Health Care Transformation Task Force

Partners in Promoting Value

PROVIDER STRATEGIES FOR ADVANCING HEALTH EQUITY THROUGH VALUE-BASED CARE

The Health Care Transformation Task Force (HCTTF) has advocated for health equity as a foundational principle of delivery system transformation since the organization was founded in 2014. Health and health care are central to each person's ability to live well and should not be dependent on a person's socioeconomic status or identity – whether racial, ethnic, linguistic, or based on sexual orientation or gender identity. Addressing disparities in health care access, quality, and outcomes is a moral imperative. It is also a smart business decision – preventing disease and avoiding emergencies saves money. Health care providers are uniquely positioned to address health disparities in the care they deliver to patients and the way they engage in their communities. Value-based care (VBC) arrangements can support this work by financially rewarding high-quality care and providing flexible funding that supports innovative care delivery methods.

This resource presents eight case studies of provider organizations that are operationalizing health equity initiatives. It is a companion to the HCTTF resource on payer health equity strategies. This resource builds upon previous HCTTF health equity work, including the Raising the Bar framework that establishes foundational health equity principles for health care organizations, as well as the Health Equity Business Case, which offers practical information on how to engage leadership in health equity investments. In addition, this resource draws on the Health Care Payment Learning and Action Network's theoretical framework describing how VBC can support health equity through care delivery redesign, performance measurement, and payment incentives. Collectively, these resources support health care organizations as they operationalize their health equity goals.

KEY HEALTH EQUITY STRATEGIES FOR PROVIDERS

The case studies in this resource demonstrate how providers are operationalizing health equity initiatives through: (1) the clinical care delivered to patients, (2) performance measurement and incentives, and (3) partnerships with community members and organizations. For example, many large provider organizations incorporate health equity into their internal operations and engagement with the community, as well as through the clinical care they deliver. Other organizations have developed targeted interventions to identify and address the needs of high-risk patients, based on both clinical and social risks.

The providers highlighted in this resource include several large health care systems –Sentara Health, Trinity Health and the Cleveland Clinic – that deliver integrated primary, specialty and tertiary care across numerous markets. The resource also includes Sun River Health, a Federally Qualified Health Center (FQHC), which delivers integrated primary care and behavioral health. In addition, the resource highlights organizations that partner with other providers to take on VBC arrangements – such as agelon health, Aledade, PSW and Premier – offering support on care delivery transformation, financial risk, and analytics.

Clinical Care

The delivery of high-quality clinical care is a central focus for all the provider organizations in this resource. Clinicians in each organization strive to engage patients in person-centered care that is culturally and linguistically appropriate. Each organization measures quality and stratifies their performance by key demographic variables to identify and close gaps. As illustrated in the case studies, the details on how this care is delivered depends on the organization type and the market(s) where they operate. For example, providers are striving to remove racial bias from clinical algorithms that influence organ transplant for patients with chronic kidney disease. Providers are also working with communities to identify and address the root causes of disparities in maternal health and colon cancer. Many providers also invest in equity by hiring care managers, social workers, community health workers (CHWs), and medical translators to supplement care delivery.

The organizations in this resource support this clinical work to advance health equity through leadership commitment, staff hiring and training practices, and in ongoing investments in the people and infrastructure needed to operationalize health equity initiatives. Each provider highlighted here funds these initiatives as a core part of their clinical operations, with supplemental funding in some cases from specific VBC models or grants. While many have used a specific VBC program as an entry point to pilot equity initiatives, all seek to instill the principles of health equity beyond a single VBC arrangement or patient population. Thus, the incorporation of equity into clinical care is generally not limited to specific patient groups but informs the care for all of the provider's patients.

Performance Measurement & Incentives

Each organization highlighted here is heavily invested in VBC models, creating a direct tie between the quality of care they deliver and their financial performance. For the large health systems and regional providers, VBC arrangements comprise a meaningful share of their operations, although a significant portion of their funding continues to come through traditional fee-for-service payments. However, several of these providers are exclusively funded through VBC arrangements, meaning all their revenue is at financial risk based on quality outcomes, as well as financial performance.

All of these provider organizations seek to measure disparities within their patient populations and incentivize the closure of these clinical care gaps. For providers that take on VBC risk, this creates organizational incentives to close gaps for critical populations. Many organizations also establish incentives for clinicians to close these gaps, for example by tying health equity measures to compensation for employed clinicians.

To identify gaps, organizations require data on patients' demographics – such as race, ethnicity, language, sexual orientation, and gender identity – as well as patient-level health related social needs (HRSNs). HRSNs include concerns related to food, housing, transportation, utility needs, and interpersonal safety. Many organizations are collecting patient-level data at the point of care, which is integrated into the electronic health record (EHR) to inform clinical care and algorithms that assess patients' clinical and social risks.

While these data elements are often collected together, it is critical to distinguish between them. Demographic factors relate to core elements of a patient's identity. These demographic factors are not themselves risk factors but can result in health disparities due to structural racism and other forms of systemic oppression. In contrast, HRSNs represent a patient-level need that is not part of the patient's identity, but HRSNs may be correlated with equity issues. Provider organizations that engage in health equity work typically stratify quality measures using all the data they have – including both demographics and HRSNs – to identify and close gaps.

In cases where providers do not collect these data – or if it is collected but not integrated into the EHR in a machine-readable format – provider organizations draw on other data sources. For example, most organizations draw on claims for patients treated through VBC arrangements to assess clinical and social risk, with factors such as dual eligibility and low-income subsidy status used as proxies for social risk. Some organizations also use validated geographic-based measures like the Area Deprivation Index (ADI) and/or Social Vulnerability Index (SVI), while others purchase proprietary data sets with proxy demographic data. Most organizations featured in this resource combine all available data into algorithms that assess individual patients' clinical and social risks, flag those risks for clinicians, and identify available programs and resources to address any clinical care gaps or HRSNs.

Community Partnerships

Each provider organization in this resource partners with community-based organizations (CBOs) to address patients' HRSNs. Some organizations also have internal resources to support patients directly – such as care managers, social workers, and CHWs – but all recognized the importance of developing referral networks to CBOs to extend their reach. These organizations also work on tracking referrals to ensure that the patient gets connected to the services they need. Several organizations achieve this by using software platforms like Unite Us. In cases where that technology is unavailable, care managers follow up individually with each patient until they confirm that the referral loop is closed.

Many providers have spent years developing and strengthening partnerships with CBOs. This is particularly true for organizations with deep roots in specific communities, such as the health systems and FQHC highlighted here. These organizations seek to support local CBOs to expand their capacity, such as by giving grants or offering low-interest loans.

Many provider organizations seek to increase trust among patients and communities. These efforts go beyond CBO partnerships to include involvement in community events organized by faith-based organizations, listening sessions with community members, and grantmaking to community organizations outside of traditional health care (e.g., back to school drives). Providers have also built clinics in historically underserved communities and have invested in mobile clinics to bring primary care and preventive services to specific neighborhoods or events. In addition, providers recognize the opportunities as a large employer, to hire local people and contract with local businesses that reflect the diversity of their communities. Collectively, these efforts are intended to build trust with and uplift their neighbors.

LOOKING FORWARD

Health equity efforts require long-term organizational commitments to identify and address disparities in access, quality, and outcomes. The case studies highlight efforts at eight organizations that have invested in health equity, representing a snapshot in time. As organizations obtain more data and experience, they intend to build on this work moving forward. Due to the intersectionality of this work, key opportunities include deeper partnerships with CBOs, broader deployment of patient-reported outcomes and experience measures, and efforts to address affordability for patients.

Established in 2014, the Health Care Transformation Task Force brings together patients, payers, providers, and purchaser representatives to act as a private sector driver, coordinator, and facilitator of delivery system transformation. In addition to serving as a resource and shared learnings convener for members, the Task Force is also a leading public voice on value-based payment and care delivery transformation.

CASE STUDIES

Sun River Health

Founded in 1975 by four African American women, Sun River Health is a not-for-profit, New York State licensed network of nearly 50 FQHCs. The organization delivers culturally sensitive, linguistically appropriate, full life cycle primary, preventative, behavioral and oral health care, providing services to medically underserved populations throughout the Hudson Valley, New York City, and Long Island. Sun River Health prides itself on delivering high-quality, affordable care to those who need it most regardless of race, religion, income, or insurance status.

The founders of Sun River Health recognized the health center model as one that empowered communities to establish and direct health services at the local level via patient-governing boards. This means that health centers are led and guided by the people and communities they serve. Health centers engage their patients in producing accessible, high-quality care that yields compounding benefits for communities through health, wellness, engagement, and empowerment.

Sun River Health renewed its commitment to equity in the wake of George Floyd's murder in 2020, with the adaptation of strategies that influence their internal operations, clinical care delivery, and collaboration with the broader community. While Sun River Health is heavily invested in VBC, the organization's work in health equity goes beyond these contracts to encompass all patients.

Sun River Health's Justice Equity Diversity & Inclusion (JEDI) journey began with establishing a shared purpose and commitment to continuously fostering an environment that promotes diversity and inclusion in all its forms, across gender, race, religion, sexual orientation, disability, ethnicity and background. Sun River Health began deliberately focusing on anti-racist practices as a result of the Undoing Racism training provided by the People's Institute for Survival and Beyond. The training helped provide an understanding of the history of race and racism in the United States and a language related to anti-racist practices. Additionally, Sun River Health worked to operationalize equity through a deep understanding of the root causes underlying the disparities that exist in the organization. Working with Equity & Results to learn and implement the Antiracist Results-Based Accountability methodology, the

organization has incorporated equity within its key performance indicators and developed work plans to support these efforts.

As part of the clinical care it delivers, Sun River Health actively works to identify and address disparities in access and quality of care. To identify these gaps, Sun River Health collects patient-reported data on race, ethnicity, sexual orientation, and gender identity as part of the patient registration process. The organization focuses on educating both patients and staff about how this data helps ensure cultural competency and responsiveness.

Sun River Health seeks to center patient voices by working directly with patients to solicit feedback. For example, Sun River Health worked with patients to determine that disparities in maternal health outcomes were driven in part due to HRSNs, which at times impeded a patient's ability to attend prenatal and post-partum visits. To help mitigate these constraints, the organization provided patients with remote blood pressure monitors, which helped them monitor and treat preeclampsia to improve maternal health outcomes.

Sun River Health also focuses on addressing HRSNs in the community. Through its foundation, the organization seeks to address community needs including food insecurity, housing, and transportation. The organization also partners with CBOs to address HRSNs for their patients. Sun River Health uses the platform Unite Us at many of its health centers to refer patients electronically to CBOs that can address identified HRSNs. Through this platform, staff can track referrals and close the loop electronically.

Sentara Health

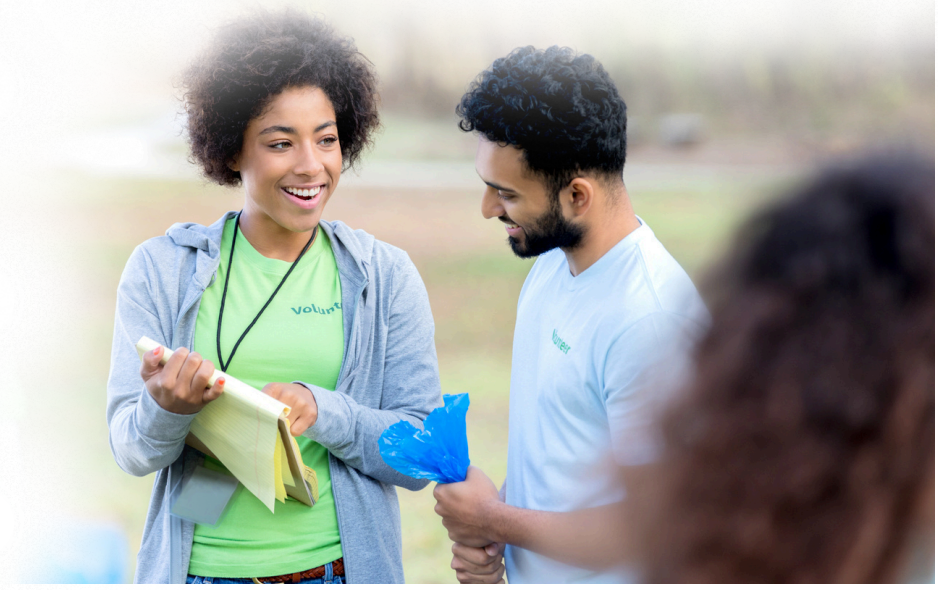
Sentara Health is an integrated, not-for-profit health care delivery system based in Virginia, which operates in three states with 12 hospitals, more than 400 sites of care, and a health plan that serves more than 1 million members. Sentara seeks to embed health equity in all aspects of their organization, including their leadership commitments, internal operations, clinical care, and community partnerships. Sentara emphasizes that equity is about delivering high-quality, accessible care to all patients, particularly those with historically marginalized identities based on race, ethnicity, language, sexual orientation and gender identity. Patients may face disparities in care even if they do not have HRSNs, meaning that diversity efforts must go beyond seeking to identify and address social needs. While Sentara is deeply invested in VBC, its equity efforts go beyond these contracts to encompass all the patients it serves.

To truly impact health equity, Sentara seeks to instill clinical cultural sensitivity and awareness among its clinicians, to provide care that respects and responds to the diverse backgrounds of the system's patients, neighbors, and consumers of care. This is key to sustaining trust and improving health outcomes. In support of this work, the Sentara leadership has committed to incorporating health equity as performance metrics for their administrative leadership as well as their clinical staff. All at-risk compensation includes metrics related to health equity, including the portion of clinician compensation that is linked to quality performance. The organization also incorporates diversity, equity and inclusion metrics for hiring and training employees.

To identify and address disparities, Sentara has built a Health Equity Dashboard. This dashboard combines data from multiple sources – including the EHR, data from the Sentara health plan, and patient-level data on demographics and HRSNs – to identify disparities in access, quality, and outcomes. Sentara is also working to reduce algorithmic bias from their clinical care delivery. For example, by removing race from algorithms related to kidney disease, Sentara reduced wait times for Black patients on the kidney transplant list by 1.9 years. The system is also engaged in translational research, to assess the impact of their clinical interventions for the patients it serves.

In addition, Sentara is deeply engaged in the local community. The health system wants to be seen as a neighbor that is seeking to earn the trust of its community. To do this, Sentara has a presence at many community events, bringing mobile clinics to events held by faith-based organizations and schools. The mobile clinics screen patients for chronic conditions and HRSNs, make referrals to CBOs to address identified HRSNs, and help patients get connected to primary care providers if patients do not already have one. Sentara has also established permanent clinics near populations that face substantial access barriers, with one clinic established in a homeless shelter and another in an apartment building in a community that has been historically underserved.

Sentara works closely with CBOs to establish referral networks and holds listening sessions with the community to learn directly from people about their priorities, such as maternal health. These partnerships with community members and organizations inform Sentara's charitable work, including grants to non-profits and faith-based organizations, sponsorship for community events, and community health needs assessments. In addition, Sentara uses its role as a large employer to ensure it contracts with businesses that reflect the diversity of the communities it serves.



Trinity Health

Trinity Health is one of the largest not-for-profit, faith-based health care systems in the nation, with 101 hospitals, 126 continuing care locations, the second-largest Program of All-Inclusive Care for the Elderly in the country, 136 urgent care locations, and many other health and well-being services. Founded by nuns in the mid-nineteenth century, Trinity Health remains committed to its core value of serving those experiencing poverty and other vulnerabilities. Trinity Health seeks to improve access, quality, and outcomes while reducing disparities.

To achieve these goals, Trinity Health integrates health equity principles into both its administrative operations and care delivery. Anti-racism and anti-bias practices are incorporated into hiring and other employment practices, all colleague training, and supplier diversity commitments. Trinity Health systematically collects patient-reported demographic data, such as race, ethnicity, language, sexual orientation, gender identity, and health-related social needs. The organization stratifies key quality and performance measures to identify disparities and gaps, to focus improvements for current and historically marginalized populations. Trinity Health monitors and reports quality measures by practice, and coaches clinicians to help them improve when gaps are identified. In addition, Trinity Health is removing race from clinical algorithms related to kidney disease, pulmonary function, and vaginal birth after cesarean section.

Further, Trinity Health systematized the assessment and resolution of patient social needs through standard care team workflows including referral to community-based resources. A standard HRSN screening tool is embedded in the systemwide EHR and more than 80 percent of ambulatory patients are being screened. When a need is identified, ancillary staff such as CHWs work directly with patients to address their needs and share community resources directly to patients on the after-visit summary or via their preferred method of communication. Trinity Health works with key CBOs, training them on using a cloud-based community resource database to receive and update the status of patient referrals to facilitate a closed-loop referral process.

Trinity Health deploys its CHW workforce in two ways: (1) by embedding CHWs in outpatient clinics that see many patients with HRSNs, and (2) by having CHWs within Trinity Health's population health care team, which provides centralized services to support care delivery to patients dually enrolled in traditional Medicare and Medicaid. Trinity Health is scaling the CHW program across its patient populations and markets. Currently, the health system focuses its CHW resources on patients attributed through VBC programs, and the goal is to continue expanding these services to more patient populations.

Trinity Health works to ensure that CBOs can address local needs. In 2022, Trinity Health launched the Transforming Communities Initiative, which provides grants to CBOs in nine communities that have experienced the most historic lack of investment in the communities they serve. Trinity Health also provides low-interest loans to support affordable housing development, food access, and beyond through the Community Investment Program. This is a Board-level commitment supporting local CBOs in addressing community needs, which represents a $75 million portfolio.

The Cleveland Clinic

The Cleveland Clinic is a multi-specialty academic medical center. Headquartered in Cleveland, Ohio, the organization includes 14 hospitals and 20 health centers statewide, as well as affiliated facilities in other states and countries. The Cleveland Clinic has a system-wide health equity strategy that encompasses its internal operations and community partnerships, as well as its clinical care delivery and research.

The Cleveland Clinic grounds its health equity strategy in its community health needs assessment. Through this process, the organization prioritizes collaboration with community stakeholders to identify the most pressing health needs, including engagement with residents, CBOs, the public health department, and elected officials. Based on this collaboration, the Cleveland Clinic has identified three priorities for its community: (1) lead poisoning prevention, (2) food, nutrition, and hunger, and (3) infant and maternal health. The Cleveland Clinic partners with CBOs to help them address these needs in their community. Through this work, the Cleveland Clinic seeks to develop trusting relationships with the communities it serves.

The Cleveland Clinic hires CHWs from the local community to work with patients that experience access issues or have HRSNs to help address patient needs. Social workers, patient navigators, and CHWs screen patients for HRSNs. Both demographic and HRSN data are documented in the EHR, to inform patient care at the bedside as well as performance measurement. When needs are identified, CHWs refer patients to CBOs using the platform Unite Us. CBOs close the referral loop through this platform, so that CHWs can confirm that the patient has received the resources they need. The organization has achieved an 85 percent care gap closure rate within 90 days.

The Cleveland Clinic also works to identify and address disparities in access, quality, and outcomes – which may be driven by demographics rather than HRSNs. For example, the organization conducted a clinical intervention to reduce disparities in outcomes after heart attack, which focused on fast and accurate identification of clinical symptoms across different populations. To assess the impact of interventions such as this, the organization conducts and publishes translational research to support high-quality care in their community and beyond. In addition, the Cleveland Clinic seeks to improve access by locating outpatient services in historically underserved communities. For example, the system opened

an obstetrics and gynecology clinic in downtown Cleveland, which resulted in a higher proportion of patients being able to attend their appointments.

The Cleveland Clinic participates in VBC arrangements, including the Medicare Shared Savings Program (MSSP). These arrangements serve as an opportunity to pilot key health equity interventions, such as the collection of demographic and HRSN data. However, the organization does not want to limit this work to patients served under VBC arrangements, since this could inadvertently exacerbate disparities between patients with different forms of insurance coverage. Instead, the Cleveland Clinic seeks to learn from these pilots, to expand high-quality health equity interventions to their full patient population.

Aledade Inc.

Aledade, the largest network of independent primary care providers, provides actionable insights and dedicated support for clinicians to keep their patients healthy while generating more revenue. Aledade forms and supports accountable care organizations (ACOs) by providing technology platforms, workflows, data analytics, and patient-facing materials and services. To inform its analyses, Aledade aggregates multiple data sources, including EHR data, claims shared by payers, patient self-reported data collected by ACOs (e.g., through Z codes or EHR), and publicly available data sources. Aledade's technology platform integrates with over 100 EHRs and practice management software. The platform puts hospital, lab, pharmacy, and claims data all in one place, showing patient insights to drive improved care coordination and quality. Eighty-eight percent of current partners rate Aledade's products and services as high quality. Aledade's diverse team leverages performance improvement techniques, cultural competence skills, and advanced coaching strategies to support health equity and achieve VBC.

The majority of Aledade ACOs participate in MSSP, and Aledade also participates in innovation initiatives, such as the ACO Realizing Equity, Access, and Community Health (ACO REACH) model, as well as direct payer contracting with Medicare Advantage and commercial arrangements. Aledade helps drive engagement by bearing the risk of financial losses under VBC arrangements while sharing the savings generated with participating providers.

Aledade seeks to embed health equity in its clinical workflows and technology platforms. For example, three clinical initiatives that explicitly incorporate health equity include:

1. **Kidney care management program:** Provides kidney care management to patients with advanced chronic kidney disease who also face other clinical and social risk factors, using artificial intelligence to identify geographically based risk factors from public databases.
2. **Hypertension control:** Seeks to reduce racial/ethnic disparities in blood pressure control, with services offered in multiple languages.
3. **Comprehensive advance care planning:** Strives to reduce disparities in hospice care by increasing access to advance care planning and providing translation services.

Aledade supports practices by identifying patients who are at the highest risk of adverse health conditions, helping prioritize meaningful interventions and care to support these patients, as well as providing wrap-around services – such as translators available by phone – to augment provider staff.

agilon health

agilon health is a VBC enabler that partners with independent providers, particularly large physician-owned practices and health systems. The organization focuses on long-term partnerships, typically 20-year joint ventures in which agilon bears 100% of the financial risk and shared savings are shared jointly between agilon and its partners. agilon supports independent providers with capital, data, payer relationships, and contracting support to help them adopt VBC arrangements and succeed under risk-based arrangements.

agilon health's strategy centers on investing in primary care access, quality, and early intervention to drive improved patient outcomes. The organization supports its provider partners by identifying the highest-risk patients, using claims data and clinical algorithms, to help practices conduct targeted outreach and care management. agilon measures the success of these initiatives by tracking the total cost of care, key outcomes such as emergency department use, readmissions, and quality measures related to preventive care and patient satisfaction.

Because agilon partners with physician practices in different environments, their patients' health equity needs vary widely. While agilon does not impose specific requirements related to screening for HRSNs, the organization has begun updating its clinical risk algorithms to incorporate the ADI as a proxy for patient-level HRSN data. agilon is exploring flagging patients living in areas with high ADI as higher risk, even if their clinical conditions alone would not flag them as high risk. This allows providers to identify and close any gaps in care between patients living in areas with high versus low ADI.

The use of ADI as a proxy for HRSN draws on the ACO REACH model, in which many agilon practices participate. Under this model, the Center for Medicare and Medicaid Innovation (CMMI) incorporates ADI into the risk adjustment methodology as a proxy for patient-level HRSN data. Participants in the model must also create annual health equity plans and collect and share patient-level demographic data. Based on this methodology, agilon evaluated the data for its practices and identified meaningful gaps in care for patients living in high ADI areas, which inspired the systemic incorporation of ADI into agilon's platform.

PSW

PSW is a VBC enabler that works with provider organizations to help them succeed in VBC arrangements. PSW offers utilization management, provider engagement, compliance, and care management services. In some cases, PSW bears risk on behalf of provider organizations, through participation in MSSP, ACO REACH, or contracts with private payers. In other cases, providers bear risk but receive implementation support from PSW, such as the delivery of care management services.

PSW's comprehensive care management program seeks to address patient risks, including clinical and social risk factors. Care managers work directly with patients to help identify and mitigate health concerns. As part of this process, care managers collect information on HRSNs and demographics that may influence a patient's risk profile. Care managers work with provider organizations to address patient's clinical needs and connect patients with CBOs to address HRSNs. Care managers follow up with patients to ensure their needs have been met by the CBO. In addition to patient-reported data on HRSNs and demographics, care managers use the SVI as a proxy to identify communities where additional care management services may be necessary.

Because PSW works with a range of providers in different markets, the specific services available at local practices and CBOs vary. PSW care managers seek to plug gaps, especially in rural areas with limited resources. For example, in one community, PSW identified smoking cessation as a key need for patients with Chronic Obstructive Pulmonary Disease, but many patients were unable to afford smoking cessation aids. PSW care managers worked with patients to obtain smoking cessation support, leverage insurance coverage where possible, and also identified and sought to address HRSNs that may support smoking cessation efforts (e.g., stable housing).

In addition, PSW has experience working with providers to identify and implement multi-year health equity plans. For example, PSW worked with one health system to establish a five-year Health Equity Strategic Plan, which included four key priorities: community engagement, population health data, language access and communication, and culturally informed care. This health system has collected patient-level data on race, ethnicity, and language for the past five years, and is now beginning to collect data on sexual orientation and gender identity. These data are included in the EHR, to allow the health system to identify and address disparities. PSW is also working to develop a proprietary population health dashboard that would include similar data across all payers.

Premier, Inc.

Premier partners with hospitals and health systems to offer group purchasing, technology, consulting, advocacy, and learning collaboratives. Premier has quality and health equity tools, which it uses to inform the work of its collaboratives. In the collaboratives, leaders in health care organizations share data and experience with one another, to identify gaps and learn from organizations that are performing well. Premier recently launched a Health Equity Collaborative, and has other collaboratives focused on bundled payments and population health, which include MSSP and ACO REACH participants, as well as a Perinatal Improvement Collaborative with over 200 members. However, Premier's work in health equity goes beyond these to also inform their other collaboratives such as workforce innovation, as well as their research and advocacy work.

As part of the Health Equity Collaborative, Premier has developed a health equity dashboard. This dashboard incorporates multiple data sources, including EHR, claims and purchased datasets. The purchased data includes the Lexis Nexis patient-level demographics and the Agency on Healthcare Research and Quality (AHRQ) patient-level data on social drivers of health. The health equity dashboard seeks to integrate data from these sources to provide a comprehensive picture of quality and equity measures. Premier combines their dashboard with learning opportunities related to health equity. For example, to address HRSNs, Premier offered educational resources about food as medicine and integration with CBOs.

In addition, Premier is developing a health equity index to measure performance in this domain. As this work continues, Premier intends to use the data to inform the work of multiple collaboratives and other elements of its work. Premier is also assessing how the health equity index changes as hospitals and health systems implement initiatives to address HRSNs and health disparities.