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COMMENTARY: POPULATION HEALTH IMPROVEMENT & RURAL HOSPITAL BALANCED SCORECARDS

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Now is the time for Balanced Scorecard driven strategic planning to incorporate population health measures. The growing expectation of healthcare providers regarding health improvement and healthcare costs suggest that healthcare providers join with public health and other community leaders to “look upstream” for opportunities to prevent illness and reduce future healthcare expenses. Community leadership must act, and hospitals are part of that leadership.

The Balanced Scorecard is a practical performance improvement tool that rural hospitals are increasingly integrating into their strategic planning and management processes. The goal of the Balanced Scorecard is to link strategy with action and to identify cause/effect relationships among short and long-term objectives. Robert Kaplan and David Norton helped to popularize Balanced Scorecard in the early 1990s and they organized key objectives into four *domains*: Financial, Customer, Internal Processes, and Learning and Growth.¹ Since then, strategic planning consultants and hospital leaders have been adapting, applying, and evolving the tool for healthcare.

David Kindig and Greg Stoddart define *population health* as “ ‘the health outcomes of a group of individuals, including the distribution of such outcomes within the group.’ These populations are often geographic regions, such as nations or communities, but they can also be other groups, such as employees, ethnic groups, disabled persons, or prisoners. Such populations are of relevance to policymakers. In addition, many determinants of health, such as medical care systems the social environment, and the physical environment, have their biological impact on individuals in part at a population level.”²

Many hospitals, across the country, have long been involved in key community-wide interventions – this is not new. However, the concept of including local population metrics in a hospital’s Balanced Scorecard is challenging because hospitals, not unlike other community organizations, are not solely responsible for their communities’ health. As best expressed by a rural hospital ceo during a focus group discussion at the Rural Wisconsin Health Cooperative in early 2004, when population healthcare outcomes are everyone’s responsibility, it is, as a practical matter, no one’s responsibility.

However the time is right to address this fundamental challenge. The Institute of Medicine (IOM) of the National Academies of Science in its 2002 report, *Fostering Rapid Advances In Healthcare: Learning From System Demonstrations* stated, “The healthcare system of the 21st century should maximize the health and functioning of both individual patients and communities. To accomplish this goal, the system should balance and integrate needs for personal healthcare with broader community-wide initiatives that target the entire population.”³ In its November 2004 report, *Quality Through Collaboration: The Future of Rural Health*, the IOM went further, emphasizing the increasingly critical need for America to adopt this integrated approach and cites the unique advantages and major role rural communities can have in leading the way.⁴ That is the opportunity.

Although the disciplines of population health analysis and Balanced Scorecard-based management are well-established, the two have not previously been considered together. Furthermore, rural hospitals may accept an implicit and informal role in its community health, but that role is easily subjugated by the more pressing demands of revenue-generating activity.

As often the de facto local healthcare system leader, and now subject to an increasing private and public sector demand for non-profit hospital accountability, rural hospitals may be ready to assume a greater role in population health improvement.

Barriers to hospitals taking on this expanded role fall into two sets, strategic and technical. First among the strategic barriers is tradition. With some notable exceptions, the role of the hospital has been seen as treating individual patients. Concern about the population as a whole has been seen as “the job” of local and state public health departments, notwithstanding that sector’s chronic under-funding. The second is obvious – hospitals and clinics that are struggling to address traditional responsibilities with tight budgets are not looking for new roles “that no one will pay us to do.” The third is the conflict or discomfort that most of us feel when talking about addressing population health issues, many of which relate to individual behaviors – other people’s choices and their freedom to make those choices.

Population health improvement has long been the purview of public health departments, not hospitals. Despite its noble mission, U.S. Public Health has long lived in the shadow of traditional medical care (provided by physicians and nurses to individuals in hospitals and clinics). Although the causal relationship between funding and outcomes is complicated and often obscure, our public health outcomes are discouraging compared to other industrialized countries spending far less per capita. Why is that so? The answer must be multi-factorial. However, the U.S. is a culture of “rugged individualism,” technology fascination, and quick-fix expectation – each the antithesis of public health endeavors. We undermine public (or community) health right out of the gate. Thus, hospitals have risen as an alternative locus of community-based healthcare. It need not necessarily be that way, but in the hospital are strong potential resources – preferably in partnership with public health professionals and local physicians – to foster population health improvement efforts. Thus far, this new potential hospital role as population health improver is an uncomfortable fit.

We need to emphasize that the issue is not whether or not hospitals should be in charge, but whether or not hospitals have a collaborative leadership role to play – along with other key players in the community: the local public health agency, local businesses, clinicians, schools, employers, etc. In some communities, a hospital may play a facilitator or convener role, but in no communities should this be about the hospital “taking charge” of the community’s health. Even if you could find a hospital that wanted that role, the nature of the work requires community-wide collaborations to get the job done. Similarly, this is not a competition between individualism and a community focus, but creating a synergy between two important frames – personal health and population health.

We often think of Americans as individualists, but our country’s tradition is more complex than the well-worn expression, “good fences make good neighbors,” first lets on. Robert Frost’s poem “Mending Wall” goes on to say, “I let my neighbor know beyond the hill, and on a day we meet to walk the line and set the wall between us once again.” Even this American icon to self-sufficiency is expressed within the cultural context of selective cooperation being used to maintain individualism.

Physicians also have an important potential role in community health, yet that role is not fully supported. Physicians have four primary responsibilities – to prevent illness, to cure disease, to

comfort the dying, and to be a wise steward of resources. In reality, the resource steward responsibility often becomes lost in the first three. Physician socialization rightly reinforces individual patient advocacy, but often does so regardless of the cost burden placed on the population (a pool of potential patients). Healthcare, as provided in the U.S., is costly beyond any international comparison. What better investments might we make to improve our health? Investment in population health improvement might bring us better value for the healthcare dollar. Thus, to turn the ocean liner of cultural individualism and physician socialization to embrace a need for community thinking, we need to understand that our vast investments in healthcare provide only modest returns in population health. We need a new focus on population health *in concert with* a continued focus on personal health. A bilateral approach is critical.

If cultural barriers to population health improvement were not difficult enough, technical barriers, while narrower in scope, remain challenging. Most metrics found to be useful for Balanced Scorecards are measured on a monthly or quarterly frequency. Consequently, results of interventions aimed at moving the data can be tracked and used to test intervention effectiveness, identify unintended consequences, and motivate change. In contrast, traditional population health metrics are available annually at best, and typically represent a geographic area that doesn't align with a hospital service area. We need new approaches to address these data gaps.

In addition we need to link health improvement efforts to a population health outcomes. This is one of population health's greatest challenges. Yet, we can use proxies for population health outcomes; such as, high blood pressure control for cardiovascular disease or HgbA1c rates for diabetes. Preventive Quality Indicators (previously Ambulatory Care Sensitive Conditions) measure hospital admission diagnoses that could have been avoided by good preventive care. In addition, certain statistical techniques may ameliorate the challenge of low outcome incidence. Secondly, how do we define the boundaries of our communities? Should a hospital be responsible for the health of its community, county, or region? Researchers at Dartmouth have identified hospital and primary care service areas based on prior utilization. Yet, any definition of "community," and any population health improvement measure or effort, must include those individuals that have not yet accessed healthcare services. The above barriers are not insurmountable.

But we must come back to the overriding problem that "when population healthcare outcomes are everyone's responsibility, it is, as a practical matter, no one's responsibility."

If some entity(s) must step up and take leadership in the quest for optimal health, the healthcare sector has significant responsibility and opportunity – a responsibility given the nature of the profession and the significant amount of public and private resources it is entrusted with (not to mention its legal community benefit responsibility), and an opportunity given the trust that most people put in healthcare providers and organizations. If this is true, rural hospitals may have an opportunity to take a lead given the smaller size of the organization, the general interrelatedness of the different sectors in rural areas (healthcare, education, social services, public health, local government), and the importance of the rural hospital and health systems in the local economy.

The very essence of Balanced Scorecards is that successful organizations focus on those objectives and related outcomes, that if achieved, go a long way to advancing the organization's

vision. If organizational success is directly affected by measures of population health, hospitals will engage. But hospitals don't print money and few rural hospitals have separate foundations with any substantial resources. The challenge is as it has always been, how do we pay for caring for today's patients while finding the funds to become more proactive to reduce the future healthcare needed.

The trick is to define the right level of responsibility for any one organization. Some have suggested that a new entity such as a Health Outcome Trust take on the convening role.⁵ As pay for performance models become more widespread, and as health outcomes begin to be purchased instead of just services, all of this will become much easier. We are beginning to see pay-for-performance developments in both medical care and education, but not yet rewards for health outcome improvement at the population level.

Exact models for Health Outcome Trusts have not been developed or fully specified. Many "Healthy Community" partnerships are trying to do this, and enlightened state and local public health leaders envision such a role for the new public health. What is required is a coordinated effort between the public and private sectors, as well as financial resources and incentives to make it work. The task is almost certainly too big for voluntary efforts, particularly when producing health is viewed as involving hospitals, doctors, public health and environmental agencies, schools, and non-profit advocacy groups. There may be more promise for such models being developed in rural areas where the relationships are already at a smaller and even personal level. In such settings, hospitals are natural candidates for a leadership role, while clearly acknowledging that the full responsibility is beyond the hospital or medical care sector alone. Where do we start? The 2004 IOM report *Quality Through Collaboration: The Future of Rural Health*.⁶ gives important guidance for national and state initiatives. With or without the timely implementation of these recommendations, much can be done at the local level by rural hospitals to foster population health awareness and new collaborative interventions, such as:

- Devote a periodic Board meeting or a portion of every Board meeting to review available population health indicators.
- Add Board members with specific interest and/or expertise in population health measurement and improvement.
- Create a "population health" subcommittee of the hospital board to explore opportunities for hospital partnerships with other community organizations to improve proactively population health.
- Consider hospital employees or employees of a proactive local employer as a "community" and develop interventions to improve employee health. Then, expand the experience to the larger community.

Business schools cite railroads as a classic example of a sector's failure to adapt to changing times; falling from tycoon status in the late 19th century to bankruptcy in the 20th. The railroads kept on doing what initially had been a successful business strategy – selling access to rail cars and track. However, the railroads failed to adapt to a market that was redefining transportation as cars and airplanes, not trains. In a similar fashion, healthcare "markets" are being redefined;

shifting from purchasing service units to purchasing quality outcomes. Importantly, quality care is increasingly defined in both personal and population perspectives. This developing redefinition of healthcare markets needs to be reflected in hospital strategic planning. This is a great opportunity for rural hospitals and the communities they serve.

REFERENCES

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³ *Fostering Rapid Advances in Healthcare: Learning from System Demonstrations*. Institute of Medicine. The National Academies of Science Press. Washington, DC. 2002.

⁴ *Ibid*.

⁵ Kindig, D. *Purchasing Population Health: Paying for Results*. University of Michigan Press. Ann Arbor. 1997.

⁶ *Quality Through Collaboration: The Future of Rural Health*. Institute of Medicine. The National Academies of Science Press. Washington, DC. 2004.