GOOD GOVERNANCE CASE STUDY

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Cedars-Sinai: A Shared Vision for System-Wide Quality

A Case Study Series Featuring Honorees from
The Governance Institute's Health System Quality Honor Roll 2022

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Cedars-Sinai: A Shared Vision for System-Wide Quality

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In 2022, The Governance Institute conducted our second iteration of research looking into the quality performance of multi-hospital systems. Our goal is to identify systems that have consistently high quality of care across all of the hospitals in their system and learn from those systems. We are focusing our research on systems in particular due to the expansion of hospital consolidation over the past decade touting the benefits to include reducing clinical variation, increasing standardization, and therefore improving quality while lowering the total cost of care. We have been interested in learning from systems that have made progress on these goals, exploring what they believe are the specific actions of the senior leadership team and board that have enabled consistent high performance across the hospital members of their systems.

Our updated research methodology employed the most recently available set of CMS Star Ratings to generate a CMS Quality Rating. We used NRC Health's Market Insights data to create a parallel Consumer Quality Rating, in each case rolling up hospital-level data into system-level indices. We then identified the multi-hospital systems (i.e., at least two hospitals and with greater than 25 beds) that performed at least 1 standard deviation above the mean on both indices to create our 2022 Honor Roll list.

Next, we spoke with system leaders, executives responsible for quality, and board members at several of the Honor Roll organizations to learn more about what they believe is driving their success, with a specific focus on the actions taken by senior leaders and governing boards.

This article features the lessons learned from Cedars-Sinai Health System, an academic health system serving greater Los Angeles via 4,500 physicians and nurses, over 40 care locations and five hospitals. We spoke with CEO Thomas Priselac; Rick Jacobs, Executive Vice President of System Development & Chief Strategy Officer; Rick Riggs, M.D., Senior Vice President of Medical Affairs & Chief Medical Officer; and Joyelle Sudbury, Vice President of Medical Affairs & Chief Quality Officer.

Key Board Takeaways

Cedars-Sinai recognizes that its hospitals do not have the same problems at each location. Rather than applying system-wide quality improvement projects that require the same implementation tactics at each location, the system leadership has worked with local hospital boards to agree on:

1. Key hospital quality metrics that are the significant indicators of hospital quality with a clear expectation for excellent performance.
2. Guiding principles for how local hospitals identify and choose goals, metrics, and targets, to enable each hospital to identify what its biggest local priorities and opportunities are, and help each hospital move its own performance needle in a desired direction.

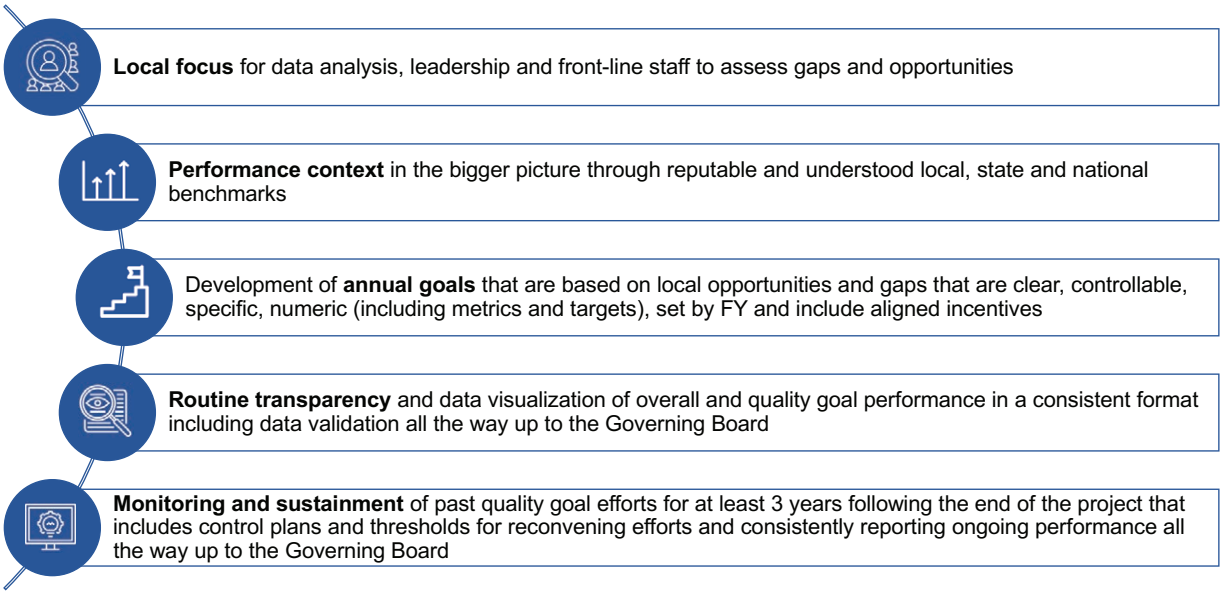
Organizational Intent

When Cedars-Sinai Medical Center became Cedars-Sinai Health System in the mid-1990s, two primary principles were determined to be immutable by the leadership:

1. Build a system that includes partners who share our vision, commitment, and passion for quality.
2. Apply the philosophy of bringing the best of what each member organization can bring to the system without assuming that "we know all the answers already" regarding how to build a successful system.

Like most health systems, Cedars-Sinai has developed and evolved over the last several decades. Sudbury said, "An improvement culture requires humility. Staying flexible for what we learn along the way is a big part of this." Along with the principles above, leaders identified core fundamentals for every program offered, regardless of setting, as shown below.

Quality Philosophy | Cedars-Sinai Quality Program Fundamentals



Various QI programs across the system are at different levels of maturation, so the first thing they work to ensure is foundational capability—having good data available; then building the infrastructure and oversight for what to do with the data; and finally it requires leadership prioritization. System synergy includes identifying economies of scale, standardizing key elements of the quality and safety program, providing support and expertise/sharing best practices; and synergy of specific efforts and transparency to learn together and from each other.

Cedars-Sinai Mission

As a leading academic healthcare organization, our mission is to elevate the health status of the communities we serve.

- We deliver exceptional healthcare enhanced by research and education.
- We prioritize high-quality care for all with equity and compassion.
- We transform biomedical discoveries and innovations for better health.
- We educate tomorrow's physicians, nurses, researchers, and healthcare professionals.

Vision

Trusted and respected worldwide, Cedars-Sinai will advance health and healthcare in Los Angeles and beyond.

Values

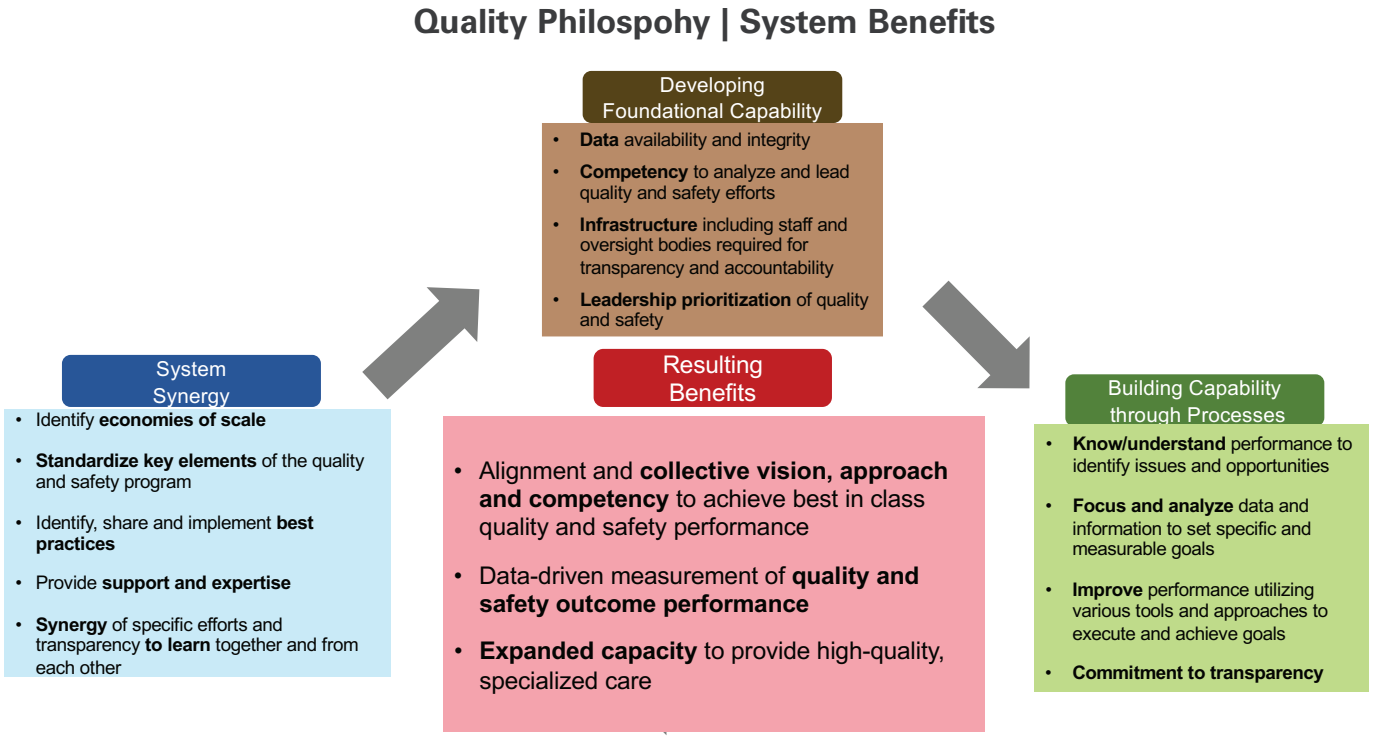
We hold ourselves accountable to these values:

- **Excellence:** We seek always to be the best and to bring out the best in each of our colleagues, and to nurture a culture that delivers excellent clinical quality, patient safety, service, and discovery.
- **Integrity:** We earn trust and respect by acting in every circumstance with knowledge, honesty, discretion, and fairness.
- **Diversity, Equity, and Inclusion:** We celebrate the richness of human diversity in an inclusive environment in which all stakeholders participate to build a better future.
- **Respect:** We recognize and treat each person and ourselves with dignity and honor.
- **Compassion:** We treat each other and those we serve with kindness and understanding.
- **Teamwork:** We honor and value the special skill that each colleague brings to our work together. We learn from each other and from our patients and their families.
- **Innovation:** Our purpose is to heal. We will always seek new means to advance this purpose, with imagination and enthusiasm for new ideas and methods.
- **Accessibility:** Our duty is to improve access to the healthcare we provide and to continuously extend this care to the communities we serve.
- **Affordability:** We are committed to providing quality healthcare to everyone in the community who needs it and to constantly improve our effectiveness and efficiency.
- **Stewardship:** We are thoughtful champions of the resources under our responsibility, to ensure their best and highest use to advance our Mission.

Aligning Goals

While standardizing care remains an aim for the system, each care setting in the system has different patient populations, acuity rates, and other non-homogenous factors making it difficult to apply the same standards, goals, and improvement processes at each location. So they remain "careful" about standardization: "We aim for that but it doesn't all end up looking the same," Sudbury said.

Instead, system leaders seek ways to enable a synergy of learning efforts, focusing on alignment and a collective vision via data-driven measurement: "We learn together." For example, they hold collaborative meetings to talk about specific topics, but problems at the main medical center aren't always the same problems in other locations. "Top-down, standardized solutions don't always work when local problems are different," Sudbury said.



Instead, they work to build consensus around the right metrics (e.g., "common measures"), and to agree that mediocre or poor performance requires action to address and improve. This is core to the organization's culture and is promoted amongst all senior leadership and the board—there is an expectation for excellence.

Local hospitals have their own goals, whether that includes working towards a CMS 5 Star Rating and/or broad surveillance of internal and comparative performance informed by their own fiscal-year goals. The questions leaders always ask themselves to focus their efforts is:

- What are we trying to achieve? This is informed by what is important locally as well as system-level common measures.

- How will we measure controllable improvements? (with an emphasis on precision).
- How much will we improve and by when? (focus on stretch targets with the greatest impact).

"We aren't telling people what to work on, but we have an agreed approach for how we do this," said Sudbury. Close to 60 to 70 percent of the goals are being worked on or overlapping at every location, but the targets or tools being applied may be different to allow for any local differences.

Local goals must be/have:

- Annual
- Laser-focused on a limited number of the highest priorities (about five; no more than eight)
- Those with the greatest estimated specific impact (cause and effect) to meet health system goals, common measures, and entity goals
- Engaged stakeholders and willing/aligned partners and collaborators

System Direction, Local Autonomy

The system board focuses on 21 system-wide quality metrics. All the hospitals know what those metrics are and revisit them every year to ensure those are still the right ones to be monitoring at this level. "In governance we have made an effort to continue to empower the local boards in a couple of key areas, and the top of that list is the quality oversight function," Priselac explained. "So everything ultimately flows through individual member hospital boards, within this construct created by the system, but as if they were still standalone." (The local boards retain fiduciary duties and are also responsible for medical staff relations and credentialing/privileging.)

Quality is at the top of the agenda at most board meetings, system and local. Local CQI committees meet quarterly, but boards receive quality reports monthly. Local executive committees every other month or every month, and at each of those meetings quality is also a scheduled agenda item. The reports are "meaty—board and committee members delve into them and they are incredibly engaged. They ask a ton of questions and sometimes this knocks the agenda off time," Priselac said.

Dr. Riggs added that there are organizational goals in relation to how quality is measured, with the STEEP definition as their primary guideline. System leaders created a portfolio of total board and organizational goals, of which quality makes up close to 50 percent, in relationship to digital, academics, philanthropy, financial performance, etc.

Safety has an equal emphasis and is integrated into the quality improvement focus. The system has a fundamental commitment to excellence in everything it does, which has been in place since Priselac arrived in 1979. "It's simply part of the DNA of this place," he said.

Standardized Governance Reporting

Governance reporting from the system to each local organization/board is aligned and standardized to include the CMS Common Measures, IPPS Report (value-based purchasing, readmissions, etc.), local hospital quality snapshots, Culture of Safety survey results, patient experience key metrics, and Leapfrog, *U.S. News* rankings, and other reputational/publicly available performance, including comparisons to other hospitals/systems.

In the outpatient arena, "We have equally robust quality oversight processes for medical and ambulatory networks," Jacobs said. "As the nation has shifted [away] from being hospital centric, we did that a long time ago." Each board looks at the inpatient versus outpatient metrics like they are the same conversation. "The medical foundation board also has a singular focus on quality, so from the beginning of the creation of the foundation, quality and safety performance in the medical network has been a topic on that agenda," Priselac added.

The evolution over the last five years for Cedars-Sinai has been creating and expanding the "interrelationships that need to be occurring between what happens in the ambulatory network and what happens in the institution, including readmissions and end-of-life care," explained Priselac. COVID enabled the hospitals to become more of a team in a very accelerated manner, and there was a focus from the outset recognizing the need to work very closely together on quality related to COVID patients—they saw this as an opportunity to shine as a system. The academic clinical researchers who were working on publishing their learnings from treating a huge volume of COVID patients were able to share that expertise with leaders and clinical staff at the main medical center, before there was published literature about how to handle quality for COVID. Collaboration at that level was "amazing" according to Sudbury. Even smaller clinics and surgical hospitals within the system were able to take advantage of the learnings of the main medical center.

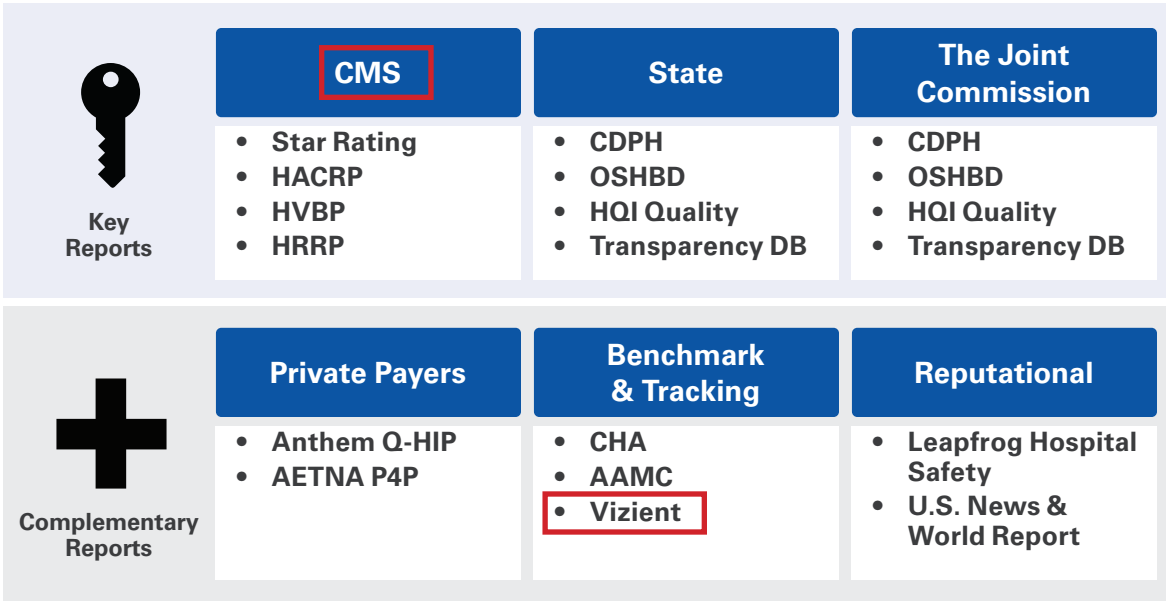
Reputation Is a Motivator

In many ways, the system exists in a fishbowl because of its location and prominence; events, both good and bad, are magnified by local, national, and sometimes international media. Being a low-cost provider remains a challenge, so they emphasize value. "Because of who we are, what we do, and who we serve, in the marketplace of prices we are not the least expensive alternative. We believe that we owe it to those who buy from us to give them a product that is worth it from a quality and safety standpoint," Priselac said.

So, reputation matters. "Six months after I started in this position, I had to inform Tom [Priselac] we had a CMS 1 percent Hospital Acquired Condition Reduction Program [HACRP] penalty," Dr. Riggs explained. "We showed leaders that there were areas below benchmark and scoring red in each of the component areas. I asked, 'Who is tracking this? Where is it being discussed? How is it being elevated?' There wasn't a forum for this at the time." As a result, Dr. Riggs ensured from then on that there was such a forum to discuss adverse quality performance and how to fix it. He organized an external reporting unit to analyze every third-party quality report

including CMS, the state hospital association, Joint Commission, and private payers. (They use Vizient as a "compass" because the data is more current and allows for internal and external rankings.) The reports include equity and cost metrics. "We have local granularity this way and it helps us better understand how we get to where we need to be," Dr. Riggs said. "It also reassures us that we are on the right track to meeting our goals, or it helps us figure out how to get back on track."

Publicly Reported Data Represent One Important Focus for Surveillance



Priselac added that he has tried to be very clear internally that the system manages its reputation by its performance against these measures. The marketing and communications team doesn't engage in promotional investment to the extent that many other health systems do. They have been recognized as a top system by *U.S. News & World Report,* but the reason for acknowledging that "is not to manage reputation, but rather to be part of a virtuous cycle to send a message to our people and communities about the important work we do every day and how that makes a difference," Priselac said.

Changing the Board-Level Conversation

In looking towards the future and how things may need to change going forward, Priselac described the system board as "very involved and very interested." Dr. Riggs, who has served as a physician board member even prior to becoming CMO for a total of 11 years, added, "The shift I see is that hospital capacity wasn't the issue before that it is now. One important question now is whether increased capacity is impacting the care we deliver. Behind that are local factors of payers, providers, hospitals closing, things out of our control. But we have shown that we can provide care at alternate, sometimes less than ideal settings, even at the same level of quality." The system employs a multi-modal approach to keep the ED open and accessible, and

leaders emphasize the importance of the board understanding the work it takes to do that.

"To the board's credit and as a reflection of their astuteness, throughout COVID, and in this post-COVID era, their expectation was that quality of care should not diminish, and that has not changed a bit," Priselac said. "They consider this our burden to figure out. The healthcare system across Los Angeles is really compromised right now. Two major facilities have closed adjacent to us in the last five years. We have 915 beds. On a typical day, we are looking for beds for 950 people. It's not uncommon to be looking for 1,000 to 1,050 at the peak."

A Best Practice Perspective

Our first case study featuring Main Line Health demonstrated a remarkably different approach and structure (an operating company with centralized control at the system level with a single governing board and unified medical staff), when compared with the relative independence of local hospitals and the leadership structure at Cedars-Sinai. We found it poignant that both organizations have strong leadership marked by a long-tenured CEO. But both have some key similarities that can be applied at any organization:

1. Both maintain a continuous culture of learning, with the necessary humility that comes with that.
2. Both are precision-focused on driving decisions through data and stratifying it to identify disparities.
3. Both have leaders and boards who maintain a relentless commitment to quality improvement and excellence in everything they do.

The following are some discussion questions for boards and senior leaders to help apply lessons from Cedars-Sinai's quality story:

1. What are some things we can change to enable more alignment across hospitals, leadership, and boards in our system?
2. Do we need (more) buy-in from local leaders, boards, committees, and medical staffs? If so, what actions can we take at the system level to achieve that buy in and accelerate single-direction movement towards standardization, clinical integration, and aligned metrics?
3. Do we have the technical capability to stratify data and make it action-oriented? Do we know where we have disparities in care, and are we taking actions to close those gaps?
4. Does our strategic plan incorporate quality, safety, and equity in a way that will enable us to achieve higher performance across all of our hospitals?
5. How are we driving the quality conversation at the board level to include outpatient metrics to the same degree as the inpatient focus?