

# PATHWAYS TO POPULATION HEALTH

**Compass**  
An assessment and  
intervention planning  
tool for health care  
change agents



## PARTNERS



American Hospital  
Association™

*Advancing Health in America*



Institute for  
Healthcare  
Improvement



Network for  
Regional Healthcare  
Improvement




Stakeholder Health

AN INITIATIVE  
FACILITATED BY



100 Million  
Healthier Lives

WITH GENEROUS  
SUPPORT PROVIDED BY

  
Robert Wood Johnson  
Foundation

## Authors

- Somava Saha Stout, MD, MS: *Executive Lead, 100 Million Healthier Lives, and Vice President, IHI*
- Saranya Loehrer, MD, MPH: *Head of the North America Region, IHI*
- Marie Cleary-Fishman, BSN, MS, MBA, CPHQ: *Vice President Clinical Quality, American Hospital Association/Health Research & Educational Trust*
- KellyAnne Johnson: *Senior Project Manager, IHI*
- Randall Chenard: *Executive Director, HealthDoers Network, Network for Regional Healthcare Improvement*
- Gary Gunderson, MDiv, DMi: *Vice President of Wake Forest Baptist Medical Center*
- Rebecca Goldberg: *Project Manager, IHI*
- Jessica Little, MS, RD: *Senior Manager Strategic Operations, HealthDoers Network, Network for Regional Healthcare Improvement*
- Julia Resnick, MPH: *Senior Program Manager, American Hospital Association/Health Research & Educational Trust*
- Teresa Cutts, PhD: *Research Professor, Wake Forest School of Medicine*
- Kevin Barnett Dr. PH., MCP: *Senior Investigator, Public Health Institute*

### Citation:

Stout S, Loehrer S, Cleary-Fishman M, et al. Pathways to Population Health Compass. Boston: 100 Million Healthier Lives, convened by the Institute for Healthcare Improvement; 2020. (Available at <http://www.ihl.org/p2ph>)



This work is licensed under a Creative Commons Attribution-ShareAlike 4.0 International License. To view a copy of the license, visit <https://creativecommons.org/licenses/by-sa/4.0/>

Attribute to: Somava Stout, MD, MS; Saranya Loehrer, MD, MPH; Marie Cleary-Fishman, BSN, MS, MBA, CPHQ; KellyAnne Johnson; Randall Chenard; Gary Gunderson, MDiv, DMi; Rebecca Goldberg; Jessica Little, MS, RD; Julia Resnick, MPH; Teresa Cutts, PhD; Kevin Barnett Dr. PH., MCP

# Pathways to Population Health Compass

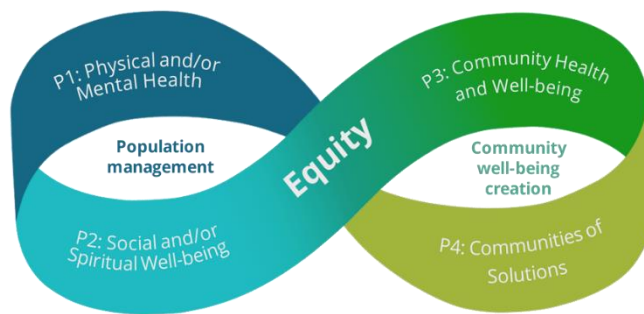
## Introduction

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.
<b>At the beginning</b> 0	<b>Making initial progress</b> 1	<b>Making moderate progress</b> 2	<b>Making substantial progress</b> 3	<b>Implementing broadly</b> 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.
<b>At the beginning</b> 0	<b>Making initial progress</b> 1	<b>Making moderate progress</b> 2	<b>Making substantial progress</b> 3	<b>Implementing broadly</b> 4

## Payment

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

<p>We are entirely fee for service and do not take on financial risk for the health outcomes of any defined populations.</p>	<p>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.</p>	<p>We have several risk-based contracts for defined populations that cover 5% to 20% of our patients and/or employees.</p>	<ul style="list-style-type: none"> <li>• 21% to 50% of our patient and/or employee population is covered under a global payment/shared savings arrangement.</li> <li>• We are actively exploring adding new patient populations or additional payers over time.</li> <li>• We embrace new financial models to improve the health of our patients and communities.</li> </ul>	<ul style="list-style-type: none"> <li>• More than 50% of our patient and/or employee population is covered under a global payment/shared savings arrangement.</li> <li>• We are expanding to create mechanisms to share risk and savings across sectors in our communities.</li> </ul>
<p><b>At the beginning</b> 0</p>	<p><b>Making initial progress</b> 1</p>	<p><b>Making moderate progress</b> 2</p>	<p><b>Making substantial progress</b> 3</p>	<p><b>Implementing broadly</b> 4</p>

## 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.

<p>We do not have formal mechanisms to engage patients, families, or others with lived experience in co-designing the care experience.</p>	<p>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.</p>	<p>We routinely engage our PFAC or others with lived experience to help identify quality improvement priorities.</p>	<p>All quality improvement projects are co-designed with patients and family members, who remain active members of the improvement teams.</p>	<p>People with lived experience co-lead improvement initiatives in our organization or in our community.</p>
<p><b>At the beginning</b> 0</p>	<p><b>Making initial progress</b> 1</p>	<p><b>Making moderate progress</b> 2</p>	<p><b>Making substantial progress</b> 3</p>	<p><b>Implementing broadly</b> 4</p>

## 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.

<input type="checkbox"/> We collect data to proactively manage the physical health of discrete populations. <input type="checkbox"/> We collect data to proactively manage the mental health of discrete populations. <input type="checkbox"/> Our strategic planning staff present basic GIS Zip code data of key patient cohorts as part of our community benefit assessment. <input type="checkbox"/> 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. <input type="checkbox"/> We use our data in improvement initiatives related to mental and/or physical health.			
<b>We don't do any of these things</b> 0	<b>We do a few of these things</b> 1	<b>We do most of these things</b> 2	<b>We do all these things!</b> 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.
<b>At the beginning</b> 0	<b>Making initial progress</b> 1	<b>Making moderate progress</b> 2	<b>Implementing broadly</b> 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.
<b>At the beginning</b> 0	<b>Making initial progress</b> 1	<b>Making moderate progress</b> 2	<b>Implementing broadly</b> 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.	<ul style="list-style-type: none"> <li>We have ways to identify individuals in need of care management and direct them to a dedicated person/team.</li> <li>We are exploring how to identify at-risk populations for outreach by our care management team.</li> </ul>	<ul style="list-style-type: none"> <li>Our multidisciplinary care management team includes patients and families.</li> <li>A core care management team function is actively identifying and engaging community partners to support patients and populations for social/spiritual needs.</li> </ul>	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.
<b>At the beginning</b> <b>0</b>	<b>Making initial progress</b> <b>1</b>	<b>Making moderate progress</b> <b>2</b>	<b>Implementing broadly</b> <b>3</b>

## 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.

<input type="checkbox"/> We collect data to proactively manage the social well-being of defined populations. <input type="checkbox"/> We collect data to proactively manage the spiritual well-being of our discrete populations. <input type="checkbox"/> We share data with all relevant clinical stakeholders, with whom we are collaborating to improve the social and spiritual well-being of discrete populations. <input type="checkbox"/> 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. <input type="checkbox"/> We use our data in improvement initiatives related to social and/or spiritual well-being.			
<b>We don't do any of these things</b> <b>0</b>	<b>We do a few of these things</b> <b>1</b>	<b>We do most of these things</b> <b>2</b>	<b>We do all these things!</b> <b>3</b>



## 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).
<b>At the beginning</b> <b>0</b>	<b>Making initial progress</b> <b>.75</b>	<b>Making moderate progress</b> <b>1.5</b>	<b>Making substantial progress</b> <b>2.25</b>	<b>Implementing broadly</b> <b>3</b>

## 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.

<ul style="list-style-type: none"> <li><input type="checkbox"/> We collect community-wide data on a <u>specific</u> area of focus in our community work.</li> <li><input type="checkbox"/> We use tools like geotagging to understand the relationship of place to <u>specific</u> health and well-being outcomes in our community.</li> <li><input type="checkbox"/> 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).</li> <li><input type="checkbox"/> We analyze our community-level data with a health equity lens with all relevant community stakeholders (including those most impacted).</li> <li><input type="checkbox"/> We use data to risk-stratify and prioritize opportunities with our community partners to improve <u>specific</u> health and well-being outcomes.</li> </ul>			
<b>We don't do any of these things</b> <b>0</b>	<b>We do a few of these things</b> <b>1</b>	<b>We do most of these things</b> <b>2</b>	<b>We do all these things!</b> <b>3</b>

## 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.
<b>At the beginning</b> <b>0</b>	<b>Making initial progress</b> <b>1</b>	<b>Making moderate progress</b> <b>2</b>	<b>Implementing broadly</b> <b>3</b>

## Community Benefit

Consider all the statements below about community benefit.

<ul style="list-style-type: none"> <li><input type="checkbox"/> We have dedicated FTEs for community benefit programming who report to senior leadership.</li> <li><input type="checkbox"/> We have dedicated FTEs for community benefit programming who are accountable for our organization's community benefit performance.</li> <li><input type="checkbox"/> Our community benefit team includes key community organizations and stakeholders.</li> <li><input type="checkbox"/> Our community benefit investments address gaps identified in our community health needs assessment.</li> <li><input type="checkbox"/> 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.</li> <li><input type="checkbox"/> Our community benefits staff have timely access to data and resources to support community benefit programming.</li> <li><input type="checkbox"/> We report our community benefit performance and our population health performance to our governing board.</li> <li><input type="checkbox"/> We partner with other health care organizations in our community to co-invest community benefit dollars to achieve greater community and regional impact.</li> <li><input type="checkbox"/> We evaluate whether community benefit investments lead to improvement in the health and well-being of our community and change our approach accordingly.</li> </ul>			
<b>We don't do any of these things</b> <b>0</b>	<b>We do a few of these things</b> <b>1</b>	<b>We do most of these things</b> <b>2</b>	<b>We do all these things!</b> <b>3</b>

## 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.

<ul style="list-style-type: none"> <li><input type="checkbox"/> Community stakeholders across sectors drive the collection and integration of community-level data to monitor <u>overall</u> trends in health, well-being, and equity in our community.</li> <li><input type="checkbox"/> We use tools like geotagging to understand the relationship of place to <u>overall</u> health and well-being outcomes in our community.</li> <li><input type="checkbox"/> Together, we collect both people-reported well-being measures and proxy measures related to major initiatives we are working on.</li> <li><input type="checkbox"/> We have data sharing agreements and integration platforms in place to promote interoperability. This helps us proactively identify trends in integrated data across sectors.</li> <li><input type="checkbox"/> 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.</li> <li><input type="checkbox"/> We use our data for community-level planning around resources to address the social drivers of health and well-being in our community.</li> </ul>			
<b>We don't do any of these things</b> <b>0</b>	<b>We do a few of these things</b> <b>1</b>	<b>We do most of these things</b> <b>2</b>	<b>We do all these things!</b> <b>3</b>

## Nontraditional Roles/Levers

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

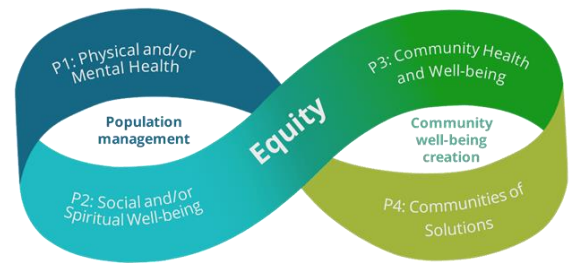
<ul style="list-style-type: none"> <li><input type="checkbox"/> Employer (e.g., develop career pipelines in communities with poor equity outcomes; join efforts to “ban the box”; offer a living wage for all employees; invest in peer workforce from underserved communities such as community health workers; incentivize employees to live in communities that are racially segregated to help with integration)</li> <li><input type="checkbox"/> Purchaser (e.g., procure selectively from vendors, or in communities, that have poor equity outcomes to build community wealth)</li> <li><input type="checkbox"/> 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)</li> <li><input type="checkbox"/> 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)</li> <li><input type="checkbox"/> Environmental steward (e.g., be responsible for your overall environmental footprint and work to reduce emissions and health care waste)</li> <li><input type="checkbox"/> Funder (e.g., use community benefit dollars to support the community)</li> <li><input type="checkbox"/> Builder (e.g., choose to locate new facilities in communities with poorer health outcomes to support job promotion)</li> </ul>			
<b>We don't do any of these things</b> <b>0</b>	<b>We do a few of these things</b> <b>1</b>	<b>We do many of these things</b> <b>2</b>	<b>We do all of these things!</b> <b>3</b>

## Policy

Consider all the statements below about policy.

<ul style="list-style-type: none"> <li><input type="checkbox"/> We have institutional policies to improve working conditions for staff and contractors (e.g., livable wages).</li> <li><input type="checkbox"/> We have institutional policies to increase contracting with local vendors to enhance local economic development.</li> <li><input type="checkbox"/> 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.</li> <li><input type="checkbox"/> 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).</li> <li><input type="checkbox"/> 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.</li> </ul>			
<b>We don't do any of these things</b> <b>0</b>	<b>We do a few of these things</b> <b>1</b>	<b>We do most of these things</b> <b>2</b>	<b>We do all these things!</b> <b>3</b>

# 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 3: Community Health and Well-being

Data \_\_\_\_\_

Community Partnerships: \_\_\_\_\_

Community Benefit: \_\_\_\_\_

**Score:** Sum multiplied by 11 \_\_\_\_\_

## Portfolio 2: Social and/or Spiritual Well-being

Data \_\_\_\_\_

SDOH Screening and Referrals: \_\_\_\_\_

**Score:** Sum multiplied by 16.5 \_\_\_\_\_

## 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 (Appendix A)** for practical tools and resources to get started and **create your Action Plan (Appendix B)** to organize your next steps.

# Appendix A: P2PH Oasis of Tools and Resources

An oasis is a place that provides refuge, relief, and pleasant contrast (Merriam-Webster's Dictionary, 2018). The Pathways to Population Health Oasis is a place to find a curated set of tools and resources to accelerate your improvement journey. It is also where you can find refuge and relief along your journey to population health.

## Topic Areas

**Stewardship**

**Equity**

**Payment**

**Data**

**Partnerships with People with Lived Experience**

**Portfolio 1: Physical and/or Mental Health**

**Portfolio 2: Social and/or Spiritual Well-Being**

**Portfolio 3: Community Health and Well-Being**

**Portfolio 4: Community of Solutions**

**Databases of Population Health Resources**

## Stewardship

**1. [Stewarding Regional Health Transformation: A Guide for Changemakers](#)**

*A guide to help individual leaders and multisector collaborations create and sustain successful stewardship structures to lead regional transformation. Created by ReThink Health. ([Portfolios 3 and 4](#)).*

**2. [Alignment of Governance and Leadership in Healthcare Program Logic Model](#)**

*A tool that outlines strategies, actions, and short- and long-term metrics for the alignment of governance within health care organizations. Produced by Kevin Barnett at the Public Health Institute. ([Portfolios 1 through 4](#)).*

## Equity

**3. [Achieving Health Equity: A Guide for Health Care Organizations](#)**

*This white paper provides guidance on how to reduce health disparities. It includes a framework, guidance for measuring health equity, a case study, and self-assessment tool. Created by the Institute for Healthcare Improvement (IHI). ([Portfolios 1 through 3](#))*

#### 4. [Equity of Care: A Toolkit for Eliminating Health Care Disparities](#)

*A how-to guide to help accelerate the elimination of health care disparities and ensure leadership teams and board members reflect the community served. Equity of Care is a national collaborative effort of the American Hospital Association, American College of Healthcare Executives, America's Essential Hospitals, Association of American Medical Colleges and Catholic Health Association of the United States. ([Portfolios 1 through 4](#))*

## Payment

#### 5. [A Typology of Potential Financing Structures for Population Health](#)

*This table describes potential financial structures including what it takes to access these structures and when to use them. Produced by Rethink Health. ([Portfolios 3 and 4](#))*

#### 6. [Healthcare Affordability: Untangling Cost Drivers](#)

*This website features a report that provides a multi-region analysis of total cost of care and its drivers. The site also provides resources to help stakeholders (e.g., providers, policy makers, employers, and health plans) take action. Produced by the Network for Regional Health Improvement. ([Portfolios 1 through 4](#))*

## Data

#### 7. [Community Health Needs Assessment Data Tool](#)

*A web-based platform to help health care organizations understand the needs and assets of their communities by identifying the most vulnerable populations. Use it to run indicator reports on health and quality of life at the local and regional level. Administered by Community Commons. ([Portfolios 3 and 4](#))*

#### 8. [Well Being in the Nation \(WIN\) Measures](#)

*Core measures and key indicators at the national, state, county, and city level that show connections between social conditions, health, community, and well-being. Created by 100 Million Healthier Lives. ([Portfolios 1 through 4](#))*

#### 9. [Vital Signs – Core Metrics for Health and Health Care Progress](#)

*A report that proposes a streamlined set of 15 measures, with recommendations for their standardization and application at every level: national, state, local, and institutional. Produced by the National Academy of Medicine. ([Portfolios 1 through 4](#))*

## Partnerships with People with Lived Experience

#### 10. [Better Together – Partnering with Families](#)

*A toolkit to give hospital leaders the rationale, tools, and support needed to change visiting policies and improve family participation. Provided by the Institute for Patient- and Family-Centered Care. ([Portfolios 1 and 2](#))*

#### 11. [Practice Improvement Team Toolkit](#)



*A toolkit for engaging patients and health care team members in redesigning primary care to work better for patients. Produced by the Cambridge Health Alliance based on their Patient-Centered Medical Home Transformation Journey. ([Portfolios 1 and 2](#))*

**12.** [Engaging Community Residents with Lived Experience](#)

*A report with best practices and recommendations for engaging individuals with lived experience in their own communities, based on lessons learned from the Spreading Community Accelerators through Learning and Evaluation (SCALE) project. ([Portfolios 3 and 4](#))*

## **Portfolio 1: Physical and/or Mental Health**

**13.** [Steps Forward: Implementing Team-Based Care](#)

*A step-by-step implementation guide for a Team-Based Care model, including an online module, downloadable tools, and case examples. Provided by the American Medical Association.*

**14.** [Models for Integrating Behavioral Health into Primary Care](#)

*A curated list of best practices and models for integrating behavioral health into primary care. Created by SAMHSA-HRSA Center for Integrated Health Solutions.*

**15.** [Primary Care Team Guide: Behavioral Health Integration](#)

*A guide that describes steps for integrating behavioral health into primary care. Created by the Primary Care Team-LEAP Program.*

## **Portfolio 2: Social and/or Spiritual Well-Being**

**16.** [Social Needs Screening Toolkit](#)

*Based on the latest research on screening patients for social determinants, this toolkit includes best practices, a recommended tool, and a library of questions. Written and updated by Health Leads.*

**17.** [Religious Health Assets Mapping](#)

*Introduces an approach to understanding the religious and health assets in a community through Participatory Inquiry into Religious Health Assets, Networks, and Agency (PIRHANA). Created by Stakeholder Health. The University of Cape Town offers a detailed facilitators' workbook for PIRHANA that can be accessed [here](#). ([Also Portfolio 3](#))*

## **Portfolio 3: Community Health and Well-Being**

**18.** [A Playbook for Fostering Hospital-Community Partnerships to Build a Culture of Health](#)

*A playbook of methods, models, tools, and strategies for health care organizations to create new community partnerships. Created by the Health Research & Education Trust (HRET).*

**19.** [CACHE Community Benefit Insight \(CBI\)](#)

*A searchable platform for hospital 990 Schedule H data to support quick calculations and comparisons of community benefit expenditures and related policies across institutions over time. Created by the Center to Advance Community Health & Equity (CACHE). (Also Portfolio 4)*

**20. [The Community-Centered Health Homes Model: Updates & Learnings](#)**

*A publication providing a framework to address community conditions that impact health as well as lessons learned from health care organizations that have implemented the Community-Centered Health Homes (CCHH) model. Produced by the Prevention Institute.*

**21. [Health Impact in 5 Years \(HI-5\)](#)**

*Database of evidence-based community health initiatives that result in positive health outcomes within five years with cost savings. Provided by the Centers for Disease Control and Prevention (CDC).*

## **Portfolio 4: Community of Solutions**

**22. [Hospitals Aligned for Healthy Communities](#)**

*A set of toolkits to help hospitals and health systems build community wealth through inclusive hiring, investment, and purchasing. Created by the Democracy Collaborative.*

**23. [Anchor Mission Playbook](#)**

*Recommendations to help hospitals and health systems align their institutional resources (including hiring, purchasing, investment, and volunteer base) with community needs. Prepared by Rush University Medical Center and the Democracy Collaborative.*

## **Databases of Population Health Resources**

**24. [Community Toolbox](#)**

*Curated evidence-based resources to improve health within health care and the community. A service created by the Center for Community Health and Development at the University of Kansas. (Portfolios 1 through 4)*

**25. [County Health Rankings & Roadmaps What Works for Health](#)**

*Extensive database of resources for improving community health. Find strategies by topic area (e.g., health behaviors, clinical care, social and economic factors, and physical environment). The program is collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. (Portfolios 1 through 4)*

## Appendix B: P2PH Action Planning Form

Name:	
Title:	Organization:
Date Updated (Today's Date):	

**Overview and Purpose:** This Pathways to Population Health Action Plan is intended to help you prioritize plans and next steps based on the opportunities you identified in the Compass. We recommend updating your Action Plan each time you retake the Compass to assess your progress (we suggest every 6 months).

**Overall Aim for this Quarter (you might wish to fill this out after completing the other sections):**

By [DATE, "by when"] \_\_\_\_\_,  
 we will [outcomes]: \_\_\_\_\_

\_\_\_\_\_

This work will benefit [“for whom”]: \_\_\_\_\_

\_\_\_\_\_

Our main partners for this work are: \_\_\_\_\_

\_\_\_\_\_

**Actions for Stewardship, Equity, Payment, and Partnerships with People with Lived Experience**

In the grid below, note your current strengths or recent wins, your vision for each area, and any actions in this quarter. You may not have actions in all areas (far right column) for this quarter.

Area	Assets, Where We Are Strong Now or Gains in the Last Quarter	Overall Vision for this Area	Actions this Quarter to Get Us Closer to Our Overall Vision
<b>Stewardship</b>			
<b>Equity</b>			
<b>Payment</b>			
<b>Partnerships</b>			

**Actions for Portfolios:**

As noted in the Compass, the portfolios connect and build on one another and are intended to represent a balanced portfolio of population health efforts. In the grid below, note your current strengths or recent wins, your vision for each Portfolio, and any actions in this quarter. You may not have actions in all Portfolios or subtopics (data, behavioral health integration) for this quarter.

<b>Portfolio &amp; Associated Components</b>	<b>Assets, Where We Are Strong Now or Gains in the Last Quarter</b>	<b>Overall Vision for this Area</b>	<b>Actions this Quarter to Get Us Closer to Our Overall Vision</b>
<b>Portfolio 1 (Mental and/or physical health):</b> <ul style="list-style-type: none"> <li>• Data</li> <li>• Behavioral Health Integration</li> <li>• Team Based Care</li> <li>• Care Management</li> </ul>			
<b>Portfolio 2 (Social and/or spiritual wellbeing):</b> <ul style="list-style-type: none"> <li>• Data</li> <li>• Social Determinant Screening and Referrals</li> </ul>			
<b>Portfolio 3 (Community health and wellbeing):</b> <ul style="list-style-type: none"> <li>• Data</li> <li>• Community Partnerships</li> <li>• Community Benefit</li> </ul>			
<b>Portfolio 4 (Communities of Solutions):</b> <ul style="list-style-type: none"> <li>• Data</li> <li>• Leveraging Nontraditional Roles</li> <li>• Policy</li> </ul>			