Improving Quality in Health Systems: How Do They Do It?

A Toolbook for Healthcare Boards and Executives

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Improving Quality in Health Systems: How Do They Do It?

While it is relatively easy to identify high-performing hospitals utilizing publicly available ratings such as the CMS Star rating system or Leapfrog's safety ratings for individual hospitals, it is not as easy to look at multi-hospital system quality performance.[1] CMS, Leapfrog, HCAHPS, and NRC Health Market Insights surveys all look at individual hospital performance as opposed to system-level performance. At The Governance Institute (TGI), we were curious to try and identify which multi-hospital systems might be considered top performers in quality then seek to understand what drives that performance. What do these systems do from a leadership and governance perspective to deliver "top decile" quality and safety performance across their system?

This research project was driven by our review of research studies and news reports over the past several years indicating that the rapid consolidation of hospitals into larger systems industry-wide has not yet revealed expected improvements in quality, cost, or standardization of care. Indeed, when we embarked on this project, we found that very few, if any, systems in the datasets we analyzed showed consistent quality across *all* of their hospitals. The assumption of critics is that growing health systems "generally have not done much yet to achieve consistent operational processes, clinical protocols and outcomes, and patient experience across all their facilities."[2] Some studies are in dispute about whether systems have been able to demonstrate improvements in quality and cost to benefit patients.[3] There have been several reports of rising prices as consolidation increases due to systems' better ability to leverage better rates from payers.[4] Finally, other research shows that integrated health systems do have what it takes to raise the bar, but we have to be patient to see the results.[5]

However, we do know that achieving "systemness" as far as standardization of clinical protocols, reducing or eliminating unwarranted variation, and maintaining a similar level of quality across the system's service lines, is a marathon process, not a sprint. While hospitals that are part of a system can benefit from the system's resources, clinical expertise, and economies of scale, each individual care site has its own challenges to tackle, which may be different from a sister hospital across town or yet another hospital across the county or state line in a larger system. Our work with systems reveals that while the benefits of systemness might not be showing in the data yet, they are working diligently to ensure acceleration of these efforts such

1 For the purposes of this paper, the term "quality" encompasses safety, outcomes, experience, and value.
2 Harris Meyer, "Health Systems Are Working to Live Up to Their Name," *Modern Healthcare,* May 11, 2019.
3 See e.g., Alex Kacik, "Monopolized Healthcare Market Reduces Quality, Increases Costs," *Modern Healthcare,* April 13, 2017; and for a counter argument, Monica Noether, Ph.D. and Sean May, Ph.D., *Hospital Merger Benefits: Views from Hospital Leaders and Econometric Analysis,* Charles River Associates, January 2017, and their 2019 update, Views from Hospital Leaders and Econometric Analysis – An Update.
4 Leemore Dafny, et al., The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry, Harvard Business School, May 31, 2018.
5 William B. Weeks, M.D., Ph.D., M.B.A., et al., "Potential Advantages of Health System Consolidation and Integration," *The American Journal of Medicine,* Vol. 128, Issue 10, October 1, 2015; pp. 1050–1051.

that we can anticipate seeing better results in the near future. Some are further along on this journey than others. Our aim with this publication is to demonstrate important actions taken at the leadership and governance level that have helped to drive quality at some of the higher-performing systems in the U.S.

Methodology

Utilizing the CMS Hospital Compare database[6] and TGI data resources, we identified multi-hospital systems with at least three listed hospital facilities. We then created a system "star" score[7] based on the weighted reported inpatient bed count from each CMS scored hospital to identify a cohort of "top-performers." From this group, we identified 37 systems with a weighted star score greater than 4.0, a cutoff point that was approximately equal to top-decile performance using our algorithm for all systems. We then checked Leapfrog, HCAHPS, and NRC Health Market Insights performance and eliminated systems with uneven performance across multiple rating systems. Finally, we winnowed our final selection down to healthcare systems that had an existing relationship with TGI and invited system senior leadership to participate in an online leadership survey focused on identifying drivers of system-wide quality and safety performance. Seven healthcare systems responded to our invitation and 24 senior leaders from the invited systems (two to five senior leadership respondents per system) participated in the survey.

The seven systems that responded to our invitation are generally top performers across multiple public quality rating systems. **Table 1** is sorted by CMS Weighted Star Score and displays system size and system average performance across CMS, Leapfrog, HCAHPS, and Market Insights rating systems.[8]

Table 1. Top Health Systems Included In the Study

System	Number of Beds in System	Number of Reported Hospitals in System	CMS Weighted Star Score	Average Leapfrog Grade	Average HCAHPS Score	Market Insights Quintile
Bellin Health	161	3	5.00	5.00	4.00	5.00
St. Lukes Health System (Boise, ID)	895	8	4.84	5.00	4.00	4.00
Intermountain Healthcare	1965	23	4.76	5.00	3.94	4.00
St. Lukes University Health Network	1058	8	4.38	4.88	3.38	3.00
Duke Health (AKA Duke University Health System)	1430	3	4.33	5.00	4.00	5.00
Atlantic Health System	1382	5	4.25	4.40	2.80	3.00
Main Line Health	1060	4	4.03	4.50	4.20	5.00

6 We utilized the most current CMS data available from October, 2019.

7 CMS displays hospital performance based on a rating of one to five stars. For purposes of our analysis, five stars = 5, four stars = 4, etc.

8 We used simple averages rather than weighted averages in this stage of the study since not all hospitals affiliated with each system had scores in all categories. Further, we converted Leapfrog letter scores into a five-point scale (A = 5) and used quintile cutoff points for comparing average Market Insights scores (5 = top 20 percent).

> Leadership and governance behaviors as well as quality structure are critical to achieving system-wide high-quality performance.

Key Findings from the Survey

There is no single "silver bullet" that drives consistent system-level quality and safety performance. In the survey we sought to explore with system-level leaders what they think are the most important drivers of quality and safety performance as reflected in public ratings and rankings. That said, it does appear from the survey results that leadership and governance behaviors as well as quality structure are critical to achieving system-wide high-quality performance:

- 100% of respondents indicated that system-wide quality and safety results were reviewed monthly by the senior leadership team.
- 92% of respondents indicated that they have local quality governance committees and functions that report up to a system-level quality committee.
- Two-thirds of the respondents indicated that they review external quality ratings and comparisons with their system-level boards or quality committees either monthly or quarterly, and the remainder of the respondents indicated such review takes place at least annually or periodically/as needed.

When asked about the most important factors driving performance, two-thirds of the respondents chose either *leadership focus* or *organizational culture* as the most important factor driving quality and safety performance across their system. The *quality management system* was chosen by four respondents as the most important factor and two respondents chose *board expectations* as the most important factor. Interestingly, only one respondent chose *financial resources* as a top factor.

Respondents were also asked to list other key factors that are key drivers of quality and performance in their systems. Comments generally fell into categories of leadership behaviors, execution of strategies, use of measurement and data, engagement of physicians and frontline staff and/or specific improvement methods or processes. Examples of responses include:

Leadership Behaviors

- High reliability organization (HRO) principles to shape how individuals, teams, and leaders behave and how we design our systems and processes to improve quality and prevent safety events.
- System CEO sees quality as top priority.
- Highly engaged board that challenges us to fulfill our vision of being a model healthcare system.
- Organizational commitment to eliminate harm.
- We strive to have quality and safety discussed as much as finance and we work to be sure that the operating system has a focus that has quality and safety leading their work.
- Transparent communication.

Measurement

- Visibility and drilldown into data focusing on process measures driving outcome measures.
- Focus on key quality measures targeted at payer/regulatory metrics.
- Consistent use of data scorecards.
- Steadfast reliance on measuring performance against best practice outcomes; no excuses!!!

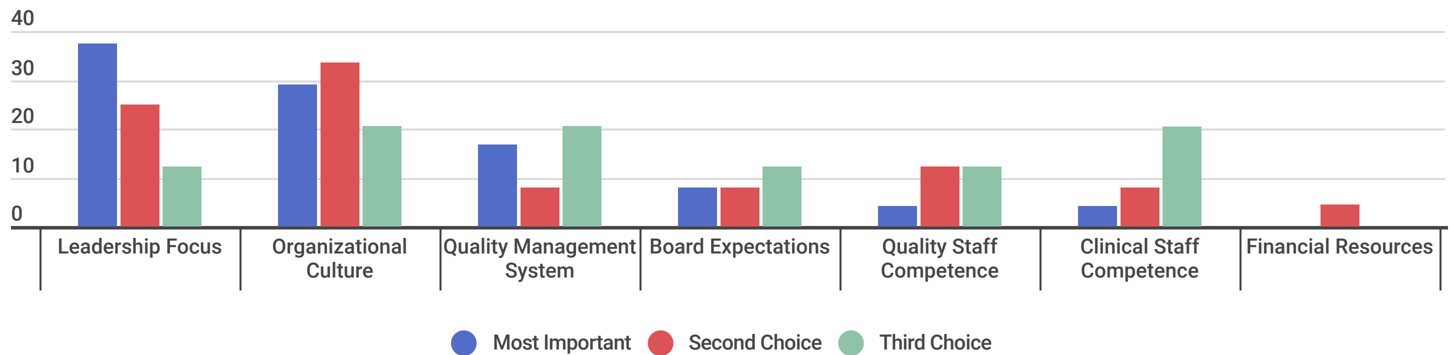
Strategy

- Having a strategic focus on quality and safety.
- Our safety and quality performance program is driven by our mission, "helping people live the healthiest lives possible," and is aligned strategically as part of the system's focus on our fundamentals of extraordinary care: safety, quality, equity, experience, access, stewardship, and engaged caregivers.

The Governance Institute's Recommended Board Practices for Quality Oversight

The following practices are recommended for adoption for most types of hospitals and health systems. In the context of systems, some of the practices listed below would take place at the system-board level, while others might take place at both system and local levels, while others might occur only at the local level, depending on how the system has set up its oversight structure for quality (and in regards to structure, no two systems are the same!).

1. The board approves long-term and annual quality performance criteria based upon industry-wide and evidence-based practices in order for the organization to reach and sustain the highest performance possible.
2. The board requires all hospital clinical programs or services to meet quality-related performance criteria.
3. The board annually approves and at least quarterly reviews quality performance measures for all care settings, including population health and value-based care metrics (using dashboards, balanced scorecards, or some other standard mechanism for board-level reporting) to identify needs for corrective action.
4. The board includes objective measures for the achievement of clinical improvement and/or patient safety goals as part of the CEO's performance evaluation.
5. The board devotes a significant amount of time on its board meeting agenda to quality issues/discussion (at most board meetings).
6. The board has a standing quality committee.
7. The board annually approves and regularly monitors employee engagement/satisfaction metrics, including issues of concern regarding physician burnout.
8. The board, in consultation with the medical executive committee, participates in the development of and/or approval of explicit criteria for medical staff recommendations for physician appointments, reappointments, and clinical privileges, and conducts periodic audits of the credentialing and peer review process to ensure that it is being implemented effectively.
9. The board is willing to challenge recommendations of the medical executive committee(s) regarding physician appointment or reappointment to the medical staff.
10. The board allocates sufficient resources to developing physician leaders and assessing their performance.
11. The board ensures consistency in quality reporting, standards, policies, and interventions such as corrective action with practitioners across the entire organization.



Method or Process

- Defined, standardized approach to our culture of safety and a system view to decreasing variation while building process.
- Continuous improvement methodologies are employed to drive change with an emphasis on engaging frontline caregivers in the process and standardizing across the system.
- Constant investment in continuous improvement; willingness to learn from best practices.
- Ability to remove bureaucracy of process to timely implementation of improvements.
- Leveraging accomplishments and experiences from within our 11-campus health network.
- Delineated responsibilities across the system and within individual sites, along with a transparent tiered escalation process for issues, ensures alignment, scalability, and accountability across the system.
- Time for frontline staff to participate in quality and safety initiatives.

Engagement

- Physician engagement and participation.
- Medical staff leadership.
- Strong alignment between medical staff and hospital leadership.
- Professional training and professionalism. Choosing the right people with the right commitment.
- In addition to the overall culture, I believe provider desire to constantly improve care and willingness to cooperate and help each other achieve these goals is an important ingredient.
- Ownership by frontline staff.

Creating a leadership focus on desired quality and safety results requires discipline and structure. Respondents were asked to identify which management approaches were commonly used in their organizations for creating focus and alignment and integrating quality and safety performance into the daily work of management. Not surprisingly, respondents indicated wide use and integration of management methods and systems to drive performance (see **Table 2** on the next page).

Respondents also utilize a wide range of quality improvement frameworks and methods for improving performance. 100% of respondents routinely use root cause analysis and over 70% cite using HRO principles. Lean, IHI Model for Improvement, Lean/Six Sigma were each listed by over 50% of the respondents as common approaches for improvement within their systems.

Just as respondents use a wide range of tools and methods, they also utilize wide networks of knowledge sources and expertise in the quality and safety efforts. Seventy-five percent (75%) of the respondents indicated that they look to the Institute for Healthcare Improvement (IHI) and/or the Joint Commission as a source of guidance. However, that is not exclusive. Respondents provided a long list of other external resources including consulting firms, regional collaboratives, and local associations as sources of knowledge and help. Finally, respondents were asked to provide in their own words the key factors that enable high levels of quality and safety performance in their system and explain why.

Lessons Learned

From the survey responses and descriptive results, the following 10 ideas emerge as key drivers of system-wide quality and safety performance:

1. Unequivocal board commitment and executive leadership focus.
2. A commitment to excellence—wanting to be the best—with a focus on patients at the center. HRO is a commonly used framework.
3. Clear expectations and goals for quality and safety performance are set by the board and senior leadership.
4. Patient safety is an organizational and leadership priority and a demonstrated cultural value.
5. Quality and safety are seen as strategic and aligned with the organizational mission.
6. Management process and structures are designed to deliver quality and safety results. There is a process of systematic review of performance against targets/goals.
7. There is system-wide use of measurement, data, and transparency.
8. There is significant engagement of physicians, clinicians, and frontline staff in quality and safety efforts.
9. They have invested in creating capacity for improvement. Methods, process, and structure exists to support the efforts.
10. They celebrate success.

Table 2. Common Management Approaches to Focus and Align Quality/Safety with Daily Work

Tactic/Effort	% Respondents
Annual performance objectives	88%
Strategy execution	83%
Routine operational performance reviews	83%
Leadership rounding	75%
System leadership/management incentive compensation plans	71%
Recognition systems	71%
Physician compensation plans	54%
Annual budgets	25%
Hospital/functional unit incentive compensation plans	21%
Other (please specify): • Regular quality and patient safety updates given at our various board and board committee meetings and in all management and departmental meetings • Goals cascade based upon organizational strategic objectives and actionable internal data • HRO culture • Annual quality awards	17%

We had a chance to talk to Jack Lynch, CEO of Main Line Health, about the role of the board in supporting leadership efforts to deliver high quality and safety performance. Lynch said that Main Line has four themes that are the basis of their strategic plan and integrated into the governance function of the board:

1. Eliminate harm
2. Top-decile quality performance
3. Equity for all
4. Affordability

One of the things Lynch and his team did early on was to develop a quality and safety scorecard that is the equivalent of the financial statement presented to the board. Organized by the four themes listed above, metrics are reported at every board meeting and reviewed in depth at every meeting of the system board's Quality, Safety, and Equity Committee.

Transparency is critical. Lynch said, "Boards have to understand that bad things do happen. There is not an event that is so bad that I am not going to tell the board. We present our root-cause analysis and our action plans, and the board asks questions about our plans and how we are going to ensure that such an event does not happen again." Lynch gave an example of an incident involving the use of a new catheter that was unfamiliar to staff and its use resulted in harm to a patient. When reported to the board, the board did not focus on why that incident happened but instead wanted to know how the organization was going to ensure that when new devices and equipment are used anywhere in the organization that staff are properly trained.

Finally, Lynch said, "You can never stop asking, why?" He expects the board to hold him and his management team accountable for safety and quality performance. He said, "If the board does not hold leadership accountable, then it is unlikely that leadership will hold management accountable and unlikely that management will hold staff accountable."

Discussion Questions for Boards and Senior Leaders

As you share these findings with your board, the following questions are intended to help generate strategic-level discussion resulting in concrete actions your board and senior leadership can take as a result of these findings:

1. How does our system compare? What is our "composite score" using an algorithm similar to the one used in the study?
2. How might governance and leadership create increased organizational focus on delivering quality and safety results?
3. If we were to evaluate our efforts against the 10 key drivers listed above, where are we strong and where are there gaps in our efforts?
4. What is our quality strategy and where do we need to focus our efforts over the next year?