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AGLH Hospital/Health System Self-Assessment Tool

This tool is intended to serve as a resource for hospitals and health systems to assess progress to date in health care transformation, with attention to building population health capacity. 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. In determining the optimal actions to be taken, this tool is intended to assist in the identification of entry points that are relevant and offer the best opportunity to build on efforts to date.

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 ONE level (A, B, C, or D) and a numerical value (1, 2, or 3) that best reflects the current status in each area of interest.¹ 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 NewStrokes

We are beginning to see some results from efforts to date, and are ready to take innovations to scale.

Within each of these levels, please rate your progress within each level as **1 (low)**, **2 (moderate)**, or **3 (high)**. 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 3 would indicate that you have fully implemented the letter and spirit of the statement.

¹ With the exception of Section VII, Policy Development, which is not organized under the four levels of engagement.





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

Section I response explanation:

Choose ONE level and numerical value. Then, provide a brief explanation.





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 for alignment of care management and population health 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

Section II response explanation:

Choose ONE level and numerical value. Then, provide a brief explanation.





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 cohorts 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

Section III response explanation:

Choose ONE level and numerical value. Then, provide a brief explanation.





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 in at least one site, have established referral systems with external human service organizations, and have established metrics and a system to monitor progress towards achievement of Triple Aim objectives.

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

Section IV response explanation:

Choose ONE level and numerical value. Then, provide a brief explanation.





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 reporting 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

Section V response explanation:

Choose ONE level and numerical value. Then, provide a brief explanation.





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 **implementation** of community health improvement strategies.

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

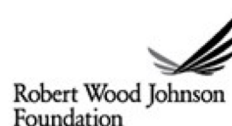
Level D

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

Section VI response explanation:

Choose ONE level and numerical value. Then, provide a brief explanation.





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

Section VII response explanation:

Check ANY that apply and provide a brief explanation.



Stakeholder Health

