Hospital/Health System Self-Asssessment Tool
Policy Leadership for Health Care Transformation

This tool was originally created for use in the Public Health Institute's "Alignment of Governance & Leadership in Healthcare: Building Momentum for Transformation" initiative, which PHI is implementing in partnership with The Governance Institute and Stakeholder Health with support from the Robert Wood Johnson Foundation. It has been modified for use in the Policy Leadership for Health Care Transformation initiative, which is being co-led by Moving Health Care Upstream[1] and PHI. This tool serves as a resource for leading edge hospitals and health systems participating in the Policy Leadership for Health Care Transformation Initiative. The term "transformation" reflects an acknowledgment that the changes demanded by the shift in financial incentives from volume to value require attention to a broad spectrum of structures, functions, and processes. **We are interested in how those changes are codified in the development and implementation of institutional policies, as well as through advocacy for public policies to address the social determinants of health.** The logic model provided with these materials provides examples of policies we seek to examine, document, and promulgate in the field. Findings from our data and associated information collection process and our strategic dialogue over the coming year will help inform efforts to scale and accelerate the transformation process in the field. ([1]Moving Health Care Upstream (MHCU) is a partnership between Nemours and the UCLA Center for Healthier Children, Families and Communities. Staff from Nemours will be co-leading this work with PHI.)

Name of organization: _____

Date: _____

My organization is a:

- ☐ **Multi-region health system**
- ☐ **One or more local facilities as a subsidiary region within a larger health system**
- ☐ **Multi-facility regional health system**
- ☐ **Independent, individual facility**
- ☐ **Other (Please describe)** _____

Please review each section and select only ONE level (A, B, C, or D) and ONE ranking value (low, moderate, or high) that best reflects the current status in each area of interest. The four levels and their underlying definitions are as follows:

Level A: Early on the Path
There has limited attention to this issue to date.

Level B: Toes in the Water
There is recognition that this is an important area of focus, but we are still exploring how to proceed.

Level C: Fully Immersed
We are taking action on multiple fronts, but the impacts to date are unclear.

Level D: Acclimated and Learning New Strokes
We are beginning to see some results from efforts to date, and are ready to take innovations to scale.

A rating of low might indicate that some elements of the statement are true, but progress may be relatively limited at this point. At the other end of the spectrum, a high rating of high would indicate that you have fully implemented the letter and spirit of the statement.

At the bottom of each page, **please identify any institutional policies** you've developed to codify and sustain desired changes, as well as specific positions your organization has taken to **advocate for public policies that address the social determinants of health**.

I. Board Engagement in Population Health

This section examines the degree and manner in which strategic conversations are brought to the board that focus on building population health capacity in the organization, both in terms of patient care and addressing health issues in the larger community.

Level A

Our board and senior leadership dialogue focuses primarily on **short term business priorities**, with occasional discussions about the difficulties of managing the care of selected patient populations.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Level B

Population health is a frequent topic of conversation among our board and senior leadership, and we have begun to explore potential areas of focus to strengthen our capacity to **manage the care of our patient populations**.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Level C

Our board provides **regular input to senior leadership in the design of systems and care design innovations** to enhance our capacity to better manage the care of our patient populations.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Level D

Our **board serves as a "think tank" for the senior leadership in pushing *beyond* care management** for patient populations to address the social determinants of health in the communities we serve.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Please identify institutional policies established (e.g, board committees formed, expansion of competencies, protocols to solicit early input on proposed actions, topical retreats, etc.) to address the **need for a board which is optimally engaged** to support the engagement of our organization in addressing the drivers of poor health in our communities:

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II. Data Systems and Measurement

This section examines progress to date in the development of data systems and the use of metrics that support strategies to improve health care quality, reduce health care costs, and improve health in the community.

Level A

We **compile and analyze data on patient utilization patterns** (e.g., readmissions, prevention quality indicators) and discuss findings with our board.

- ☐ 1. Low
- ☐ 2. Moderate
- ☐ 3. High

Level B

We **collect data on social determinants of health** (e.g., housing, support services, food insecurity), race and ethnicity, and use geographic information systems-coded data to identify geographic concentrations of health disparities.

- ☐ 1. Low
- ☐ 2. Moderate
- ☐ 3. High

Level C

We **convene clinicians, analysts, community benefit staff, and senior leaders** to identify opportunities to **align care management and community health improvement strategies** and have established a "**dashboard" of metrics** to document progress.

- ☐ 1. Low
- ☐ 2. Moderate
- ☐ 3. High

Level D

We **share data with other community-based organizations and other health care providers** to coordinate strategies to address the social determinants of health in geographic communities where health disparities are concentrated.

- ☐ 1. Low
- ☐ 2. Moderate
- ☐ 3. High

Please identify institutional policies established (e.g, required use of analytics, collection of SDH data, data sharing, protocols for cross-departmental strategizing, etc.) to address the **need for a new approach to data collection, analysis, and sharing across organizations to** address the drivers of poor health in our communities:

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III. Financing / Payment Models

This section focuses on work to date in the redesign of financing mechanisms to support movement towards value-based reimbursement.

Level A

All, or the majority of our care is **financed through a fee-for-service system**, and we are focusing care coordination efforts on reducing readmissions (and associated penalties).

- ☐ 1. Low
- ☐ 2. Moderate
- ☐ 3. High

Level B

We are **exploring the formation of an accountable care organization** (ACO) to coordinate care for specific oohorts of patients.

- ☐ 1. Low
- ☐ 2. Moderate
- ☐ 3. High

Level C

We have **established an ACO** for specific patient cohorts, and are engaged in conversations with external entities to **explore increasing risk sharing arrangements**.

- ☐ 1. Low
- ☐ 2. Moderate
- ☐ 3. High

Level D

All, or the majority of our care is financed through a full risk capitated system, or we are sharing risk with one or more payers.

- ☐ 1. Low
- ☐ 2. Moderate
- ☐ 3. High

Please identify institutional policies established (e.g, establishment of ACOs, reporting requirements, investment in building functional capacity, new departments, positions, etc.) **to support a shift from FFS to value-based reimbursement**.

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IV. Delivery System Re-Design

This section examines efforts to date to engage, train, and deploy multi-disciplinary teams, and strategies to partner with other stakeholders to improve patient care and broader population health in local communities.

Level A

We are **exploring the development of team-based care models** to better manage the care of special populations.

- ☐ 1. Low
- ☐ 2. Moderate
- ☐ 3. High

Level B

We have designed and are **piloting one or more team-based care models** to better manage the care of special populations.

- ☐ 1. Low
- ☐ 2. Moderate
- ☐ 3. High

Level C

We are **implementing inter-disciplinary team-based care across multiple sites**, are exploring referral relationships with external human service organizations, and are **establishing metrics** to document progress towards achievement of Triple Aim objectives.

- ☐ 1. Low
- ☐ 2. Moderate
- ☐ 3. High

Level D

We are **implementing inter-disciplinary team-based care on an organization-wide basis,** are engaging community health workers or other non-licensed community-based personnel in at least one site, have **established referral systems with external human service organizations**, and have established **metrics to monitor progress**.

- ☐ 1. Low
- ☐ 2. Moderate
- ☐ 3. High

Please identify institutional policies established (e.g, new care protocols, formation of inter-discipllinary teams, new working relationships with human service organizations, etc.) to redesign the care delivery process in a manner that makes optimal use of available skills sets to align quality clinical care delivery with strategies to address the drivers of poor health in our communities:

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V. Community Benefit / Community Health - Internal

This section examines the degree to which the community benefit function in our organization has sufficient capacity, competencies, and accountabilities, is integrated with data systems and care redesign processes, and has sufficient oversight to ensure a quality improvement approach.

Level A

We have **specific job descriptions and dedicated FTEs** for community benefit programming and periodic resporting to our board of trustees.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Level B

Our community benefit staff with dedicated FTEs have a **direct reporting relationship with one or more of our senior leadership team members** who is accountable for our organization's community benefit performance.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Level C

Our community benefit staff with dedicated FTEs and their senior leadership reports have **timely access to financial and clinical utilization data** and **meet with finance and clinicians to coordinate** and align organizational resources

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Level D

In addition to functional elements described in levels A, B, and C, our organization has a **board level committee that provides ongoing oversight and policies** that encourage targeting of resources in geographic communities where health disparities are concentrated.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Please identify institutional policies established to address the need for the **management and integration of community health improvement activities wth care management strategies.**

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VI. Community Health - Intersectoral Collaboration

This section focuses on the degree and manner in which our organization is leveraging our efforts through strategic partnerships with diverse stakeholders in the health and community development sectors.

Level A

We **partner with** our local public health agency, the United Way, community-based organizations, faith-based organizations, and other health care providers in the **assessment of community health needs and assets**.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Level B

We partner with **local employers and K-12 schools** to design and implement wellness programs, and have **established metrics and a monitoring system to monitor progress**.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Level C

We partner with our local public health agency, the United Way, community-based organizations, faith-based organizations, and other health care providers in the ***design and implementation*** **of community health improvement strategies**.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Level D

We are **initiating dialogue with community development organizations** to explore opportunities to align services with investments in physical infrastructure (e.g., supportive housing, childcare centers, healthy food outlets).

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Please identify institutional policies established (e.g, formal agreements) and/or **policy agendas developed in partnership with other organizations** to better address the drivers of poor health in our communities:

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VII. Policy Development

This section focuses on institutional policies we are implementing and public policies we are advocating for in order to improve health and well-being among our patient populations and for the broader community.

A. We have ***identified and revised institutional policies to improve working conditions*** for staff and contractors (e.g., livable wages).

- ☐ 1. Low
- ☐ 2. Moderate
- ☐ 3. High

B. We have ***identified and revised institutional policies to increase contracting with local vendors*** to enhance local economic development.

- ☐ 1. Low
- ☐ 2. Moderate
- ☐ 3. High

C. We have ***identified and revised institutional policies and made investments to reduce our negative environmental impacts*** (e.g., waste disposal, energy utilization) at the local and/or global level.

- ☐ 1. Low
- ☐ 2. Moderate
- ☐ 3. High

D. We are ***advocating for public policies at the national level*** to increase attention and funding to address population health issues (e.g., smoking, opioids, obesity).

- ☐ 1. Low
- ☐ 2. Moderate
- ☐ 3. High

E. We are ***working in partnership with external stakeholders to build a common platform for public policy advocacy at the local level*** to address SDH (e.g., improved schools, housing, food access, transportation, youth development).

- ☐ 1. Low
- ☐ 2. Moderate
- ☐ 3. High

Please identify institutional policies established or actions taken to build a common agenda for public policy advocacy to address the drivers of poor health in our communities:

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