Population Health Management
Organizational Self-Assessment

health care intelligence

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This self-assessment is designed to provide a preliminary indication of an organization's readiness to conduct population health management (PHM). The primary goals of this tool are to spark dialogue, encourage debate and uncover potential blind spots. It is not meant to suggest whether an organization should (or should not) build a PHM program.

The following pages cover the organizational readiness domains listed below. Each domain has a series of elements designed to evaluate an organization's existing capabilities that are relevant to PHM. Remember that there are intangibles—the political will of leaders, relationships among stakeholders, opportune moments, a board's appetite for innovation—that must be considered as well.

Self-Assessment Domains

Enterprise Characteristics

1. Strategic Alignment
2. Prior Organizational Experience

Care Delivery Infrastructure

3. Care Delivery Model
4. Behavioral Health Infrastructure
5. Workforce Model
6. Population Engagement Techniques

Technology Infrastructure

7. Technology Tools and Supporting Processes
8. Analytical Tools and Expertise

Talent and Culture

9. Governance Model
10. Physician Leadership and Commitment

For more, see Sg2's report, *Population Health Management*.

How to Use This Self-Assessment

While there are many parallels between payment reform and PHM, this tool is not expressly designed to evaluate an organization's readiness for risk-based contracting. In addition, leaders are encouraged to think broadly about their local market environment, and its impact on payment evolution and PHM deployment.

We recommend completing this assessment with the administrative and clinical leadership team in one of two ways: as a group exercise or an individual activity with the responses aggregated.

Be sure to spend time reflecting on the results and reconciling the outcomes with the team's instincts and intuition.

Enterprise Characteristics

1. Strategic Alignment		No Capability	Basic Capability	Advanced Capability
Objective: Ensure that PHM program goals are aligned with your enterprise strategic priorities.				
Do you have the following?	A planning process that allocates resources based on indices of community well-being (eg, a community health needs assessment)			
	Strong consensus across leaders and providers that an "empty bed" is acceptable			
	A willingness to redefine market share based on measurable population health goals			
	A well-defined System of CARE that integrates information, operations and logistics to take an individual through the full continuum—including owned, affiliated and virtual sites of care			
	Belief in using the most efficient, high-quality site of care, even if it is outside of your existing network of services			
	Financial capacity to withstand mistakes and cash flow outcomes			
	Sufficient access to capital for infrastructure investment			
	A population of sufficient size to manage clinical and financial risk (an industry rule of thumb is that 40,000 to 50,000 covered lives is the minimum size for a stable risk pool)			
	Strong payer and employer relationships to enable care model experimentation, payment innovation and data sharing			

2. Prior Organizational Experience		No Capability	Basic Capability	Advanced Capability
Objective: Determine if previous innovative approaches may provide a starting point for moves into PHM.				
Have you done the following?	Developed a clinical integration model and/or a compensation system that moves beyond relative value units to better align system and physician incentives			
	Participated in managed Medicare or Medicaid plans			
	Conducted process improvement projects (eg, Lean), care delivery pilots (eg, patient-centered medical homes) or other initiatives that required skillful change management			
	Engaged in efforts to improve access, satisfaction, health outcomes and costs for your organization's employees			
	Partnered with a self-insured employer to improve access, satisfaction, health outcomes and costs			
	Joined local organizations in proactive community outreach efforts, such as those to improve health literacy, screening or immunization rates, and demonstrated results			

CARE = Clinical Alignment and Resource Effectiveness.

Care Delivery Infrastructure

3. Care Delivery Model		No Capability	Basic Capability	Advanced Capability
Objective: Understand if your organization has the care delivery structure needed to manage populations and, in particular, assess the flexibility of your primary care model.				
Do you have the following?	Accreditation as a patient-centered medical home			
	A proactive end-of-life planning strategy within primary care			
	Open scheduling to improve access to primary care teams			
	Reengineered workflow within the primary care model to support technology applications for care planning and communication (eg, automated patient and provider notifications of overdue services)			
	A care management approach that is based on acuity/illness (not disease) risk: ■ Level 1: Patients with multiple diagnoses and/or polypharmacy patients requiring ongoing care manager support ■ Level 2: Serious chronic disease patients requiring interventions to prevent exacerbation or decline ■ Level 3: Patients with chronic disease history who are well, requiring prevention and education			
	Accurate medication administration and formulary management			
	A range of community-based access sites (eg, urgent care, retail clinics and employer clinics)			
	An integrated PAC network to ensure coordinated handoffs, communication and monitoring of patients in PAC settings			
	A broad approach to community outreach (eg, routine screenings, wellness education) that is based on community health needs assessment, not tied to a specific illness or injury			
	A community resource network, including community groups, schools, public health agencies and religious institutions			
	An organized effort to reduce members' use of services outside the system and, when such situations do occur, trigger case management to quickly engage patient and/or provider to direct care back within the system			

PAC = post-acute care.

4. Behavioral Health Infrastructure		No Capability	Basic Capability	Advanced Capability
Objective: Assess the strength of your organization's behavioral health infrastructure.				
Do you perform the following?	Assess and update patients' behavioral and substance abuse histories on a regular basis			
	Offer licensed clinical social worker intervention(s) for patients with depression and/or those experiencing significant losses (eg, death of a spouse)			
	Provide resources to manage conditions at the primary care level			
	Extend outreach into community settings to understand the prevalence of substance abuse and the impact on health and safety			

5. Workforce Model		No Capability	Basic Capability	Advanced Capability
Objective: Understand if your organization has the workforce model needed to manage populations.				
Do you have the following?	An optimized percentage of employed or highly aligned PCPs			
	A team-based care model that enables health professionals (eg, advanced nurse practitioners, pharmacists, social workers and mental health specialists) to work at the "top of their license"			
	Integration of selected specialties (eg, cardiology, rheumatology and endocrinology) into primary care sites			
	Enhanced panel sizes (eg, 3,000+ per physician) through technology and clinical team support			
	An optimized role for care managers by transferring a portion of their administrative tasks (maybe up to 40% to 50% of tasks) to medical assistants or other non-RN staff			
	A methodology for weighting the intensity of care management interventions (eg, the typical PCP with a panel of 2,500 patients will need 1.35 care managers or a caseload of 200 to 250 active patients per care manager)			
	An incentive structure that balances value-based outcomes (not just volume) with productivity			
	Separate hospital case managers' roles from transitional case management roles that support ED diversion and pre- and postdischarge care coordination			
	Telehealth consults or referrals through primary care (eg, retinal screening in PCP office for diabetics) to expedite transfer of medical data			

PCP = primary care physician; ED = emergency department.

6. Population Engagement Techniques		No Capability	Basic Capability	Advanced Capability
Objective: Determine if your organization has an active population engagement strategy.				
Do you have the following?	Optimally designed patient pathways for high-volume diagnoses and procedures to ensure a consistent patient experience			
	A 24/7 centralized call center with RN support			
	A robust patient portal (eg, allows appointment scheduling, prescription refills and care team messaging)			
	Community representatives involved in the planning process			
	Virtual visits (eg, email and video) capabilities			
	Mobile health applications			
	Outreach strategies to select population segments to prevent injuries (eg, falls) and promote health and safety			
	Patient activation management tools to evaluate high/low patient segments			
	Ability to track the percentage of patients seeking care outside of the health system network (ie, leakage)			

Technology Infrastructure

7. Technology Tools and Supporting Processes		No Capability	Basic Capability	Advanced Capability
Objective: Measure the pervasiveness and use of technology across your organization's System of CARE.				
Do you have the following?	Tools that provide real-time data for point-of-care decisions and are both available and flexible in order to support medical decision making and case management			
	EMR deployed across inpatient and outpatient care sites			
	Innovative ways for clinicians to access information (eg, remote EMR access and health information exchanges) in order to optimize their workflow			
	A master patient index across hospitals, physicians and payers			
	Registries that can stratify populations by health risks, diseases or other important criteria			
	Integrated registries to allow all those in use to be regularly updated to reflect program enrollment and disenrollment			
	A process for disseminating daily utilization and financial reports for use in program monitoring			
	An automated mechanism for providing real-time notifications to physician office staff and care teams regarding patient status (eg, ED visit, hospital admission and hospital discharge)			

8. Analytical Tools and Expertise		No Capability	Basic Capability	Advanced Capability
Objective: Determine if your organization has the tools and skill sets required to perform sophisticated analytics.				
Have you ever done the following?	Identified the 5% to 10% of the patient population that, as frequent fliers, drive ED use and admissions			
	Extracted data from across care sites to perform longitudinal utilization, cost and quality analysis			
	Employed advanced cost accounting approaches to more precisely measure the cost of care			
	Used risk assessment tools (eg, patient self-assessments and case management tools) to evaluate an individual's health status			
	Devised a community segmentation methodology to understand subpopulations and design targeted services			
	Segmented underserved patients and identified unique patient characteristics that create barriers to care (eg, transportation, language and health literacy)			
	Used a predictive model (eg, for readmissions or future costs)			

EMR = electronic medical record.

Talent and Culture

9. Governance Model		No Capability	Basic Capability	Advanced Capability
Objective: Determine if your governance model effectively integrates and spurs collaboration across a range of owned and affiliated practitioners and care sites.				
Do you have the following?	An executive leadership team that values collaboration over independent decision making			
	An organizational structure that supports new incentives (eg, financial and operational) to focus on population segments across the care continuum, rather than traditional system departments, silos and boundaries (eg, inpatient vs outpatient)			
	New service line or organizational structures (eg, geriatrics and chronic illness)			
	Formal selection and evaluation criteria for strategic partners			
	Properly structured agreements that incorporate the goals of PHM for key assets that are not owned (eg, mechanisms to incentivize a non-owned skilled nursing facility to achieve readmission performance targets)			

10. Physician Leadership and Commitment		No Capability	Basic Capability	Advanced Capability
Objective: Evaluate if your organization's medical staff is committed to new models of care.				
Do you have the following?	A core team of physicians who can view success beyond the individual practice and to the full health system			
	A physician leadership development program			
	Physicians who are engaged in crafting and ensuring compliance with clinical pathways that optimize and standardize care across the continuum			
	Cultural acceptance to rate physician performance and identify practice outliers and then move all toward better compliance with evidence-based care			
	An approach to care that emphasizes relationships rather than episodic interactions			
	A practice culture committed to empowering patients			
	A hospitalist and/or intensivist model to manage inpatient utilization and cost			