes data for the aggregate custom report area, the county or counties related to the custom geography, the state benchmarks, and national benchmarks

For comparison purposes, most indicators focus on percentages of or rates per a defined population. Where applicable, whole number values are shown.

Some indicators allow for ZIP Code-level breakdowns of the data. A separate tab mapping these comparisons is included.

Service Area

Service Area Map



Source: Administration and Stroudwater analysis

Service Area
■ Westfield 75%
■ Westfield Additional

×

Service Area
 Westfield 75%
 Westfield Additional

PO Name
 Ashville
 Bemus Point
 Brocton
 Chautauqua
 Clymer
 Dewittville
 Findley Lake
 Mayville
 Panama
 Portland
 Ripley
 Sherman
 Stockton
 Westfield

Define a service area

STROUDWATER

×

Population

Population

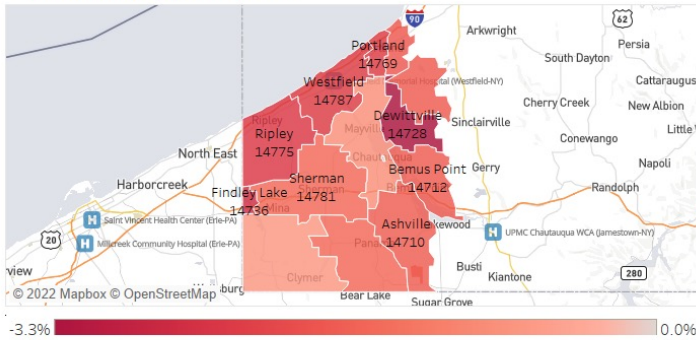
Current	5-Year
29,850	29,335

# Change	% Change
-515	-1.7%

Age Group Detail		5-Year #	5-Year %
Age Groups	Current	5-Year	
<18	6,127	5,920	-207 -3.4%
18-44	8,977	9,005	28 0.3%
45-64	8,271	7,352	-919 -11.1%
65+	6,475	7,058	583 9.0%

ZIP Code Population Detail		Current	5-Year	# Change	% Change
ZIP Name	ZIP Code				
Ashville	14710	3,403	3,345	-58	-1.7%
Bemus Point	14712	3,227	3,171	-56	-1.7%
Brocton	14716	2,645	2,598	-47	-1.8%
Chautauqua	14722	137	137	0	0.0%
Clymer	14724	2,614	2,595	-19	-0.7%
Dewittville	14728	975	943	-32	-3.3%
Findley Lake	14736	311	303	-8	-2.6%
Mayville	14757	3,531	3,500	-31	-0.9%
Panama	14767	1,901	1,872	-29	-1.5%
Portland	14769	835	816	-19	-2.3%
Ripley	14775	2,382	2,326	-56	-2.4%
Sherman	14781	2,035	2,004	-31	-1.5%
Stockton	14784				

5-Year Change (%) by ZIP Code



Source: IBM-Watson Health

- X
- Service Area
- Westfield 75%
 - Westfield Additional
- ZIP Name
- Ashville
 - Bemus Point
 - Brocton
 - Chautauqua
 - Clymer
 - Dewittville
 - Findley Lake
 - Mayville
 - Panama
 - Portland
 - Ripley
 - Sherman
 - Stockton
 - Westfield

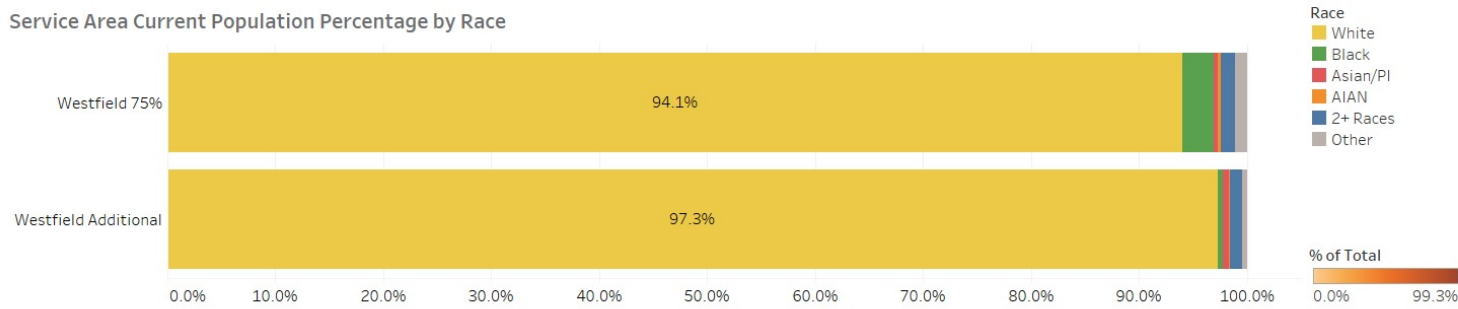
Identify total population, age cohorts and projected change by ZIP Code



Population by Race

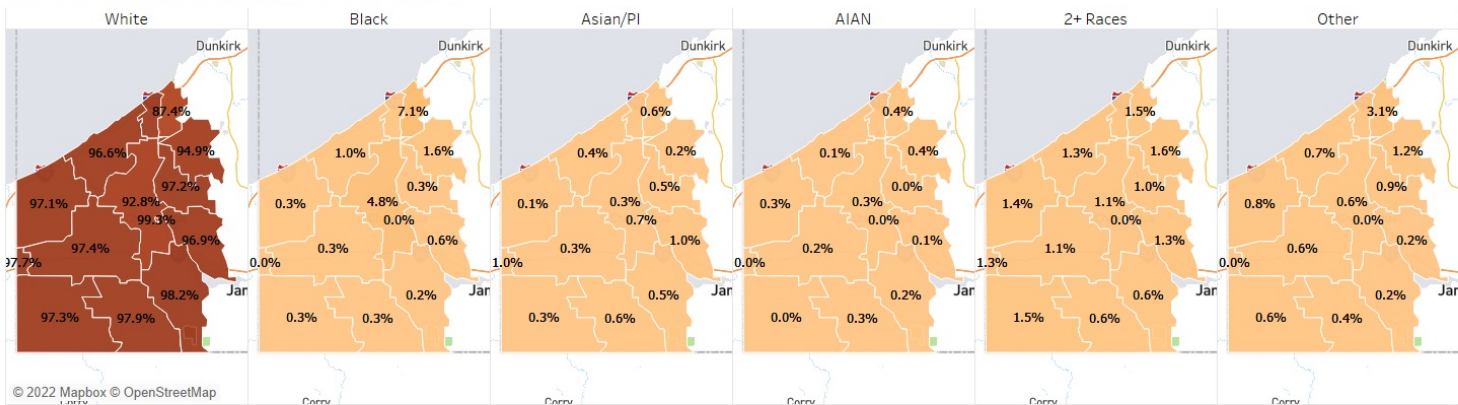
Population by Race

Service Area Current Population Percentage by Race



Identify high level population distribution by race

ZIP Code Current Population Percentage by Race



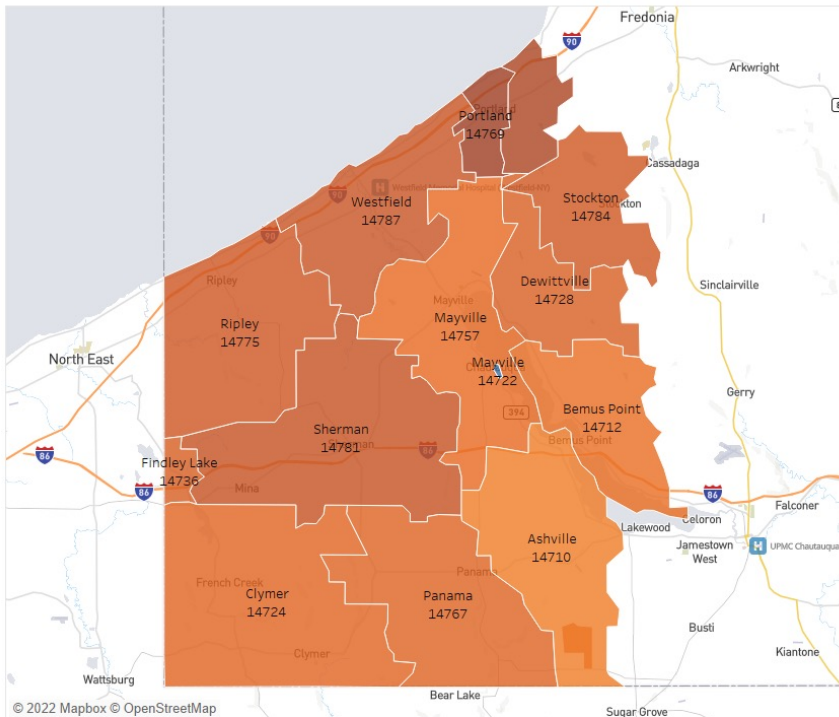
Source: IBM-Watson Health



Median Household Income

Median Household Income

Median Household Income by ZIP Code



Source: IBM-Watson Health

ZIP Code Median Household Income Detail

ZIP Name	ZIP Code	MHHI
Mayville	14722	\$103,125
	14757	\$55,303
Ashville	14710	\$59,461
Bemus Point	14712	\$56,552
Clymer	14724	\$54,052
Panama	14767	\$53,220
Dewittville	14728	\$52,174
Findley Lake	14736	\$51,500
Stockton	14784	\$49,595
Ripley	14775	\$49,309



X

- Service Area
- Westfield 75%
 - Westfield Additional

- ZIP Name
- Ashville
 - Bemus Point
 - Brocton
 - Clymer
 - Dewittville
 - Findley Lake
 - Mayville
 - Panama
 - Portland
 - Ripley
 - Sherman
 - Stockton
 - Westfield

Evaluate areas with higher and lower MHHI

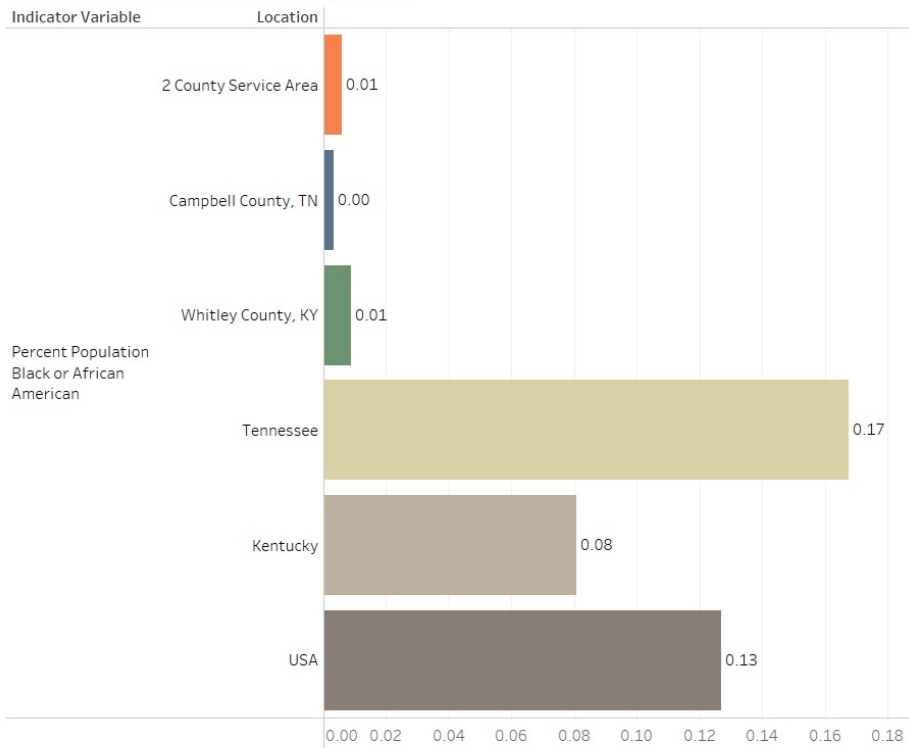
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X

Demographics

Demographics

Black or African American Population



Category

Demographics

Data Indicator

- Black or African American Population
- Citizenship Status
- Families with Children
- Female Population
- Foreign-Born Population
- Group Quarters Population
- Hispanic Population
- Male Population
- Median Age
- Migration Patterns - Total Population
- Migration Patterns - Young Adult
- Non-Hispanic White Population
- Population Age 0-4
- Population Age 5-17
- Population Age 18-24
- Population Age 18-64
- Population Age 25-34
- Population Age 35-44
- Population Age 45-54
- Population Age 55-64
- Population Age 65+
- Population Geographic Mobility
- Population in Limited English Households

Indicator Variable

All

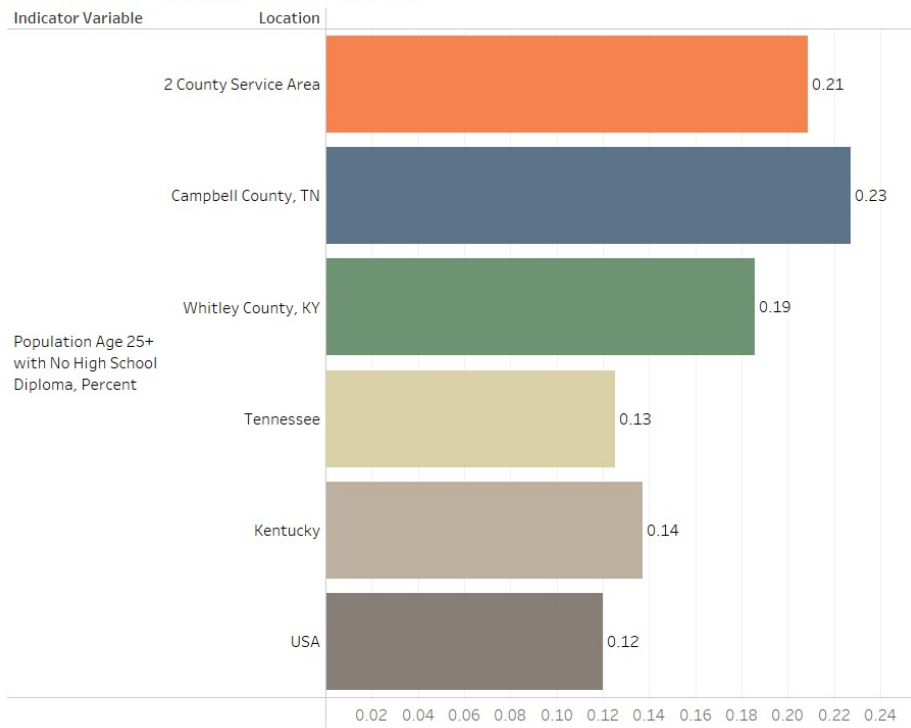
Multiple demographic categories are included

Data Source: US Census Bureau, American Community Survey, 2015-19. Source geography: Tract

Education

Education

Attainment - No High School Diploma



Note: This indicator is compared to the lowest state average. Data Source: US Census Bureau, American Community Survey, 2015-19. Source geography: Tract

Category
Education

Data Indicator

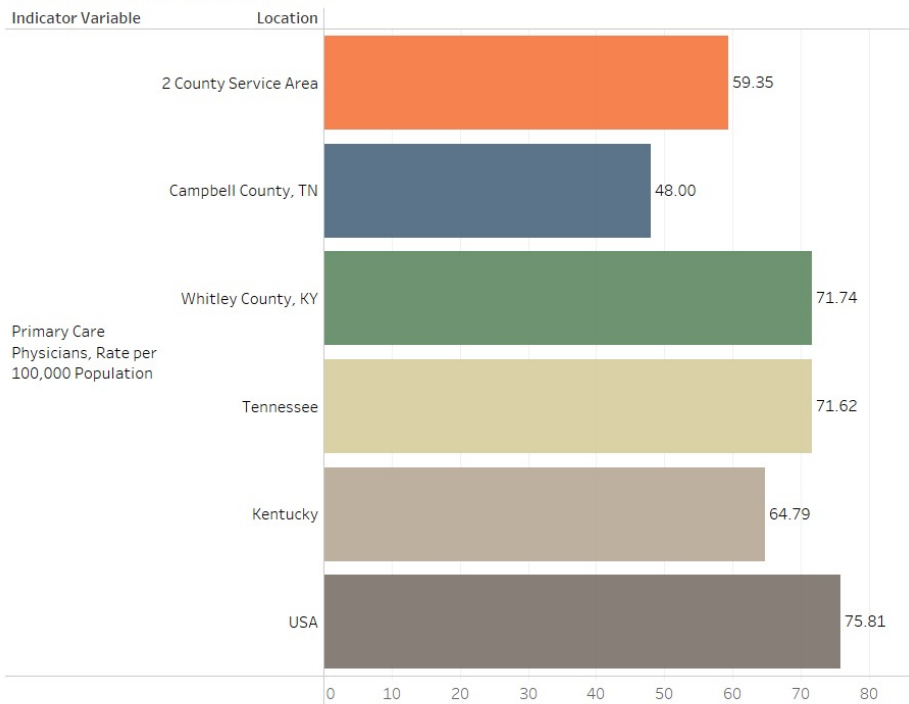
- Access - Head Start
- Access - Preschool Enrollment (Age 3-4)
- Attainment - Associate's Level Degree or Higher
- Attainment - Bachelor's Degree or Higher
- Attainment - High School Graduation Rate
- Attainment - No High School Diploma
- Attainment - Overview
- Attainment - Some Post-secondary Education
- Chronic Absence Rate
- Proficiency - Student Math Proficiency (4th Grade)
- Proficiency - Student Reading Proficiency (4th Grade)

Indicator Variable
All

Indicators highlight differences in educational attainment and proficiencies among the population

Healthcare Access

Healthcare Workforce Access to Care - Primary Care



Category
Healthcare Workforce

Data Indicator

- Access to Care - Addiction/Substance Abuse Providers
- Access to Care - Buprenorphine Providers
- Access to Care - Dental Health
- Access to Care - Dental Health Providers
- Access to Care - Mental Health
- Access to Care - Mental Health Providers
- Access to Care - Nurse Practitioners
- Access to Care - Primary Care
- Access to Care - Primary Care Providers
- Federally Qualified Health Centers
- Health Professional Shortage Areas - Dental Care
- Hospitals with Cardiac Rehabilitation Units
- Population Living in a Health Professional Shortage Area

Indicator Variable
All

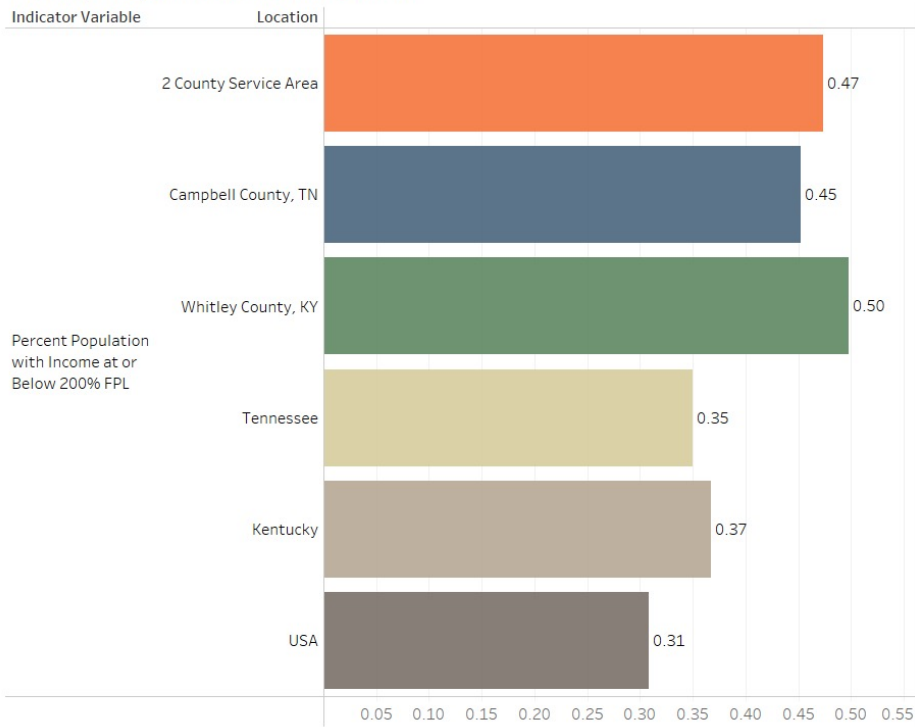
Healthcare access comparison to state and national averages spotlight disparities

Note: This indicator is compared to the highest state average. Data Source: US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Area Health Resource File. Accessed via County Health Rankings, 2017. Source geography: County

Income and Economics

Income and Economics

Poverty - Population Below 200% FPL



Category

Income and Economics

Data Indicator

- Commuter Travel Patterns - Driving Alone to Work
- Commuter Travel Patterns - Long Commute
- Commuter Travel Patterns - Overview
- Commuter Travel Patterns - Overview 2
- Commuter Travel Patterns - Public Transportation
- Commuter Travel Patterns - Walking or Biking
- Employment - Business Creation
- Employment - Employment Change
- Employment - Labor Force Participation Rate
- Employment - Unemployment Rate
- Gross Domestic Product (GDP)
- Income - Families Earning Over \$75,000
- Income - Income and AMI
- Income - Inequality (Atkinson Index)
- Income - Inequality (GINI Index)
- Income - Median Family Income
- Income - Median Household Income
- Income - Net Income of Farming Operations
- Income - Proprietor Employment and Income
- Income - Public Assistance Income
- Income - Transfer Payments
- Poverty - Children Below 100% FPL
- Poverty - Children Below 200% FPL

Indicator Variable

All

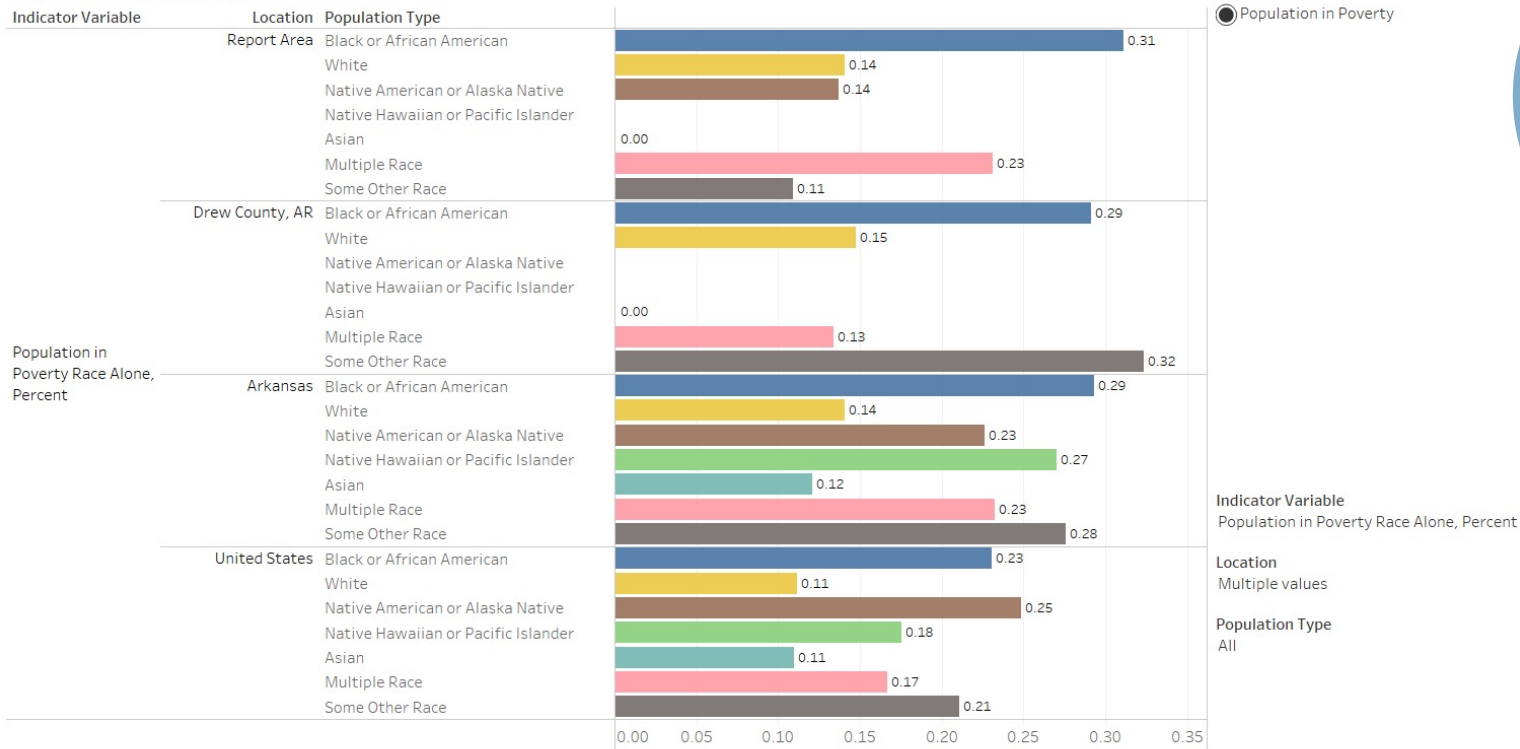
Poverty and other income indicators show the special economic obstacles a sizable portion of the population may be facing

Note: This indicator is compared to the lowest state average. Data Source: US Census Bureau, American Community Survey, 2015-19. Source geography: Tract

Race and Ethnicity

Income and Economics

Population in Poverty



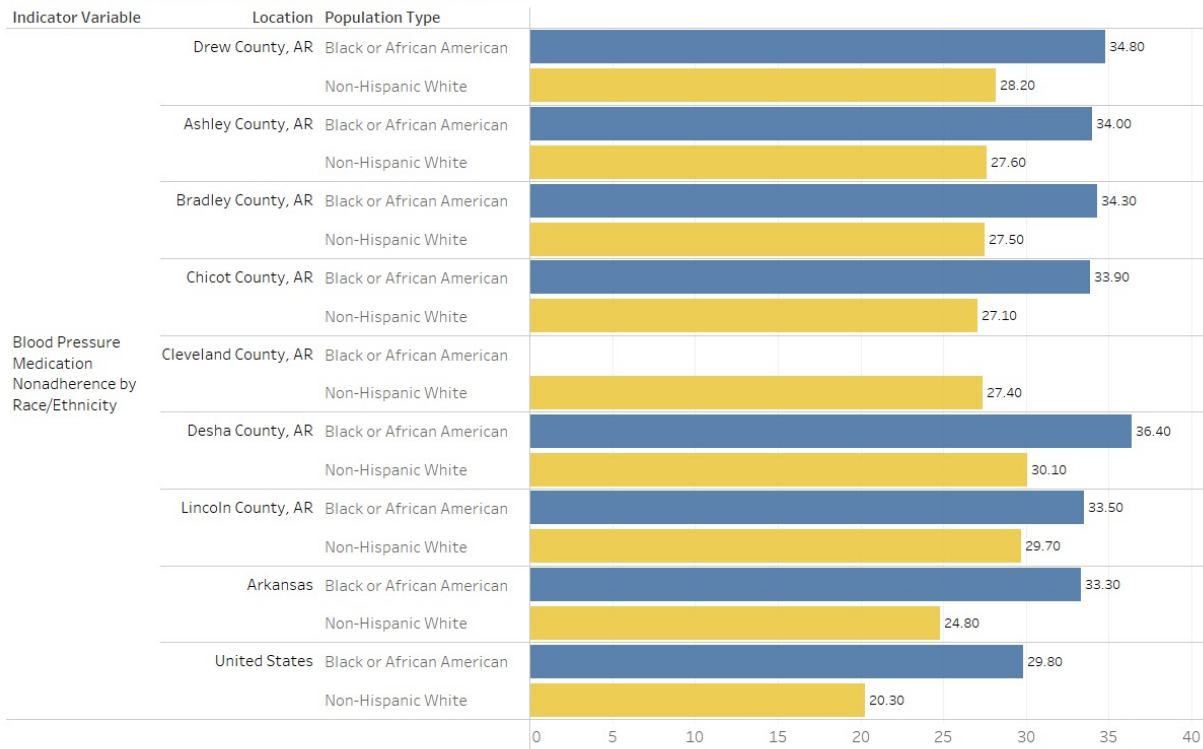
Detailed racial and ethnic economic indicators show disparities among the population

Null

Clinical Care and Prevention

Clinical Care and Prevention

Prevention - High Blood Pressure Management



Category
Clinical Care and Prevention

- Data Indicator
- Hospitalizations - Preventable Conditions
 - Prevention - Annual Wellness Exam (Medicare)
 - Prevention - High Blood Pressure Management
 - Prevention - Recent Primary Care Visit (Medicare)

Indicator Variable
All

Location
All

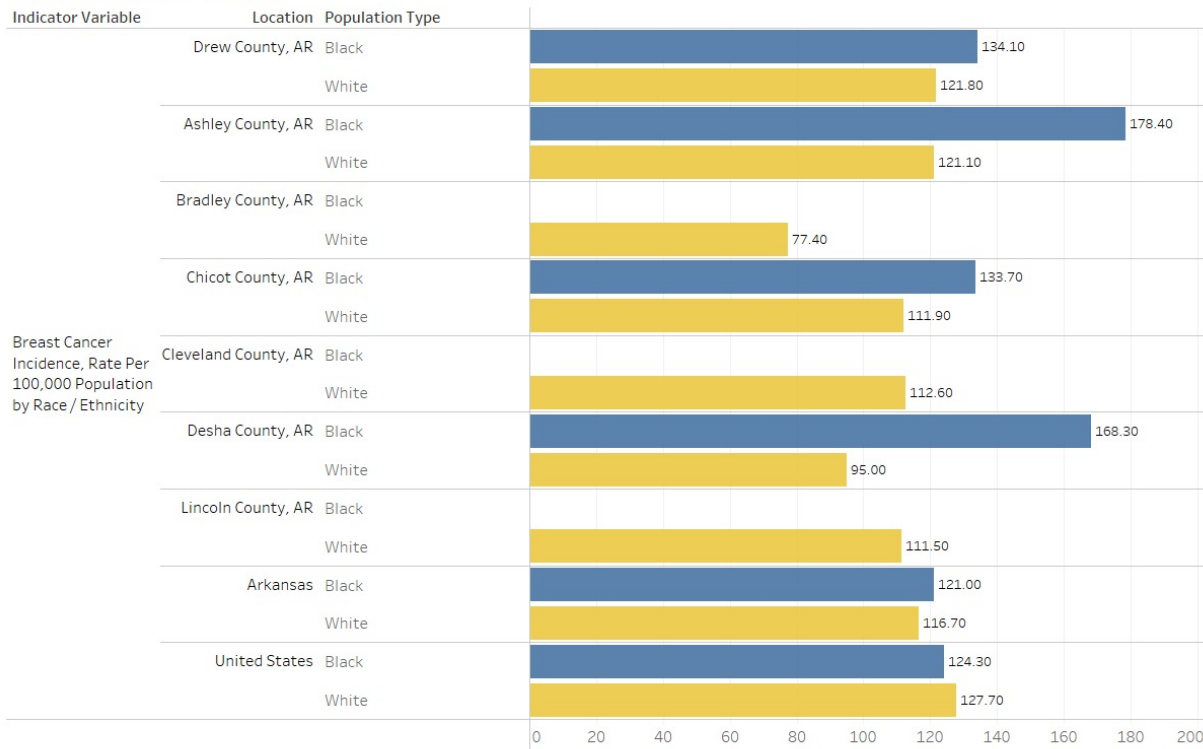
Population Type
All

Clinical care prevention detail shows gaps in racial and ethnic populations

Null

Health Outcomes

Health Outcomes Cancer Incidence - Breast



Category
Health Outcomes

Data Indicator

- Alcohol Use Disorder (Medicare Population)
- Cancer Incidence - All Sites
- Cancer Incidence - Breast
- Cancer Incidence - Colon and Rectum
- Cancer Incidence - Lung
- Cancer Incidence - Prostate
- Chronic Conditions - Asthma (Medicare Population)
- Chronic Conditions - Cancer (Medicare Population)
- Chronic Conditions - Kidney Disease (Medicare Population)
- Chronic Conditions - Chronic Obstructive Pulmonary Dise..
- Low Birth Weight (CDC)
- Mortality - Cancer
- Mortality - Coronary Heart Disease
- Mortality - Heart Disease
- Mortality - Infant Mortality (CDC)
- Mortality - Premature Death
- Mortality - Stroke
- Substance Use Disorder (Medicare Population)

Indicator Variable
All

Location
All

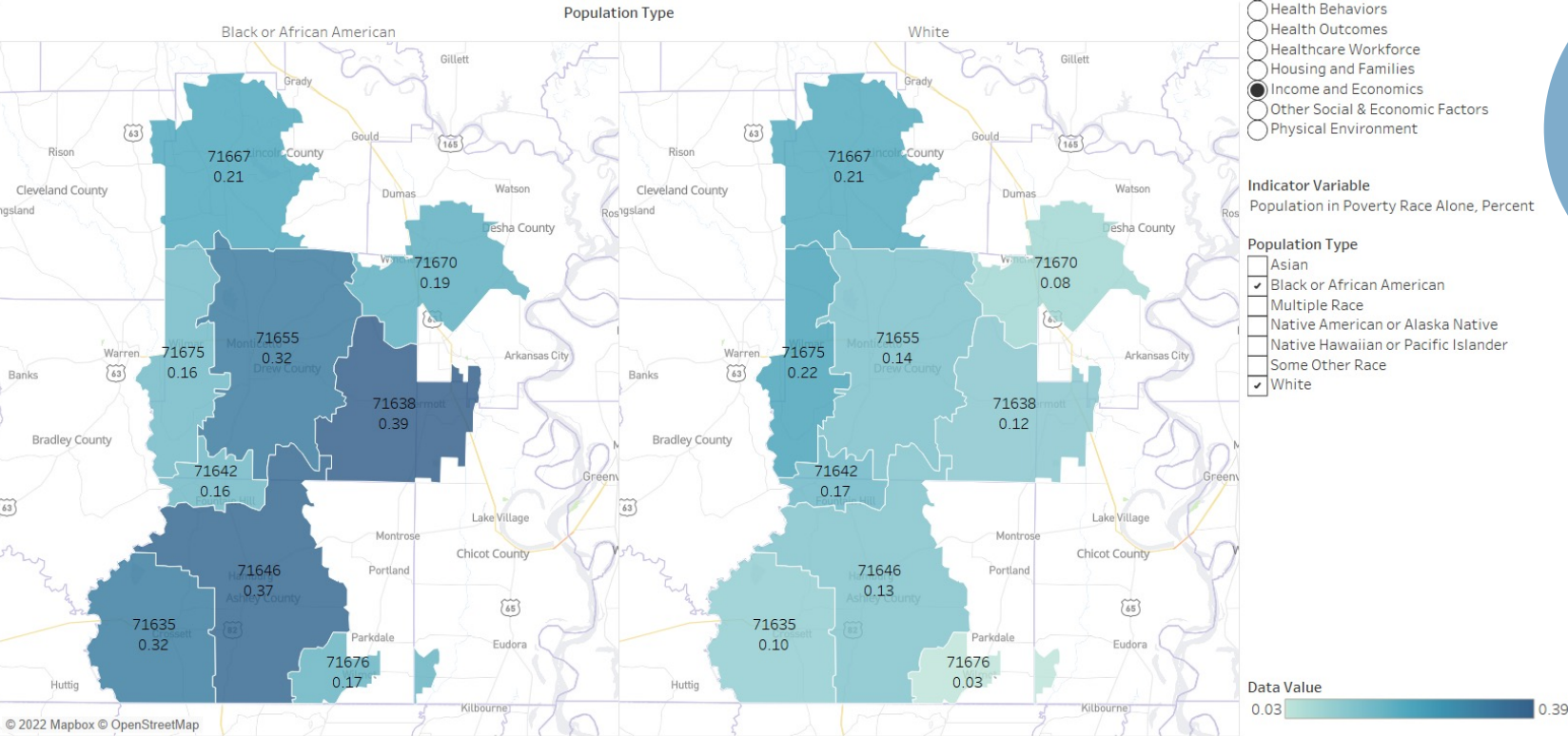
Population Type
All

Outcome differences among racial and ethnic populations can help steer population health strategies

Note: This indicator is compared to the lowest state average. Data Source: State Cancer Profiles. 2014-18. Source geography: County

ZIP Code Level Data

Income and Economics Population in Poverty Race Alone, Percent



- Category
- Clinical Care and Prevention
 - Demographics
 - Education
 - Health Behaviors
 - Health Outcomes
 - Healthcare Workforce
 - Housing and Families
 - Income and Economics
 - Other Social & Economic Factors
 - Physical Environment

Indicator Variable
Population in Poverty Race Alone, Percent

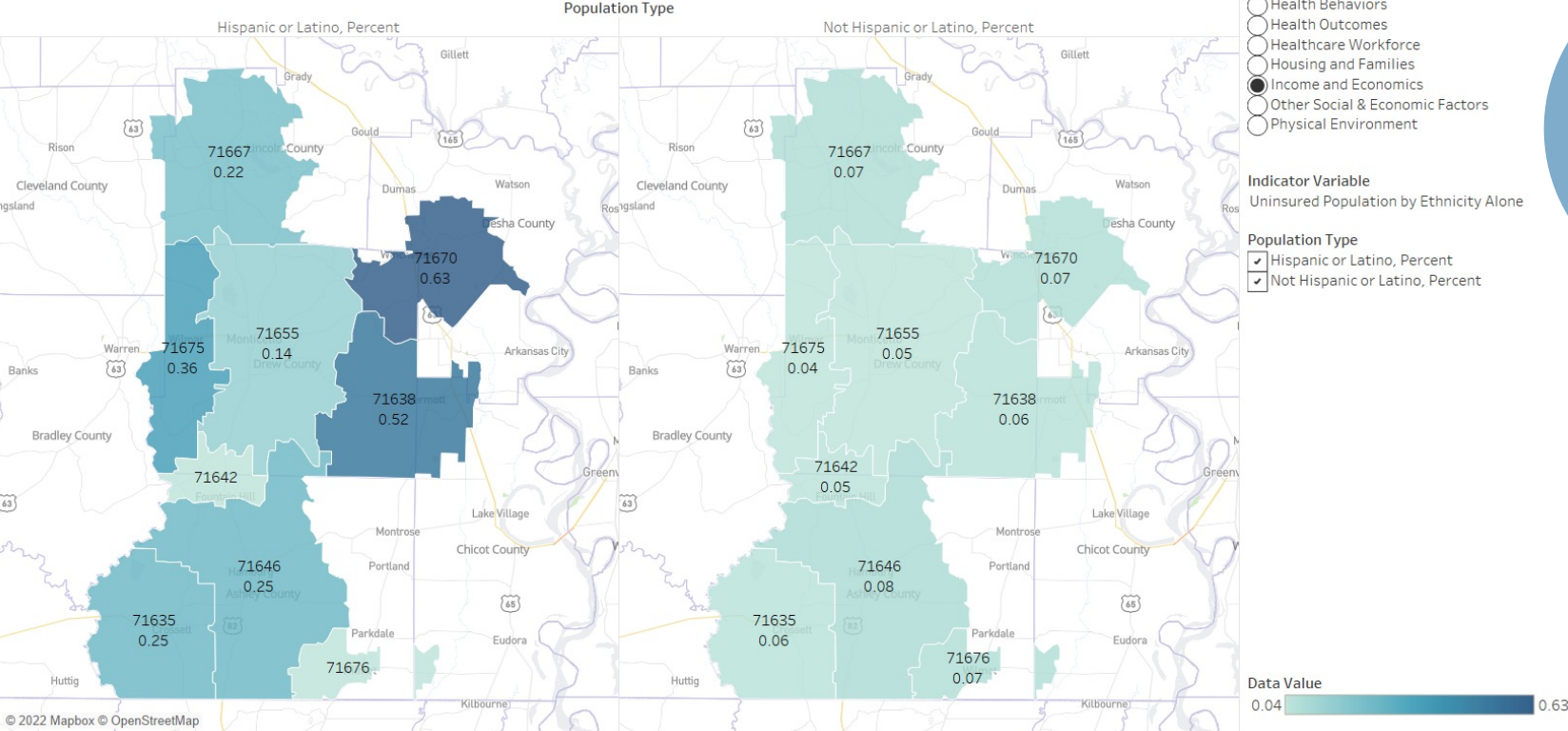
- Population Type
- Asian
 - Black or African American
 - Multiple Race
 - Native American or Alaska Native
 - Native Hawaiian or Pacific Islander
 - Some Other Race
 - White

Data Value
0.03 0.39

Certain indicators show racial/ethnic/socioeconomic detail at the ZIP Code level, which can help highlight geographic areas of focus for health providers

ZIP Code Level Data

Income and Economics Uninsured Population by Ethnicity Alone

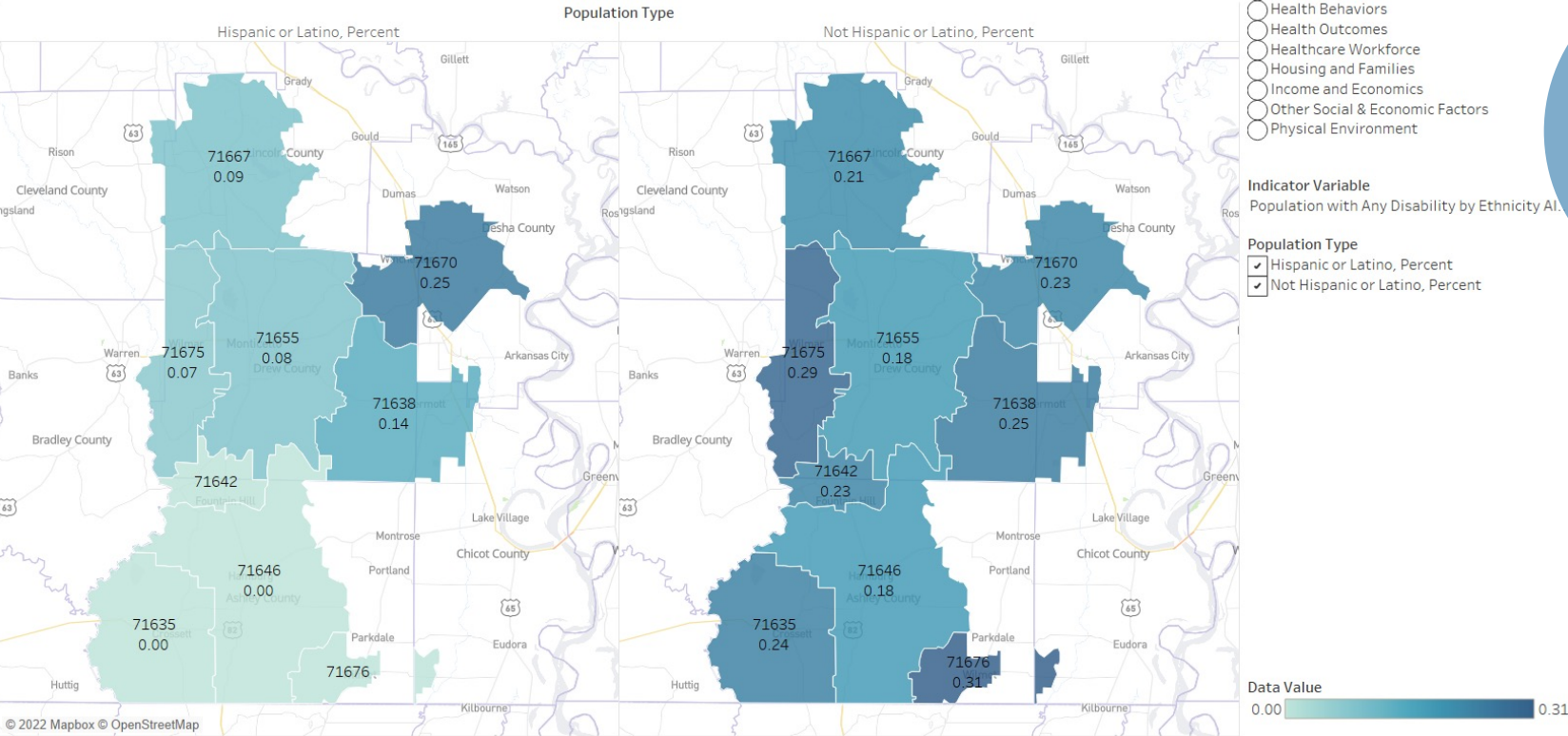


Certain indicators show racial/ethnic/socioeconomic detail at the ZIP Code level, which can help highlight geographic areas of focus for health providers

ZIP Code Level Data

Demographics

Population with Any Disability by Ethnicity Alone



Certain indicators show racial/ethnic/socioeconomic detail at the ZIP Code level, which can help highlight geographic areas of focus for health providers

Other Social and Economic Factors

Healthcare organization’s service area performs below State and National averages for the following factors:

Report Area	Total Population	Socioeconomic Theme Score	Household Composition Theme Score	Minority Status Theme Score	Housing & Transportation Theme Score	Social Vulnerability Index Score
Golden Valley	47,397	0.67	0.78	0.10	0.61	0.59
Bates County, MO	16,374	0.40	0.88	0.08	0.40	0.39
Benton County, MO	18,989	0.77	0.55	0.11	0.51	0.55
Camden County, MO	45,096	0.54	0.39	0.21	0.29	0.34
Cass County, MO	102,678	0.15	0.40	0.40	0.07	0.12
Henry County, MO	21,765	0.69	0.81	0.19	0.54	0.60
Hickory County, MO	9,368	0.77	0.52	0.35	0.12	0.47
Johnson County, MO	53,689	0.45	0.05	0.32	0.80	0.35
Pettis County, MO	42,371	0.71	0.88	0.67	0.64	0.80
St. Clair County, MO	9,383	0.64	0.79	0.05	0.47	0.50
Missouri	6,090,062	0.39	0.40	0.50	0.46	0.41
United States	322,903,030	0.30	0.32	0.76	0.62	0.40

The degree to which a community exhibits certain social conditions, including high poverty, low percentage of vehicle access, or crowded households, may affect that community’s ability to prevent human suffering and financial loss in the event of disaster. These factors describe a community’s social vulnerability.

The social vulnerability index is a measure of the degree of social vulnerability in counties and neighborhoods across the United States, where a higher score indicates higher vulnerability.

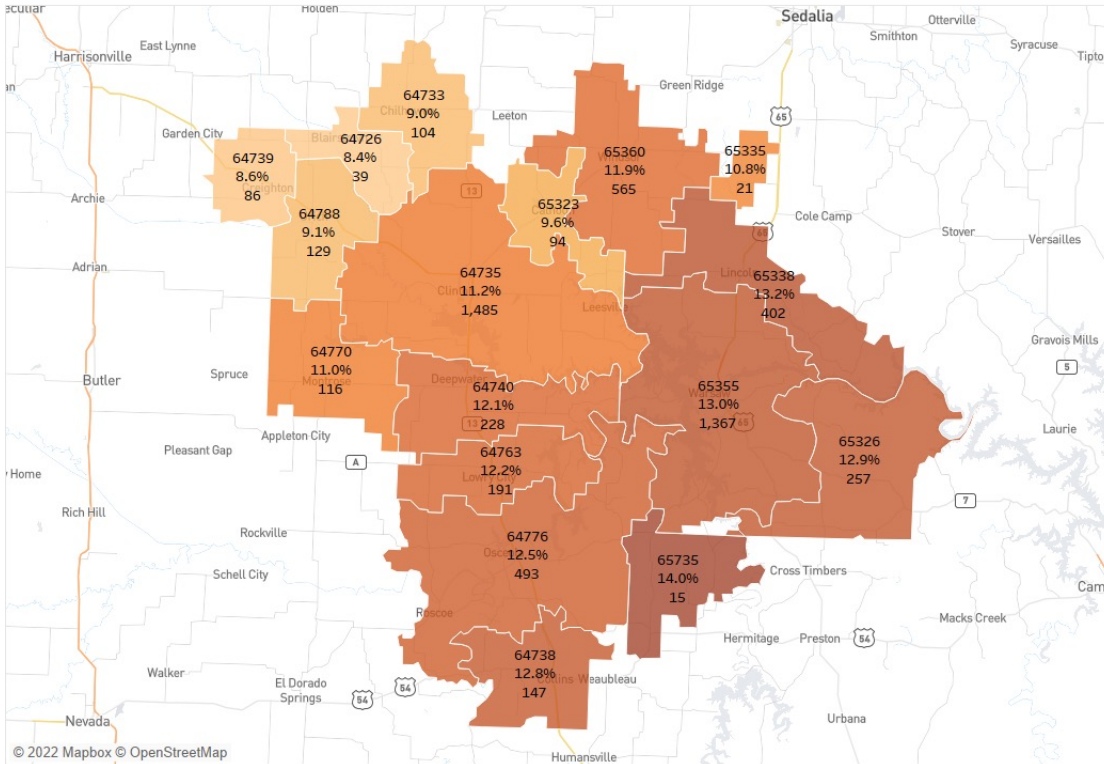
Chronic Disease Populations and Cost Estimates

- The CDC's PLACES: Local Data for Better Health, ZCTA Data 2021 estimates the incidence of 4 chronic disease-related health risk behaviors at the local geographic level
- The incidence rates, applied to the total population, give an estimate of the total number of people in the service area with the chronic condition
- Incidence rates and population are shown at the ZIP Code Tabulation Area (ZCTA) level
- **Multiplied by the average Medicare per capita cost for each chronic condition, an estimated total cost to treat a population within a service area is calculated**

COPD

Health Outcomes

Chronic obstructive pulmonary disease among adults aged >=18 years



Source: CDC PLACES 2021, CMS State/County Level Chronic Conditions Table, Stroudwater analysis

	COPD
National	\$27,255
Missouri	\$23,788
Benton	\$22,172
Cass	\$26,000
Henry	\$25,684
Hickory	\$22,918
Johnson	\$24,727
St. Clair	\$25,183
County Avg.	\$24,447

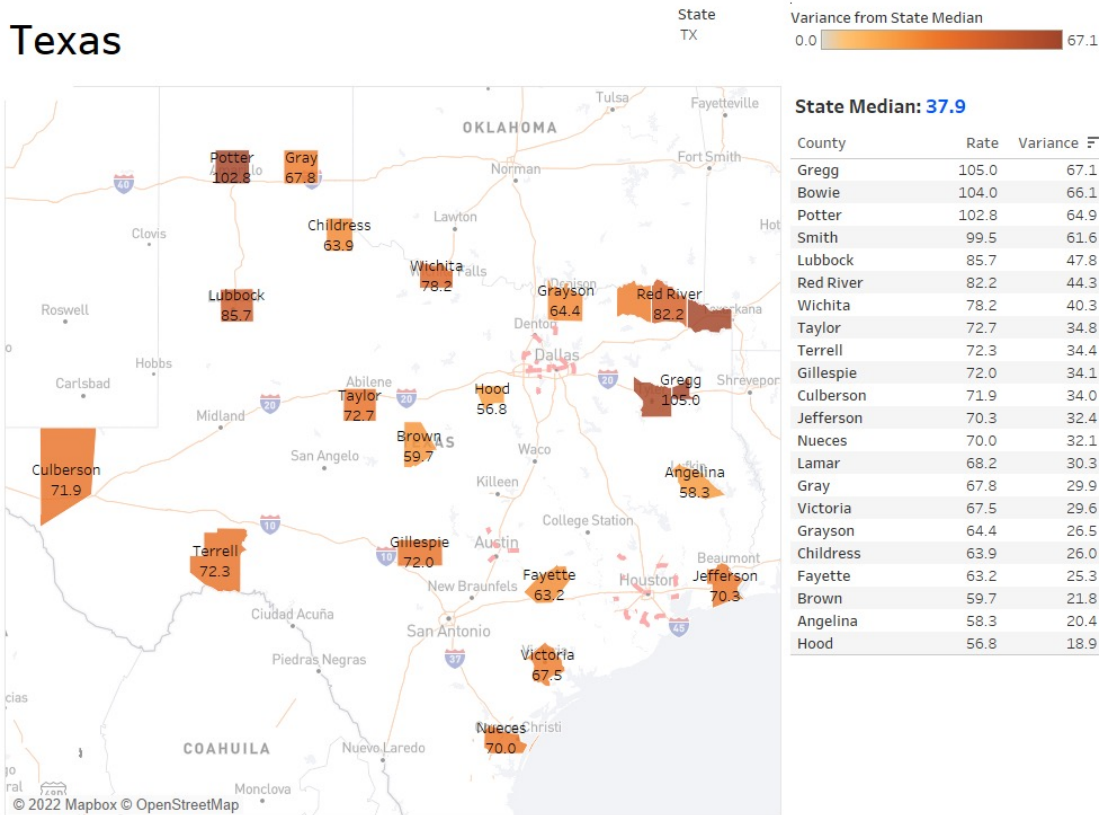
According to CDC prevalence estimates by ZCTA, the service area has over **5,700** adults afflicted with **COPD**.

With an average Medicare per capita cost of **\$24,447** (2018) for treating COPD, the estimated total service area spending to treat the disease is over **\$140 million**.

ZIP Code	Tabulation Area	Name	Est. Prevalence (%)	Total Population (Census)	Est. Population Affected	Est. Total Cost
64726		Blairtown	8.4	467	39	\$959,007
64733		Chilhowee	9.0	1,159	104	\$2,550,067
64735		Clinton	11.2	13,258	1,485	\$36,301,253
64738		Collins	12.8	1,149	147	\$3,595,469
64739		Creighton	8.6	997	86	\$2,096,135
64740		Deepwater	12.1	1,884	228	\$5,573,036
64763		Lowry City	12.2	1,568	191	\$4,676,613
64770		Montrose	11.0	1,056	116	\$2,839,764
64776		Osceola	12.5	3,942	493	\$12,046,259
64788		Urich	9.1	1,415	129	\$3,147,918
65323		Calhoun	9.6	976	94	\$2,290,586
65326		Edwards	12.9	1,996	257	\$6,294,711
65335		Ionia	10.8	196	21	\$517,494
65338		Lincoln	13.2	3,046	402	\$9,829,454
65355		Warsaw	13.0	10,519	1,367	\$33,430,539
65360		Windsor	11.9	4,752	565	\$13,824,485
65735		Quincy	14.0	110	15	\$376,484
Grand Total			8.4	48,490	5,741	\$140,349,274

County Opioid Prescribing Rates

Texas



- Texas state median for opioid prescribing rates are 37.9, which is below the US median of 43.3 per 100 people
- Counties that exceed the state median are shown. Baily and Lamb counties are below the state median.
- 2018 per capita spending on Drug Abuse and Substance Abuse averaged \$22,470 in the service area counties.

Drug Abuse/ Substance Abuse	
National	\$26,301
Texas	\$27,968
Bailey	\$25,609
Lamb	\$19,332
County Avg.	\$22,470

Includes the top 20% highest opioid dispensing counties in the United States in 2020. The 2020 U.S. median opioid dispensing rate was 43.3 per 100 persons. Source: CDC U.S. Opioid Dispensing Rates (<https://www.cdc.gov/drugoverdose/rxrate-maps/index.html>)

A large, light blue silhouette of a lighthouse tower is positioned on the left side of the page. It features a multi-tiered lantern room with a grid pattern and a small spire on top. The tower tapers slightly towards the bottom.

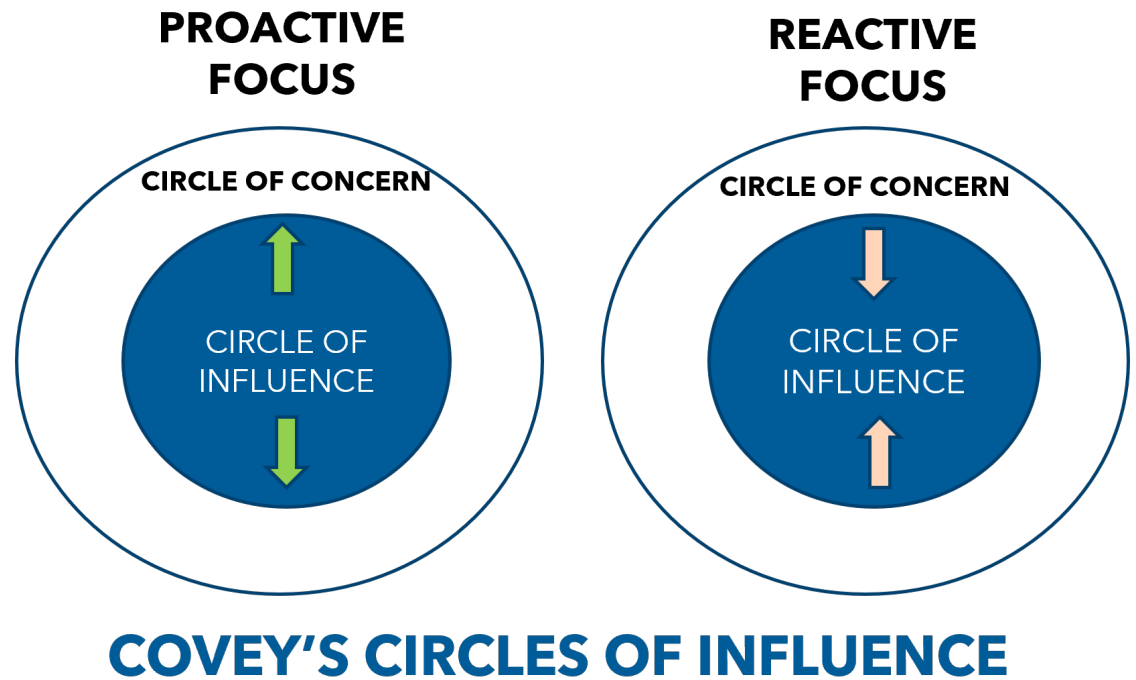
Health Equity Strategy

Health Equity & SDOH Strategy



Circle of Influence

- › Stephen Covey's book *The 7 Habits of Highly Effective People* (1989) distinguishes between proactive people – who focus on what they can do and can influence – and reactive people who focus their energy on things beyond their control.
- › **Circle of concern:** many of these things are outside your influence. Devoting energy on them may be a waste of time.
- › **Circle of influence:** includes the things we can do something about. The key is to focus your energy on those things that you can influence – this will enable you to make effective changes.
- › A team can have a wider circle of influence than an individual



Conclusion

COVID-19 raised public awareness of racial and ethnic disparities in health and health care to a new and uncomfortable level. Leading hospitals and health systems to use data to rectify long-standing problems in their communities.

Unless specifically measured, disparities in health and healthcare can go unnoticed even as stakeholders seek to improve healthcare. Closely examining stratified quality and health outcome data is the most reliable way to reveal the type and magnitude of disparity and then allocate or reallocate resources accordingly.



QUESTIONS?

