PATHWAYS TO POPULATION HEALTH

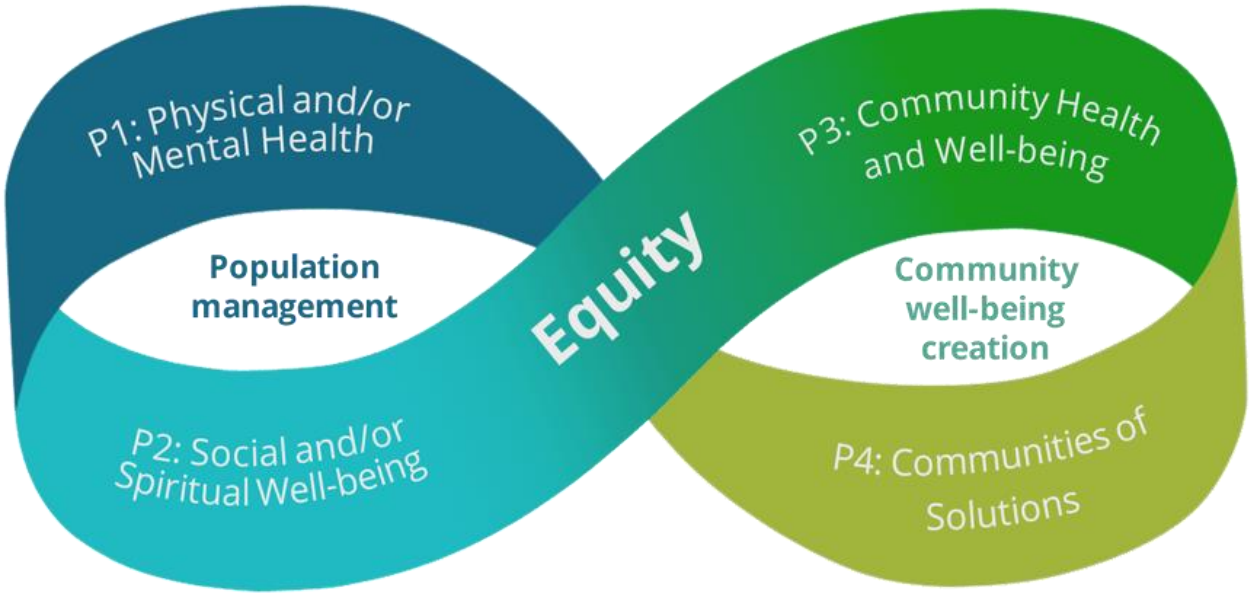
Pathways to Population Health Compass

Introduction

While health care leaders recognize the opportunity to improve the health of the communities they serve, the pathways to do so remain the roads less traveled. We hope the companion resource, Pathways to Population Health: An Invitation to Health Care Change Agents (the Framework) has helped your organization chart a potential path forward for your work.

The Pathways to Population Health Compass (the Compass) is intended to help your organization catalogue existing improvement efforts, as well as identify new opportunities to make practical, meaningful, and sustainable advances in population health.

This resource is ideally suited for individuals or teams with the agency to advance population health improvement efforts within their organization. The Compass takes approximately 20 minutes to complete and you are encouraged to review and update your responses quarterly to track progress over time.



Pathways to Population Health: Four Portfolios of Population Health

Instructions for Using the Compass

The Compass includes a series of statements to identify the current state of your organization's activities to advance different components of the Pathways to Population Health Framework:

- **Stewardship**
- **Equity**
- **Payment**
- **Partnerships with People with Lived Experience**
- **Portfolio 1:** Physical and/or Mental Health (Data, Team-Based Care, Behavioral Health Integration, Care Management)
- **Portfolio 2:** Social and/or Spiritual Well-Being (Data, Social Determinant Screening/Referrals)
- **Portfolio 3:** Community Health and Well-Being (Data, Community Partnerships, Community Benefit)
- **Portfolio 4:** Communities of Solutions (Data, Leveraging Nontraditional Roles, Policy)

As you consider your organization's journey toward improving population health, please select the description that **best** represents the attitudes, behaviors, or actions currently underway. The responses represent examples of the types of activities an organization may be undertaking. The purpose of completing the Compass is to provide a snapshot of your organization's current activities and suggest some possible next steps to help your organization progress to where it wants to be.

Please select one response per statement. The numerical value associated with each response contributes to a "score" to assess current activities for each component, and to help your organization evaluate the balance of activities across portfolios. Circle your answers within the tool, and mark the associated numbers in the scoring sheet on the last page. The scoring sheet (page 10) will walk you through how to calculate your scores, which range from 0-100, and interpret your results (page 11).

Pathways to Population Health Compass

Stewardship

As you consider the perspective of your organization's leaders as it relates to population health, please select the description that best represents the attitudes, behaviors, or actions currently underway.

Our board and senior leadership do not consider addressing the health of the population, at large, to be our organization's responsibility.	Our board and senior leadership believe we have a role to play in the health of our community, but we do not have a cohesive strategy to do so.	Our board and senior leadership believe that population health is a priority for our organization. We have dedicated resources and initiatives to improve the health of individuals and discrete patient populations.	Our board and senior leadership ensure we have dedicated resources to improve the lives of everyone in our community, regardless of whether they are our patients.	Our organization is part of a multi-stakeholder coalition working to improve health, well-being, and equity in our communities, with shared governance and dedicated resources to advance the work across stakeholders.
At the beginning 0	**Making initial progress 1**	**Making moderate progress 2**	**Making substantial progress 3**	**Implementing broadly 4**

Equity

As you consider your organization's efforts to improve **equity**, please select the description that best represents the attitudes, behaviors, or actions currently underway.

We do not discuss health equity in our organization.	We've had some discussions or educational sessions related to health equity, but have not taken any action to address equity issues.	We routinely collect data on race, ethnicity, language, and SES and have active improvement efforts underway to address health equity gaps.	We stratify community data based on key sociodemographic factors and work with community partners to close equity gaps.	We work with community partners to implement, evaluate, and improve programs and policies to address the root causes of inequities.
At the beginning 0	**Making initial progress 1**	**Making moderate progress 2**	**Making substantial progress 3**	**Implementing broadly 4**

Payment

As you consider your organization's attitudes, behaviors, or actions currently underway around **payment**, please select the description that best fits.

We are entirely fee for service and do not take on financial risk for the health outcomes of any defined populations.	We are having preliminary discussions with payers to take on financial risk for defined populations. Less than 5% of patients are currently covered under such arrangements.	We have several risk-based contracts for defined populations that cover 5% to 20% of our patients and/or employees.	• 21% to 50% of our patient and/or employee population is covered under a global payment/shared savings arrangement. • We are actively exploring adding new patient populations or additional payers over time. • We embrace new financial models to improve the health of our patients and communities.	• More than 50% of our patient and/or employee population is covered under a global payment/shared savings arrangement. • We are expanding to create mechanisms to share risk and savings across sectors in our communities.
At the beginning 0	**Making initial progress 1**	**Making moderate progress 2**	**Making substantial progress 3**	**Implementing broadly 4**

Partnerships with People with Lived Experience

As you consider your organization's efforts to **partner with people with lived experience**, please select the description that best represents the attitudes, behaviors, or actions currently underway.

We do not have formal mechanisms to engage patients, families, or others with lived experience in co-designing the care experience.	We have established a patient and family advisory council (PFAC) or equivalent group of patients and family members, but do not yet partner with them in a meaningful and systematic way.	We routinely engage our PFAC or others with lived experience to help identify quality improvement priorities.	All quality improvement projects are co-designed with patients and family members, who remain active members of the improvement teams.	People with lived experience co-lead improvement initiatives in our organization or in our community.
At the beginning 0	**Making initial progress 1**	**Making moderate progress 2**	**Making substantial progress 3**	**Implementing broadly 4**

Portfolio 1: Mental and/or Physical Health

As you consider your organization's efforts to improve **mental and/or physical health**, please select the description that best represents the attitudes, behaviors, or actions currently underway in the four components.

Data

Consider all the statements below about data.

- □ We collect data to proactively manage the physical health of discrete populations.
- □ We collect data to proactively manage the mental health of discrete populations.
- □ Our strategic planning staff present basic GIS Zip code data of key patient cohorts as part of our community benefit assessment.
- □ We use physical and mental health data in our risk stratification to proactively manage prevention, disease management, and complex care management needs for discrete populations.
- □ We use our data in improvement initiatives related to mental and/or physical health.

We don't do any of these things 0	We do a few of these things 1	We do most of these things 2	We do all these things! 3

Team-Based Care

Choose the response that best describes your organization at this time.

We don't use team-based care in our organization.	We are exploring models of team-based care in our organization.	We are starting to implement a team-based care model. The model is multidisciplinary and includes patients and families, as well as non-clinical providers.	Team-based care has been implemented throughout the organization. Our team-based care model enables each team member to work to their highest level of licensure.
At the beginning 0	**Making initial progress 1**	**Making moderate progress 2**	**Implementing broadly 3**

Behavioral Health Integration

Choose the response that best describes your organization at this time.

We provide behavioral health and medical care in separate facilities, with separate systems. We are not trying to integrate behavioral health and medical care.	We are examining approaches to address behavioral health needs within primary care. We are exploring which approach may work best based on our population, payment systems, and resources.	Primary care providers routinely communicate with behavioral health providers to share information with one another in advance of patient encounters.	Primary care and behavioral health providers partner in areas such as creating shared systems (scheduling or medical records), in person or virtual collaboration on care plans, sharing and learning about one another's roles, capabilities, etc.
At the beginning 0	**Making initial progress 1**	**Making moderate progress 2**	**Implementing broadly 3**

Care Management

Choose the response that best describes your organization at this time.

Our organization does not have dedicated staff for care management activities OR they are primarily focused on individual utilization review activities.	• We have ways to identify individuals in need of care management and direct them to a dedicated person/team. • We are exploring how to identify at-risk populations for outreach by our care management team.	• Our multidisciplinary care management team includes patients and families. • A core care management team function is actively identifying and engaging community partners to support patients and populations for social/spiritual needs.	Our multidisciplinary care management team partners with community resources to enhance services for at-risk populations to improve the health and well-being of the community.
At the beginning 0	**Making initial progress 1**	**Making moderate progress 2**	**Implementing broadly 3**

Portfolio 2: Social and/or Spiritual Well-Being

As you consider your organization's efforts to improve **social and/or spiritual well-being**, please select the description that best represents the attitudes, behaviors, or actions currently underway in the two components. As a reminder, social drivers encompass socioeconomic factors such as food, housing, education, transportation, and income, as well as social connectedness. Spiritual drivers include factors that contribute to a sense of purpose, meaning, self-worth, hope, and resilience.

Data

Consider all the statements below about data.

☐ We collect data to proactively manage the social well-being of defined populations. ☐ We collect data to proactively manage the spiritual well-being of our discrete populations. ☐ We share data with all relevant clinical stakeholders, with whom we are collaborating to improve the social and spiritual well-being of discrete populations. ☐ We include social and spiritual drivers of health in our risk stratification to proactively manage prevention, disease management, and complex care management needs for discrete populations. ☐ We use our data in improvement initiatives related to social and/or spiritual well-being.			
We don't do any of these things 0	**We do a few of these things 1**	**We do most of these things 2**	**We do all these things! 3**

Social Determinants of Health (SDOH) Screening and Referrals

Choose the response that best describes your organization at this time. Be sure to read all answer choices, as they build on each other.

We do not screen for social and spiritual needs and assets.	We screen for social and/or spiritual needs and assets, but do not have a reliable mechanism to connect individuals with the appropriate home- and community-based services.	We have reliable mechanisms to direct people to the appropriate home- and community-based services for their social and/or spiritual needs.	We have reliable mechanisms in place for follow-up and to ensure the individual's social and/or spiritual needs were met.	In addition to all activities listed in the preceding responses, we work collaboratively with community-based service partners to demonstrate impact (related to cost, quality, and experience).
At the beginning 0	**Making initial progress .75**	**Making moderate progress 1.5**	**Making substantial progress 2.25**	**Implementing broadly 3**

Portfolio 3: Community Health and Well-Being

As you consider your organization's efforts to improve **community health and well-being**, please select the description that best represents the attitudes, behaviors, or actions currently underway in the three components.

Data

Consider all the statements below about data.

- □ We collect community-wide data on a specific area of focus in our community work.
- □ We use tools like geotagging to understand the relationship of place to specific health and well-being outcomes in our community.
- □ We have data sharing agreements in place and routinely share and review our community's data with all relevant stakeholders (including the people most impacted).
- □ We analyze our community-level data with a health equity lens with all relevant community stakeholders (including those most impacted).
- □ We use data to risk-stratify and prioritize opportunities with our community partners to improve specific health and well-being outcomes.

We don't do any of these things 0	**We do a few of these things 1**	**We do most of these things 2**	**We do all these things! 3**

Community Partnerships

Choose the response that best describes your organization at this time.

We do not proactively seek partnerships with community organizations.	Our partnerships are mostly based on existing relationships that serve the needs of individuals and the organization.	We are proactively seeking partnerships with multi-sector organizations to address social determinants of health.	We are part of several community-wide, multi-sector coalitions that collectively identify and collaborate around key community health improvement efforts.
At the beginning 0	**Making initial progress 1**	**Making moderate progress 2**	**Implementing broadly 3**

Community Benefit

Consider all the statements below about community benefit.

- □ We have dedicated FTEs for community benefit programming who report to senior leadership.
- □ We have dedicated FTEs for community benefit programming who are accountable for our organization's community benefit performance.
- □ Our community benefit team includes key community organizations and stakeholders.
- □ Our community benefit investments address gaps identified in our community health needs assessment.
- □ We have a theory of what will improve the health and well-being of our community and a plan for making those improvements, developed with community stakeholders and people who are most affected, and we apply our community benefit resources accordingly.
- □ Our community benefits staff have timely access to data and resources to support community benefit programming.
- □ We report our community benefit performance and our population health performance to our governing board.
- □ We partner with other health care organizations in our community to co-invest community benefit dollars to achieve greater community and regional impact.
- □ We evaluate whether community benefit investments lead to improvement in the health and well-being of our community and change our approach accordingly.

We don't do any of these things 0	We do a few of these things 1	We do most of these things 2	We do all these things! 3

Portfolio 4: Communities of Solutions

As you consider your organization's efforts to become a **community of solutions**, please select the description that best describes the attitudes, behaviors, or actions currently underway in the three components.

Data

Consider all the statements below about data.

- □ Community stakeholders across sectors drive the collection and integration of community-level data to monitor overall trends in health, well-being, and equity in our community.
- □ We use tools like geotagging to understand the relationship of place to overall health and well-being outcomes in our community.
- □ Together, we collect both people-reported well-being measures and proxy measures related to major initiatives we are working on.
- □ We have data sharing agreements and integration platforms in place to promote interoperability. This helps us proactively identify trends in integrated data across sectors.
- □ We routinely analyze our data with a health equity lens together with those who are most affected, and use it to co-design short- and long-term improvement initiatives.
- □ We use our data for community-level planning around resources to address the social drivers of health and well-being in our community.

We don't do any of these things 0	We do a few of these things 1	We do most of these things 2	We do all these things! 3

Nontraditional Roles/Levers

Consider the kinds of nontraditional roles and levers you currently use to improve health, well-being, and equity.

- □ Employer (e.g., develop career pipelines in communities with poor equity outcomes; join efforts to "ban the box"; offer a living wage for all employees; invest in peer workforce from underserved communities such as community health workers; incentivize employees to live in communities that are racially segregated to help with integration)
- □ Purchaser (e.g., procure selectively from vendors, or in communities, that have poor equity outcomes to build community wealth)
- □ Investor (e.g., give low income loans to women and minority-led businesses or nonprofits working to improve health, well-being, and equity in the community)
- □ Food purchaser and server (e.g., offer healthy food options for patients while hospitalized; connect to local sources of healthy food in food deserts to improve market for healthy food)
- □ Environmental steward (e.g., be responsible for your overall environmental footprint and work to reduce emissions and health care waste)
- □ Funder (e.g., use community benefit dollars to support the community)
- □ Builder (e.g., choose to locate new facilities in communities with poorer health outcomes to support job promotion)

We don't do any of these things 0	We do a few of these things 1	We do many of these things 2	We do all of these things! 3

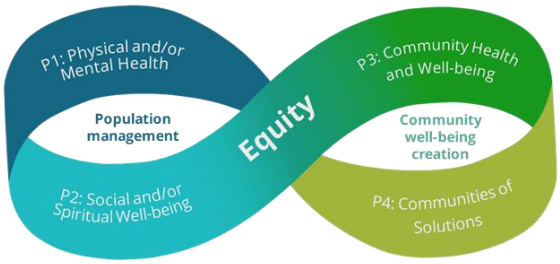
Policy

Consider all the statements below about policy.

- □ We have institutional policies to improve working conditions for staff and contractors (e.g., livable wages).
- □ We have institutional policies to increase contracting with local vendors to enhance local economic development.
- □ We have institutional policies and investments to reduce our negative environmental impacts (e.g., waste disposal, energy utilization) at the local, regional, and/or national level.
- □ We partner with external stakeholders to build a common platform for public policy advocacy at the local level to address social drivers of health (e.g., improved schools, housing, food access, transportation, youth development).
- □ We advocate for public policies at the national level to increase attention and funding to address population health issues and the social determinants that drive them.

We don't do any of these things 0	We do a few of these things 1	We do most of these things 2	We do all these things! 3

Pathways to Population Health Compass
Scoring Sheet



For *Stewardship, Equity, Payment,* and *Partnerships with People with Lived Experience,* your score is equal to your answer multiplied by 25.

Stewardship: _____

Equity: _____

Payment: _____

Partnerships with People with Lived Experience: _____

For each of the four portfolios, multiply the sum of your answers by the number indicated for each portfolio. Write your answers below, then calculate your score.

Portfolio 1: Mental and/or Physical Health

Data _____

Team-Based Care: _____

Behavioral Health Integration: _____

Care Management: _____

Score: *Sum multiplied by 8.33* _____

Portfolio 2: Social and/or Spiritual Well-being

Data _____

SDOH Screening and Referrals: _____

Score: *Sum multiplied by 16.5* _____

Portfolio 3: Community Health and Well-being

Data _____

Community Partnerships: _____

Community Benefit: _____

Score: *Sum multiplied by 11* _____

Portfolio 4: Communities of Solutions

Data _____

Nontraditional Roles/Levers: _____

Policy: _____

Score: *Sum multiplied by 11* _____

Portfolio Scores Summary

Pull your portfolio scores here

Portfolio 1: _____

Portfolio 2: _____

Portfolio 3: _____

Portfolio 4: _____

Interpreting your Results

0-20: **You are at the beginning of your work in this area.**
21-40: **You are making initial progress in this area.**
41-60: **You are making moderate progress in this area.**
61-80: **You are making substantial progress in this area.**
81-100: **Your organization has developed expertise in this area.**

1. Compare balance across portfolios

The portfolios connect and build on one another and are intended to represent a balanced portfolio of population health efforts that could be part of a health care organization's overall population health improvement strategy. Our experience indicates that nearly all organizations can identify some existing activity in all four portfolios, albeit often siloed. If one portfolio is missing from your work or is weak, you may be missing an important part of an optimal population health strategy.

2. Determine where you will focus your efforts

As you consider your opportunities for improvement in Stewardship, Equity, Payment, Partnerships with People, and the four portfolios, notice that the statements within the questions themselves contain a vision of what the next step looks like. Consider the box to the right of your current response. Think about what steps your organization could take to progress one box to the right within the next quarter.

3. Check out the Oasis for practical tools and resources to get started and create your Action Plan.