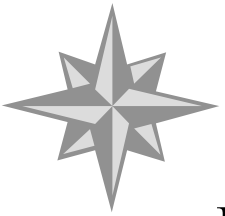

Balanced Scorecards & Population Health

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Presentation Outline of "Work In Progress"

1. Collaborators & Funding
2. Initial Four Questions & Underlying Assumption
3. Initial Findings
4. IOM Vision for American Health Care
5. AHRQ Prevention Quality Indicators (PQI)
6. Wisconsin & RWHC Data
7. Next Steps
8. Q & A

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Thanks to Collaborative Brainstorming

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MetaStar (Wisconsin's Quality Improvement Organization)

Rural Wisconsin Health Cooperative members & staff

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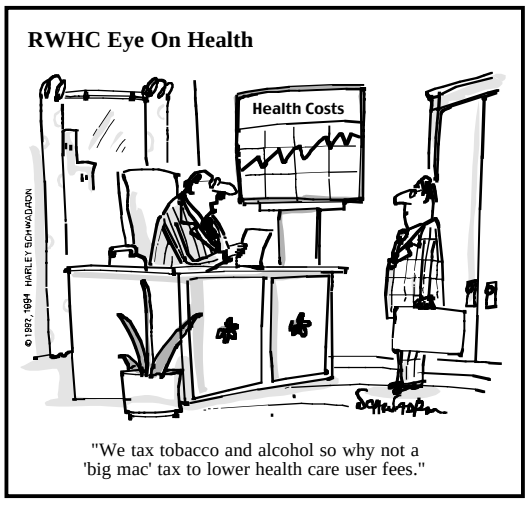
"New" Problems Need "New" Roles & Behaviors



"We tax tobacco and alcohol so why not a 'big mac' tax to lower health care user fees."

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Initial Four Questions

1. How can RWHC most effectively evolve/bundle its current performance measurement data sets to be more useful to rural hospitals using Balanced Scorecards as part of their strategic planning process?
2. How can rural networks like RWHC most effectively promote individual members linking of these performance measurement sets to their ongoing strategic planning processes?
3. What population based measures are available which can most readily, appropriately be added to the Balance Scorecards for rural hospitals?
4. What arguments for the inclusion of population-based measures are most relevant or effective with the administration and boards of directors of rural hospitals/networks?

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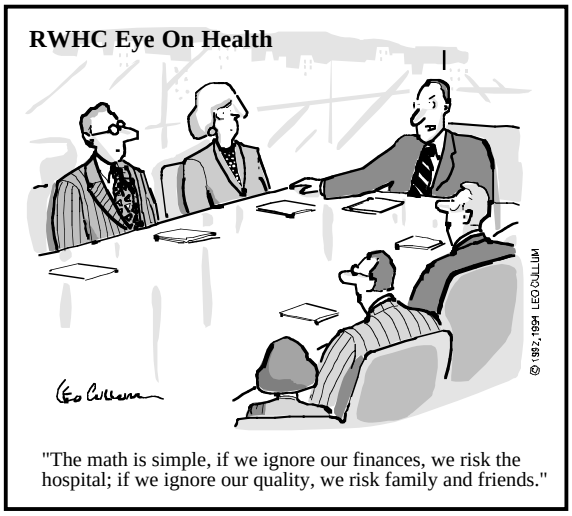
Underlying Assumption



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Initial Focus Group & Stroudwater Findings

Re Question #1: Focus group participants expressed an interest in using the existing RWHC data reporting capabilities to support individual Balanced Scorecard efforts but did not believe that RWHC needed to reconfigure its current data collection and benchmarking services to be prescriptively consistent with any Balanced Scorecard models

Re Question #2: There is widespread interest among RWHC focus group hospital representatives in pursuing the development of a Strategic Planning Roundtable Group, consistent with the collaborative but autonomous spirit of other RWHC roundtables to support member strategic planning processes, including in some but not all organizations, use of Balanced Scorecards

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Initial Focus Group & Stroudwater Findings (Continued)

Re Question #3: Traditional population-based health measures (e.g., preventive health care utilization, personal risk behaviors, socioeconomic factors, environmental factors) are currently less suitable as Balanced Scorecard measures because they do not represent hospitals' "core" services. However, proxies for population health deserve consideration. Hospital data specific to "ambulatory care sensitive conditions" may be an appropriate bridge between the hospital and population based interventions.

Re Question #4: Because purchasers currently do not reimburse hospitals for population health improvement, and it is not a "core" hospital service, population-based measures are less relevant to hospital administration and Boards at this time.

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IOM Vision for American Health Care

"The health care 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 health care with broader community-wide initiatives that target the entire population. The health care system must have well-defined processes for making the best use of limited resources." *Fostering Rapid Advances In Health Care: Learning From System Demonstrations*, Institute of Medicine of the National Academies, 11/02

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Why Is Population Health Perspective "Catching On"?

- Growing "business case" that we must reduce future needs/costs.
- Health outcomes (mortality and general health status) are driven by health determinants as follows:
  - Access to Health Care (10%)*
  - Health Behaviors (40%)* e.g. smoking, physical inactivity, overweight, sexually transmitted disease, motor vehicle crashes.
  - Socioeconomic factors (40%)* e.g. education, poverty, divorce rates.
  - Physical environment (10%)*

**Wisconsin County Health Rankings 2003,* Wisconsin Public Health and Health Policy Institute

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Prevention Quality Indicators

- Prevention is a critical role for providers and community leaders.
- Providers & policy makers need data re the need for and impact of prevention services and other community wide initiatives.
- Agency for Health Research (AHRQ) Prevention Quality Indicators (PQI) are a tool that can be applied to local, state, or national data and flag potential problems.
- PQI can be used to provide a window into the community—to identify unmet community heath care needs, to monitor how well complications from a number of common conditions are being avoided in the outpatient setting, and to compare performance of local health care systems across communities.

Quality Indicators—Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Care Sensitive Conditions from AHRQ, 2001

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Prevention Quality Indicators (Continued)

- Factors outside the direct control of the health care system, such as poor environmental conditions or lack of patient adherence to treatment protocols, can result in hospitalization.
- PQI identify "ambulatory care sensitive conditions" (ACSC). ACSC are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.
- Because the PQI are calculated using readily available hospital administrative data, they are an inexpensive screening tool.
- PQI are state of the art in measuring preventive and outpatient care through analysis of inpatient discharge data.

Quality Indicators—Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Care Sensitive Conditions from AHRQ, 2001

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The Sixteen AHRQ PQI

• Bacterial pneumonia	• Hypertension
• Dehydration	• Adult asthma
• Pediatric gastroenteritis	• Pediatric asthma
• Urinary infections	• Chronic obstructive pulmonary disease
• Perforated appendicitis	• Uncontrolled diabetes
• Low birth weight	• Diabetes, short-term complications
• Angina w/o procedure	• Diabetes, long-term complications
• Congestive heart failure	• Lower extremity amputations (diabetes)

Quality Indicators—Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Care Sensitive Conditions from AHRQ, 2001

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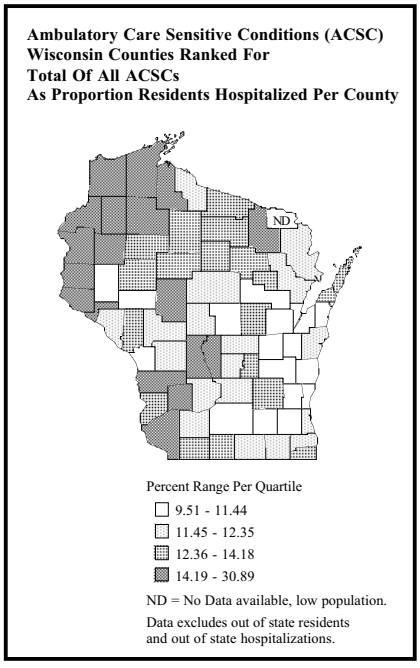

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Wisconsin Residents In Wisconsin Hospitals
Ambulatory Care Sensitive Conditions (ACSC)
(1st 3 Quarters of 2003)

	Hospitalizations		
	Number	% ACSC	% All
Bacterial Pneumonia	15,743	21.88%	2.43%
Congestive heart failure	14,905	20.72%	2.30%
Chronic obstructive pulmonary disease	7,114	9.89%	1.10%
Diabetes Cluster	7,021	9.76%	1.08%
Dehydration	6,999	9.73%	1.08%
Urinary infections	6,357	8.84%	0.98%
"Other" Cluster	13,804	19.19%	2.13%
Total ACSC Hospitalizations	71,943	100.00%	11.11%
Total All Hospitalizations	647,308		100.00%

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Selected AHRQ Prevention Quality Indicator Rates (PQI)
For Discharges from Any Wisconsin Hospital between 10/1/00 to 9/30/03
For ZipCodes in RWHC Member Hospital Service Areas (HSA)*

Dartmouth HSA*	Bacterial Pneumonia Rate/ 100K Population	Percent of WISC Rate	Congestive Heart Failure Rate/ 100K Population	Percent of WISC Rate
LOW	264	83%	266	62%
WISC	317	100%	398	100%
RWHC	401	126%	429	108%
HIGH	764	241%	678	170%

* An HSA is a cluster of zipcodes named by the town or city where the greatest proportion (plurality) of residents in each zipcode were hospitalized.

These rates are not age or gender adjusted; they do not reflect out of state hospitalizations.

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PQI Require Community Interventions

- PQI assess the quality of the health care system as a whole.
- Are of greatest value when calculated at the population level and used to address the health of community or populations.
- These indicators serve as a screening tool rather than as definitive measures of quality problems. They can provide initial information about potential problems in the community that may require further, more in-depth analysis.
- America must reduce the need for increasingly unaffordable care by providing appropriate, high-quality preventive services.
- For this to happen, however, we need to be able to track not only the level of outpatient services but also the outcome of the services people do or do not receive.

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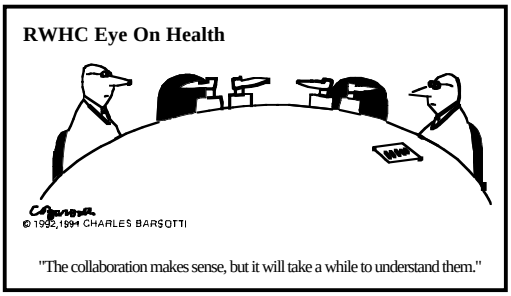
Community Interventions Require Collaboration



- Increasingly limited resources make it a necessity
- It is the only way to address population health threats
- It a traditional approach in many rural communities
- Basis of most major rural health grant opportunities (Flex, Outreach, Network, BlueCross, Kellogg, RWJ)

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Next Steps Re BSC & Population Health Integration

1. Serving as a catalyst and facilitator for rural hospitals to enhance strategic planning efficacy and applicability.
2. Advocating for improved population health measurement techniques and increased population health improvement valuation.
3. Assisting rural hospitals (and external stakeholders) to begin to link the mission of community health improvement to budget, operations, and performance measurement, starting with the PQI most numerous in RWHC service areas.
4. Partnering with University of Wisconsin, Metastar and others to develop relevant demonstration projects.

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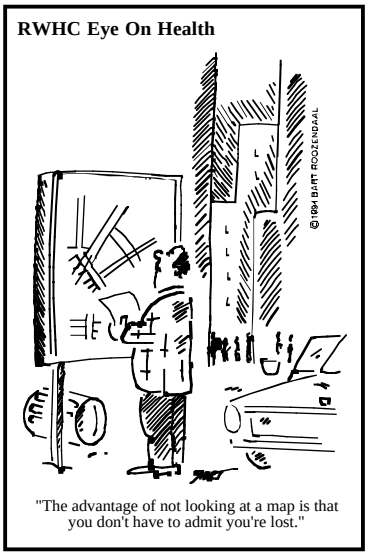
Compass & Map Are Needed For New Destinations



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