Vizient Member Networks

2024 compendium of strategies to advance health equity

Introduction

Intersections and ecosystems: These are guiding principles for how Vizient® approaches health equity. Without considering the matrix of impacts on a patient's health, from pollution and employment to transportation and nutrition, progress will be episodic and likely inequitable. This is why equity is built into everything Vizient does.

Recommendations and analysis from Sg2® and the Vizient Research Institute, for instance, consider impacts on disadvantaged populations so providers can make informed decisions. Supplier diversity and sustainability are a critical component of our environmental, social and governance work because the products you purchase and the air we breathe are intrinsically connected. The Vizient Clinical Data Base is consistently leveraged to identify examples of disparities, including through the patent-pending Vizient Vulnerability Index™, so providers have the information necessary to care for their entire community. Our networks, including the Diversity, Health Equity and Inclusion (DHEI) Network, bring leaders together to compare approaches to improving all aspects of equity to speed the adoption of leading practices and reduce variation in care.

The economics are clear: Working upstream to identify the underserved and improve their care is less expensive than simply focusing on who comes through the door of your health system. It's also a moral obligation.

Vizient will continue to expand our view of healthcare as an interconnected ecosystem and share with providers examples of how you can ensure every member of your community has a fair and just opportunity to achieve their highest level of health. In this compendium you'll find strategies, ideas and innovations that organizations have implemented to improve health equity in the communities they serve. We invite you to explore, adapt and adopt where you can and continue to share your successes and failures so we can all improve together.

The following examples from Vizient provider organizations across the country highlight strategies and interventions across three areas of intervention: **patients, people and community.**

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About Vizient Member Networks offering

The Vizient Member Networks offering connects more than 1,300 of the nation's top healthcare organizations and more than 18,500 executives and leaders through a proven offering to improve performance, advance the workforce and transform healthcare. Organizations that engage with Vizient networks, performance improvement and data outperform those that don't. That success is demonstrated by top performers in the Vizient Quality and Accountability Scorecard.

Organizational examples

Simple models for complex problems

Dartmouth Health's rural setting in northern New England creates some unique challenges in addressing social drivers of health, as there are fewer community assets like youth associations or ride-share services. But unjust variations in life expectancy and other disparities exist in this setting, too.

Simple models for complex problems help to create crisp communications that are easy for everyone in your organization and community to understand. Dartmouth Health uses two models. The first: "Our People (employees), Our Patients and Our Communities" describes the populations for population health efforts.

Our people—Equity begins with culture, the unspoken rules that shape values, beliefs, habits, patterns of thinking, behaviors and styles of communications. Each organization has a culture and subculture within teams/departments which is central to the delivery of care. It also influences patient beliefs, practices, attitudes toward caregivers and trust in the system. It shapes our interactions and natural preferences for how to resolve conflicts and how we view and (mis)interpret the behavior of others. It's essential to ask: Does the culture of your organization enable you to effectively address health disparities?

Our patients—Health systems need to design structures and processes to identify and address healthcare disparities in their patient populations. Embracing the ethos of "you can't manage what you don't measure," Dartmouth Health has focused on standard, high-quality data collection and reporting related to race, ethnicity, sexual orientation and gender identity and health-related social needs. It's vitally important to engage your community by communicating terms and why the organization is asking for this data. Dartmouth Health used the message, "We ask because we care" to support this effort and the overall message, "You belong here!"

Our communities—It's essential to have partners to address root causes of inequity. The health system is an important partner in convening the various pieces of the puzzle to set shared goals and build the capacity to work together. Explore innovative workforce options like mobile health teams, including community paramedics and nurses. Collaborate with community public health departments, visiting nurses associations and other organizations to address political determinants of health.

A second model Dartmouth Health uses to organize improvement efforts is the "stream" model: downstream (medical interventions/clinical setting), midstream (serving patients with health-related social needs through community connections) and upstream (community/political impact).

Working upstream, Dartmouth Health intentionally uses its long-term, place-based economic power and human capital to create changes that benefit their employees, patients and communities. These efforts are organized through anchor mission strategies. To build an enduring infrastructure for change, Dartmouth Health established the Center for Advancing Rural Health Equity to bring the academic community of research, education and clinical care together with community leaders.

The team goes all the way upstream and hosts a virtual learning forum to address political determinants of health. In partnership with advocacy groups across the state and Dartmouth Health's government relations, learning sessions discuss proposed state legislation to understand the potential impacts on health outcomes and health equity.

Source: Vizient Member Networks, DHEI April 2024 Meeting, Dartmouth Health

Patients

Acute care at home can be a unique fit for addressing social determinants of health

Challenge: Many patients have competing priorities when hospitalized in traditional brick-and-mortar settings. Parkland Health has a strong focus on health equity which helps drive the success of its Hospital at Home (HaH) program.

Intervention: The team used Vizient data to compare Parkland's experience with other providers, measure the success of its program and identify potential disparities related to HaH. While higher-reimbursement patients initially made up a significantly larger percentage of enrolled patients nationwide, analysis showed HaH enrollment for low-reimbursement patients surged after the COVID-19 health emergency, while enrollments for commercial insurance-covered patients declined. The team found it much more difficult to enroll commercially insured patients due to administrative burdens, making HaH uniquely successful for self-pay, charity and government-funded patients.

Nearly 92% of patients enrolled have a high or medium-high score on the Centers for Disease Control and Prevention Social Vulnerability Index and live in areas with a life expectancy 10–20 years lower than areas less than 10 miles away. The team found its HaH program enabled them to address social determinants of health for the same patients at the same time they were participating in the program, creating operational efficiencies and improved care.

Source: 2023 Vizient Connections Summit, Diversity, Health Equity and Inclusion peer-to-peer session, Parkland Health

Systemwide implementation of a social determinants of health program

Challenge: Screening is vital to identify social needs, provide resources and intervene so patients can optimize their health. At Northwestern Medicine, 60% of patients with a need don't reside in an under-resourced community, revealing that a universal (not geographically targeted) screening and response program is needed.

Intervention: With engaged leadership, clinicians and community health workers, Northwestern Medicine has screened more than 575,000 patients and responded to more than 42,000 patients who identified a need and requested support.

Source: 2023 Vizient Connections Summit, Diversity, Health Equity and Inclusion peer-to-peer session, Northwestern Medicine

Addressing racial and ethnic disparities through data quality enhancement

Challenge: Approximately one-quarter of the University of Utah Health patient population had their race, ancestry and ethnicity (RAE) coded as unknown/other, which was on par with the industry average, but creates a significant barrier to closing care gaps.

Race and country of origin options were expanded from 6 to 77 categories to better represent patients.

Intervention: A project was launched to address these barriers. Results of this work included expansion of six previous race categories to include 77 race and country of origin options, implementation of lessons learned from staff feedback related to perceived barriers and enhancements of patient race and ethnicity information within the medical record. In addition to getting 100% of Unknown/Other to make a specific RAE choice, 24% of "White" selections and 33% of "Native American" selections were updated to new options, which told the team they were on the right track. Staff were unaware of how beneficial additional training would be prior to the project rolling out and felt much more confident after new training, with self-reported comfort in asking questions increasing from 46% to 72%.

Source: 2023 Vizient Connections Summit, Diversity, Health Equity and Inclusion peer-to-peer session, University of Utah Health

Clinical trial equity: achieving representation and improving outcomes for all

Challenge: Clinical trials yield advances in treatment, and participation in clinical trials is correlated with improvements in survival through novel treatments. Yet Hispanic, Black and American Indian/Alaskan Native enrollments are drastically underrepresented in clinical trials. Access to care/location of trial is a leading reason Black patients are unable to participate in trials.

Intervention: Diversity and community engagement tend to be an afterthought and the facilities are difficult to reach with public transportation. When these factors, especially trust building in the community, are intentionally addressed during the design phase, enrollment equity is possible.

Source: 2023 Vizient Connections Summit, Diversity, Health Equity and Inclusion peer-to-peer session, The Ohio State University Wexner Medical Center, UConn Health

Vizient Member Networks Insight

Did you know that several organizations have expanded their race and ethnicity categories to more than 50 choices? Share your journey and learn from your peers by accessing the Diversity, Health Equity and Inclusion Community.

People

Diversity, equity and inclusion: the path to meeting a mission and building a workforce

Challenge: UCHealth, a Colorado-based academic health system of 30,000 employees, is using diversity, equity and inclusion (DEI) to reduce the gap between what the organization says about itself and the actual lived experience of staff, patients and the surrounding community. DEI is also an integral component supporting UCHealth in building a committed, competent workforce that reflects the communities it serves.

Intervention: A career support program was implemented with the mission of improving lives by building workforce. Since the implementation of this program, the organization has experienced an increase in number of applicants and also supports the demographic change of staff to reflect the community it serves. Meaningful metrics, the connection of DEI initiatives to organizational objectives and letting leaders go first to get buy-in are just a few of the insights gleaned since this program was launched.

Source: 2023 Vizient Connections Summit, Diversity, Health Equity and Inclusion peer-to-peer session, UC Health

What is the Vizient Vulnerability Index?

It characterizes neighborhood factors enabling organizations to quantify the impact of SDoH on their local communities

The patent-pending Vizient Vulnerability Index™ is a quantitative assessment of community social need factors that may influence a person's overall health. This index has been developed to characterize neighborhood factors that might influence a patient's access to healthcare. See page 18 for additional information.

Pairing the Vizient Vulnerability Index with workforce data

Applying neighborhood assessment of vulnerabilities to your workforce

Just as the Vizient Vulnerability Index has been used to identify neighborhood vulnerabilities in the patient population, the same assessment of neighborhoods can be applied to the workforce.

By collecting a limited data set on the workforce population of a healthcare organization, the neighborhoods in which your workforce lives can be assessed.

Example interventions from employers

- Dependent care
  - Employer funded debit cards for childcare
  - On-site subsidized childcare
- Food
  - Food bank for employees
  - Garden on property
  - Meals for employees to take home for family
  - Recovery of cafeteria food
- Housing
  - Discounted legal services to help with housing, safety or immigration needs.
  - Low or zero-interest forgivable loans, cash assistance (rental or home buyer)
  - Homebuyer financial education
  - Low-interest loans for property improvement
- Professional development and education
  - Education support for dependents of employees
  - Center for career development
  - Make uniforms, such as scrubs, readily available
  - Student loan and tuition repayment support
  - Apprenticeship initiatives

The path to health equity: understanding the organizational impact

Challenge: Healthcare organizations are challenged to use data to support executive decision-making. Opportunities exist to capture insights on how your workforce can affect health equity, strategies that can be implemented to better support the workforce and ultimately the outcomes of patients served in your community. Panelists came together and shared the following insights and recommendations.

- Finance won't be a driving force for change. It's up to clinical leaders to advocate for patients and communities.
- Many patients and providers are unaware of support resources in their communities. Consider creating a guide of organizations and resources to share with patients experiencing health disparities.
- Detailed data, down to a zip-code level, is needed to understand how socioeconomic indicators impact health outcomes. Every community can interrogate data with an equity lens to find differences in population and explore how those differences impact health.
- Focus on health equity improves morale by reconnecting providers to mission, passion and patient centered care.
- Data tools like the Vizient Vulnerability Index can provide detailed data that can help clinical leaders establish a health equity framework that uses dashboards, scorecards and metrics to make informed decisions and drive their teams to practice at the top of their license.

Source: Vizient Member Networks, Clinical Executive June 2023 Network Meeting, SSM Health, Cedars Sinai

Developing a diversity playbook

Challenge: An organization was challenged to advance diversity, equity and inclusion throughout their health system.

Intervention: Penn State Health shared their process to develop a diversity playbook, and how this playbook has been optimized to advance diversity, equity and inclusion throughout the system.

This organization encourages a culture of mutual respect and has adopted a zero-tolerance policy for racism, ending progressive discipline and activating an impressive Patient Bias Prevention Program. An Upstander Café is leveraged to discuss real scenarios in which problems with language and actions can be discussed in a safe environment. Applications to best employer ratings are used to motivate staff, establish goals/track progress and create some wow factor for the organization. Communication is, of course, key. Frequent touch points must be in place to ensure DHEI remains an integral part of an ongoing dialogue, with specific outreach for those who may not be committed.

Source: Vizient Member Networks, DHEI April 2023 Meeting, Penn State Health

Partnering with HBCUs to develop and diversify the future workforce

AtlantiCare and Cheyney University of Pennsylvania, the nation's first historically Black college or university (HBCU), have enhanced a partnership aimed at expanding student learning and career opportunities. The collaboration is increasingly strategic and intentional about creating a more diversified workforce that'll ultimately lead to greater health equity outcomes within the diverse communities.

Challenge: While the organization was achieving significant accolades for excellence in care, a marketing campaign for Magnet recognition revealed that their nursing staff was almost entirely White. This disparity isn't unique to Atlantic City. While Black Americans represent 13% of the total population, only 7.8% of nurses are Black.

Intervention: AtlantiCare collaborated with local high schools and Cheyney University to recruit high-performing students to enter the organization as techs and began a fully funded accelerated nursing degree program. The first four Cheney graduates enrolled are provided full tuition, housing, mentorship and an entry level position. They created pipelines and educational opportunities for additional clinical provider shortages, including respiratory, laboratory, social workers and internal medicine. The first three graduates who enrolled in respiratory therapy school at Thomas Jefferson University received full tuition, mentorship and apprenticeships. Students are also eligible for signing bonuses and assistance in purchasing a home. The team found the students had deficits of knowledge in health equity and health literacy and required ongoing assistance to be successful. They are now concentrating on growing the successful program.

Source: 2023 Vizient Connections Summit, Diversity, Health Equity and Inclusion peer-to-peer session, AtlantiCare

Community health worker models to improve health equity

Challenge: As organizations are challenged to meet the needs of patients with complex social needs, the community health worker (CHW) model provides an ideal point of contact to meet patients where they are in the community.

Intervention: Several organizations shared how they implemented a CHW model to improve health equity. Presenters shared that the innovative role of the CHW model can bring a new perspective to the clinical team, sharing insights and observations about living conditions and social situations.

- Main Line Health found that CHWs bring a new lens and fresh perspective that can help the clinical team, while also making direct observations about living conditions and social situations. Measures of success include primary care connections, resource connections via Connection to Community (C2C) powered by the Findhelp platform; addressing financial resource strain through health insurance enrollment, utility assistance and health system financial assistance applications; addressing transportation barriers through a partnership with local mass transit; and enrollment in the system's food delivery and produce programs. These efforts will result in improvements in patient experience and health outcomes.
- Currently, CHWs support cardiovascular, emergency department and cardio-obstetrics clinical teams. After successful implementation in these settings, the Main Line Health CHW model will expand into other clinical areas, including maternal health, hospital-to-home (H2H) transitions of care and colorectal screening outreach and education.
- The Center for Population Health Research and Main Line Performance Measures and Analytics is conducting an evaluation of the CHW model to determine whether, or the extent to which, the CHW model has an impact on hospital utilization and health outcomes.
- The outreach team at Northwestern Medicine is a group of CHWs, a social worker and nurses who provide short-term clinical and social support for patients. The portfolio of services includes SDoH follow-up, covering gaps in care, enabling transitions of care, including establishing a medical home and supporting the workforce pipeline. Northwestern has achieved an impressive engagement rate of 62.2% supporting more than 17,000 patients with nine full-time CHWs, one full-time social worker and 1.5 Registered Nurses. Escalation rates from the CHW back to the clinic or physician support are generally 0.4%, showing how well CHWs can handle identified needs.

Source: Vizient Member Networks, DHEI October 2023 Meeting, Main Line Health, Northwestern Medicine

Vizient Member Networks Insight

The CHW model is an achievable and effective model to connect with your community. Which model you use, where it reports and how it is funded will depend a lot on your organizational readiness.

Access this webinar to learn more about who the CHW is, why they are an ideal point of outreach for patients with complex social needs, and how health systems across the country are mobilizing for change.

Community

Successful partnerships drive innovation and improve community health

Challenge: As healthcare organizations continue to be challenged in supporting the health of the community, partnerships are being explored as an avenue to engage in community impact and support.

Intervention: UI Health shared how they leveraged public-private partnerships and other novel approaches to extend their reach, speed up innovation and change the way they conceptualize and address community health needs through formal collaboration.

- UI Health partners with JumpHire to provide soft skills employment training, stipend, childcare and meals. A high school internship program, CHAMPIONS, enrolls juniors and senior high school students from under-served communities in UI Health's primary service area into paid on-site summer healthcare internships for six weeks.
- Since 2017, UI Health has committed to housing via two primary programs:
  - Better Health Through Housing at UI Health has moved 90 unhoused patients to permanent scattered-site housing via a partnership with Centers for Health and Housing and an annual commitment of $350,000.
  - UI Health also contracts with The Boulevard to provide respite, transitional housing for unhoused patients being discharged from the hospital.
- Mile Square Health Center, UI Health's Federally Qualified Health Center, offers a dental assistant training program that's low cost and provides a pathway to hire.
- PRONTO is a collaboration with Kaizen Health to provide UI Health patients with post-discharge rideshares, regardless of payer. This promotes efficient discharges in addition to reducing transportation barriers.

Source: Vizient Member Networks, DHEI April 2023 Meeting, UI Health

Investing in high-social-need zip codes

Challenge: Using data from the Vizient Vulnerability Index (VVI), you can reliably demonstrate that zip codes with higher VVI scores (greater risk) are associated with significantly higher inpatient admissions and significantly lower utilization of surgeries. This correlation fits the narrative we've come to accept that more vulnerable neighborhoods have fewer resources, less preventative medicine and greater disparities, but now we can calculate the financial justification for investing in these communities.

Eleven procedures known to be under-represented in under-served neighborhoods were also found to be tightly correlated to high VVI scoring zip codes. The research revealed opportunities to provide needed care and increase revenue. View the recording and slides for more.

Intervention: There can be a tendency to pull back on health equity initiatives when urgent operational issues appear, but this research demonstrates social determinants of health are tightly correlated to inpatient utilization, and by directly addressing these issues in your communities with highest need, your organization would also be solving for those operational issues like capacity constraints.

Example: The presenters identified 11 procedures that are known to be under-represented in under-served neighborhoods and which are highly correlated to high VVI scoring zip codes, including CAR T Cell Therapy, electroconvulsive therapy, lobectomy and pneumonectomy, maintenance chemoradiotherapy, primary hip, knee and shoulder replacement, prostatectomy, revision high-replacement, surgical valve replacement and transcatheter valve procedures. Specifically, primary hip replacement use in these neighborhoods is 21% lower than in the average zip codes and 86% of that variation can be attributed to SDoH. Further, and perhaps surprisingly, the payer mix in these neighborhoods average approximately 50% commercial insurance and 40% government pay, creating a growth opportunity if you can capture the market before your competition.

Source: Vizient Member Networks, DHEI Network, December 2023

Social solutions: a focus on food and housing

Challenge: Food is medicine. Healthcare expenditures per person are more than $1,800 greater for those who are food insecure. In UC Davis' catchment area, 13.5% of the population is food insecure, higher than the state average.

Food insecure patients are 1.6 times more likely to have an ED visit or hospitalization.

Intervention: In identifying their target population, the team found food-insecure patients are 1.6 times more likely to have an ED visit or hospitalization; patients 65 and older are 1.7 times more likely to be food insecure; and older Hispanic, Black and American Indian patients are most likely to be food insecure.

Internal and external partnerships are essential to success and vary by location. Examples of community partnerships include community and regional farmer engagement, drive-through distributions, walk-up locations, The Emergency Food Assistance Program, The Commodity Supplemental Food Program, CalFresh assistance/enrollment, WIC assistance/enrollment and food delivery for elderly and medically fragile. The team also found it was incredibly important to acknowledge and understand cultural belonging and traditions to be successful.

Source: 2023 Vizient Connections Summit, Diversity, Health Equity and Inclusion peer-to-peer session, UC Davis

Vizient solutions

to support your health equity journey

Vizient Member Networks Diversity, Health Equity and Inclusion Network

The Diversity, Health Equity and Inclusion (DHEI) Network provides a forum for chief diversity officers, chief health equity officers and other executives with similar responsibilities to learn from each other, share experiences and to improve and influence belonging across the nation. Guided by a member Advisory Committee, the network concentrates on both the healthcare experience for patients to ensure equity in access, treatment and outcomes, and strategies for attracting and retaining diverse talent to build inclusive work environments. Participants gather through in-person and virtual meetings and collaboration online through the DHEI Community. View the network fact sheet to learn more.

Health equity and clinical outcomes correlation: developing the Vizient DHEI maturity model

In close collaboration with the Diversity, Health Equity and Inclusion Network, Vizient is developing an evidence-based maturity model and outcomes correlation analysis to encourage a point of view on the most effective ways to address health equity. The Vizient working hypothesis is that providers that commit to workplace culture and care delivery focused on diversity, health equity and inclusion have better patient outcomes.

The Vizient Diversity, Health Equity and Inclusion Maturity Model project aims to:

- Identify key characteristics and commonalities among the best performing organizations in the nation to inform a maturity model from which other providers can learn
- Benchmark member maturity to identify areas of opportunity and alignment
- Correlate culture/operations to patient outcomes to establish best practices and their impact on patient care
- Increase the speed of improvement through Vizient Member Networks and analytics

The maturity model is available now on request. Insights from the benchmarking survey will be available in 4Q2024, and the correlation analysis should be complete in 1Q2025.

DHEI Domains	Maturity Levels			
	Comply and Activate	**Address**	**Align**	**Anchor**
Governance and Leadership **Quality, Analytics and Outcomes** **Culturally Responsive Care** **Workforce Diversity Development** **Community Wellbeing and Partnerships**	Organizations must comply with many laws, regulations and accrediting body standards related to these domains which are not comprehensively listed here. Additionally, organizations expend significant effort to activate DHEI strategies through preliminary investigation, coalition building and developing capabilities.	This early work goes above and beyond compliance requirements and activation utilizing data to create a vision and build a foundation for DHEI as a way of doing business.	Maturity builds through internal and external collaboration with shared goals, engraining DHEI in the organization's culture and decision making.	The highest level of maturity focuses on structural- and systemic-level influences. In close partnership with the community, the organization leverages its power as an economic engine to drive sustainable change and mitigate upstream inequities.

ESG Impact Spend Program

- The Vizient Environmental, Social and Governance (ESG) Impact Spend Program helps Vizient, healthcare providers and suppliers grow sustainably and responsibly. It does this by incorporating ESG principles into buying and operational choices, improving performance, value and societal impact.
- Environmental sustainability program—Vizient employs solutions and insights to help providers reduce negative human and environmental health impacts. Examples include sustainability data available at the product purchasing level, the Environmentally Preferred Purchasing Dashboard and the Environmental Sustainability Roadmap.
- Supplier diversity program—supports providers' inclusion and use of diverse suppliers, resulting in economic development and healthier populations in all communities. We offer an Access level with data and analytics as well as a comprehensive portfolio of diverse suppliers to benefit all providers, and a Premium Platform for providers who want enhanced support.

Vizient Resource Stewardship/Fee-for-Service Offerings

- **Community Contracting**
  By implementing a local, community contracting program staffed by Vizient, providers can leverage their purchasing power by directing spend to local, diverse suppliers who in turn hire from the community, provide livable wages, health insurance and create jobs, creating a lasting, positive economic impact.
- **Supplier Diversity Advisory and Resource Services**
  Vizient Supplier Diversity Advisory Services are designed to help providers with the enhancement or implementation of their supplier diversity program through an engagement with a dedicated expert consultant. For organizations that lack a dedicated supplier diversity resource, Vizient offers a dedicated subject matter expert resource, delivering a customized approach to achieve diverse supplier identification, visibility and engagement, contract execution and utilization, and growth of diverse supplier spend.
- **Climate Performance Solutions**
  Through Climate Performance Solutions, we offer a comprehensive approach to integrate sustainability from greenhouse gas assessments to accelerating full-scale climate performance management via an all-in-one platform dedicated to providers and suppliers who want to measure, manage and reduce their CO2 emissions via the ADEME (French Agency for Ecological Transition) or GHG (greenhouse gas) Protocol methodology.
- **Environmentally Preferred Advisory Solutions**
  Through the Environmentally Preferred Advisory Solution, Vizient offers a comprehensive approach to integrating sustainable business practices. The offering is built to match a health system's needs and can cover anything from environmental data and analytics to an environmentally preferred contracting portfolio with customized advisory solutions.

Visit the ESG Impact Spend site for more information.

Vizient Vulnerability Index

The Vizient Vulnerability Index identifies social needs and obstacles to care in neighborhoods that may influence a person's overall health. The index—which is publicly available—integrates data from various sources to provide deeper insights regarding community needs across nine domains (shown in the sidebar) and the overall vulnerability index for each census tract and zip code across the United States. The index is even more insightful when combined with the Vizient Clinical Data Base (CDB), a repository of patient outcomes data from over 1,100 Vizient provider hospitals that includes more than 135 million distinct patients of all ages and payer groups.

Unlike other indices, the Vizient Vulnerability Index flexes to ensure the index values are location-appropriate. Other indices have a single index algorithm for the whole country, while the Vizient Vulnerability Index adapts to the local relevance of each domain as it correlates to life expectancy. This allows for variation in the weighting of the domains across different geographic areas depending on what's important — the most relevant factors affecting health in Lincoln, Nebraska, might not be the most relevant in New York City. Learn more.

Domains

- Economic
- Education
- Healthcare access
- Neighborhood resources
- Housing
- Clean environment
- Social environment
- Transportation
- Public safety

Related resources

Learn more about Vizient's approach to leveraging data and insights to evaluate and reduce disparities. Additional resources include:

- Vizient Member Networks Offering guide
- Performance Improvement Collaboratives Fact Sheet
- Health Equity Measurement workshop series enrollment
- Executive guidebook: a comprehensive guide on leveraging data to support and engage your workforce
- Novant CHW blog post

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