# Site-of-care shift strategy assessment

## Audit your organization's plans to move care closer to the patient

Increased demand from growing, aging populations, coupled with supply shortages, have exacerbated sustainability pressures and are straining health systems around the world. Now more than ever, there is opportunity to finally reorganize care around the patient. This involves shifting access points to sites or modalities that are less expensive, scalable, and easier to access, such as digital options or community sites.

However, despite leaders understanding these ambitions at a high level, organizations often lack critical components necessary to make care shifts a reality. This assessment encompasses 10 components of a successful site-of-care shift strategy, enabling executives to benchmark their organization's plans, infrastructure, and behaviors against those of peer organizations.

### How to use this tool

The assessment can be used at the macro level (i.e., to audit your organization's overall ambitions), or for specific care shifts (i.e., your virtual or ambulatory care shift strategy).

First, choose whether you're using this tool at the macro level or for specific care shifts. Then, for each question, select the column that most accurately describes your organization.

Next, use the tool to prioritize areas where your organization needs to improve. For a truly comprehensive strategy, organizations should agree with the "meeting the mark" statements for all 10 components. We recommend prioritizing "meeting the mark" for each component **in their ranked order** before proceeding to the next. The description of the common barrier to progress will help inform your discussion and approach for each component.

| # | Question | Just getting started | On the right track | Meeting the mark | Common barrier to progress |
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| 01 | **Vision:** What is guiding how and where your organization plans to deliver services in the future? | Our mission statement continues to reflect an ambition to improve in-hospital care. | Our strategic plan may include specific ambitions to shift sites of care, but our mission statement does not include a definitive end goal with respect to where we wish to deliver care in the future. | We've codified our long-term ambitions to deliver care closer to patients into a unifying, enterprise-wide mission statement. | An organization lacks a unifying message that reflects its long-term ambition to move care closer to the patient, leading disparate parts of the organization to continue to pursue their own local interests rather than the collective goal of moving care. |
| 02 | **Culture:** What are the collective values and behaviors your organization has with respect to shifting services to alternative sites? | Our culture maintains the hospital as the status quo site of care by discouraging staff (implicitly or explicitly) from offering suggestions that disrupt default access points. | We welcome staff to share feedback and ideas with managers, but there is no reliable structure or process through which these ideas are collected, evaluated, or implemented. | We value and reward behaviors and ideas that disrupt the system's default access points.<br>We systematically and routinely gather and incorporate feedback from staff across all levels.<br>We leverage site-of-care shifts as an engagement opportunity for staff at all levels. | An organization unintentionally stifles care-shift innovation by failing to create an environment that values new ideas and participation from staff. |
| 03 | **Decision-making:** To what extent have you standardized your approval process for shifting a service to an alternative care site? | We do not have a rubric or standardized list of criteria that proposals for new care models must meet, as most of our shifts are reactions to government mandates or payer shifts. | We primarily evaluate proposals for new models and programs based on their immediate ROI. As such, we may approve proposals that do not align with our organization's long-term ambition to move care closer to the patient. | We have a standardized decision-making framework or process to ensure that each of our shifts improves our ability to deliver services closer to the patient.<br>This decision-making framework doubles as a guardrail to keep all stakeholders across the system aligned to a singular vision for the future of our organization. | An organization does not have a standardized, agreed-upon rubric that leaders use to approve or deny new proposals or care models to shift care closer the patient. |
| 04 | **Governance:** To what extent have you assigned ownership over shifting a service to a new care site? | We have not assigned ownership over identifying opportunities for and implementing service shifts to one or more dedicated individuals.<br>When service shifts do happen, it's a top-down process, owned entirely by the C-suite. | Some of our individual clinical directors own decisions about where and how to shift priority services. As such, forecasting and implementing service shifts is an added responsibility. | We have an executive role dedicated to crafting a long-term strategy on site-of-care shift and leading all change efforts.<br>This executive leads a dedicated change management team that, in partnership with clinical directors and unit staff, plans and executes service shifts. | The person or people overseeing site-of-care-shift strategy is/are forced to treat it as side-of-desk work, meaning they are balancing it with other tasks and therefore under-prioritizing it. |
| 05 | **Data and analytics:** To what extent are you leveraging data to catalyze shifting services to alternative sites? | We have access to a data repository that we use to improve our current hospital-based service offerings, but we do not have access to the data we would need to identify specific services to move care closer to the patient. | We collect data on an ad hoc basis to shift specific, opportunistic services closer to the patient. As such, data collection to support out-of-hospital ventures is not a centralized function. | We continuously collect specific data that we use to pinpoint opportunities to shift services for specific cohorts of patients.<br>We leverage data to engage staff in our site-of-care shift strategy.<br>We assign ownership of data collection to a dedicated, multidisciplinary group of individuals. | An organization's data collection efforts are not targeted to answer specific questions about the site-of-care shift. |
| 06 | **Institutional expertise:** How well do you ensure that your success in shifting services to alternatives sites is inventoried and continuously improving? | We do not have a knowledge management system to capture learnings from each time we shift a service to an alternative site. | We incorporate lessons learned from each site-of-care shift into subsequent shifts, but have not embedded those learnings into our operational framework or designated keeper(s) of this knowledge. | We have a Center of Excellence model wherein a dedicated group of multidisciplinary staff specialize in the skills needed to shift any service to new sites or modalities. | An organization deprioritizes the essential task of codifying and centralizing knowledge about how to shift services by viewing knowledge management and dissemination as an afterthought. |
| 07 | **Patient involvement:** To what extent do patients participate in service planning and design at your organization? | Our patients are minimally involved in service and access planning. | We welcome patients to share feedback and ideas on how to improve care quality and access, but there is no structure or process through which these ideas are collected, evaluated, and implemented. | We have structures in place for collecting and incorporating feedback from patients and members of the community early in the process of designing care models.<br>We elevate stakeholder opinions through a democratic consultation process. | An organization does not elevate the patient experience or preferences from the start when they design care models. |
| 08 | **Facilities planning:** To what extent are you adapting your footprint to support the delivery of care in alternative settings? | Our long-term plans involve new hospital builds and/or expanding default, acute-centric access points.<br>Our service portfolio is built to maximize access for those who already frequently interact with and are familiar with our health system. | We sometimes repurpose existing spaces or new community space to pilot and implement new care models.<br>We are slowly shifting default access points to increase accessibility, but only when the ROI is immediate and high. | We are currently making major investments in out-of-hospital care to improve access for patients.<br>We take a "build as a last resort" approach to facilities planning, which makes executing service shifts faster and less expensive. | There is little communication between the capital planning groups and those responsible for planning site-of-care shifts. This leads to a lack of clarity around what spaces can be used and repurposed as alternative care settings. |
| 09 | **Staffing:** To what extent do you prioritize staffing vacancies in hospitals versus other care sites? | We lack visibility into vacancies in out-of-hospital settings.<br>We prioritize staffing vacancies within hospitals. | We redeploy some clinicians from hospitals to staff out-of-hospital care sites. But our picture of what staffing levels are like across our system is largely incomplete. | We have full, real-time visibility into vacancies across our entire system and can easily transfer staff across care sites.<br>We prioritize staffing vacancies in out-of-hospital settings. | An organization continues to favor filling vacancies in the hospital instead of in out-of-hospital settings. |
| 10 | **Payer relationships:** To what extent are you working with payers to implement alternative access points? | We develop care models in response to established incentives, penalties, or mandates. | We are actively tracking and open to new incentive models for new sites of care. | We seek to disrupt inpatient reimbursement models by piloting alternative care models despite the potential to increase costs in the near-term. | An organization is not willing to disrupt their own payment to make progress toward their long-term goals. |

For more on creating sustainable care models, view our webinar at **advisory.com/CareShifts** or listen to our podcast at **advisory.com/podcast**

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