

NOVEMBER 2023

Local Board Focus



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

By Michael D. Pugh, M.P.H., President, *MdP Associates, LLC* and Governance Institute Faculty; and Kathryn C. Peisert, Editor in Chief & Senior Director, *The Governance Institute*

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 is an excerpt from a case study that is part of a series featuring honorees from The Governance Institute's Health System Quality Honor Roll 2022. [Read the complete case study here.](#)

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 at each location, the system leadership has worked with local hospital boards to agree on common guiding principles for how to 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 in **Exhibit 1**.

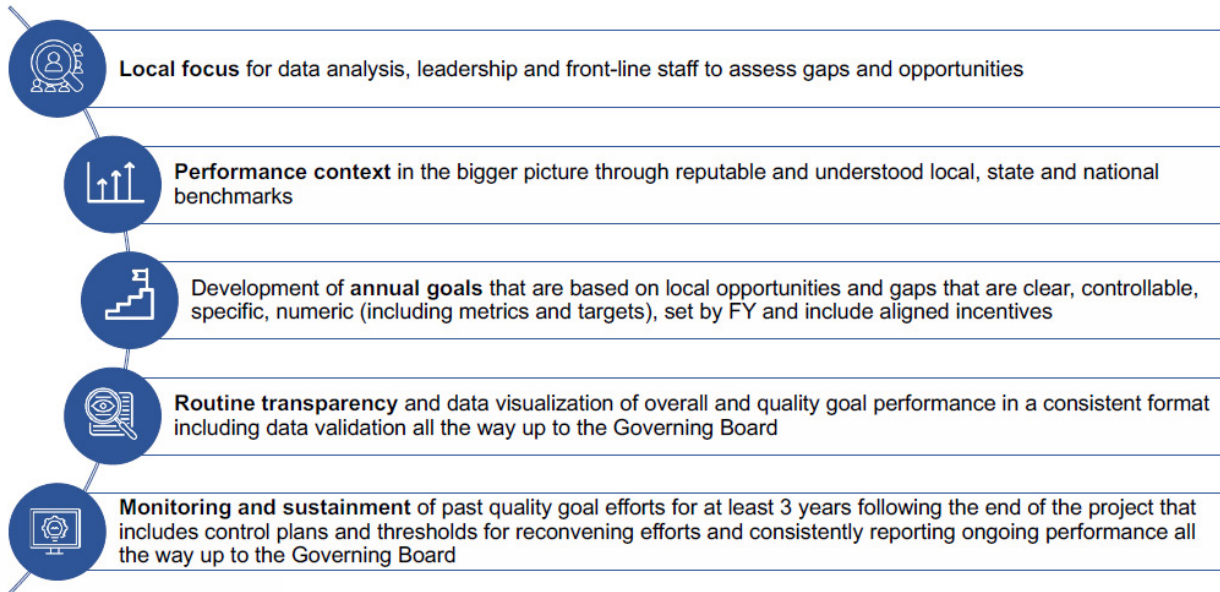
Various QI programs across the system are at different levels of maturation, so the first thing they work to ensure is foundational capability—having good data available; then building the infrastructure and oversight for what to do with the data; and finally it requires leadership prioritization. System synergy includes identifying economies of scale,

“An improvement culture requires humility. Staying flexible for what we learn along the way is a big part of this.”

*–Joyelle Sudbury,
Vice President of
Medical Affairs &
Chief Quality Officer*

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.

Exhibit 1: Quality Philosophy | Cedars-Sinai Quality Program Fundamentals



©Cedars Sinai Medical Center—All rights reserved
Joyelle Sudbury, M.P.H., Chief Quality Officer

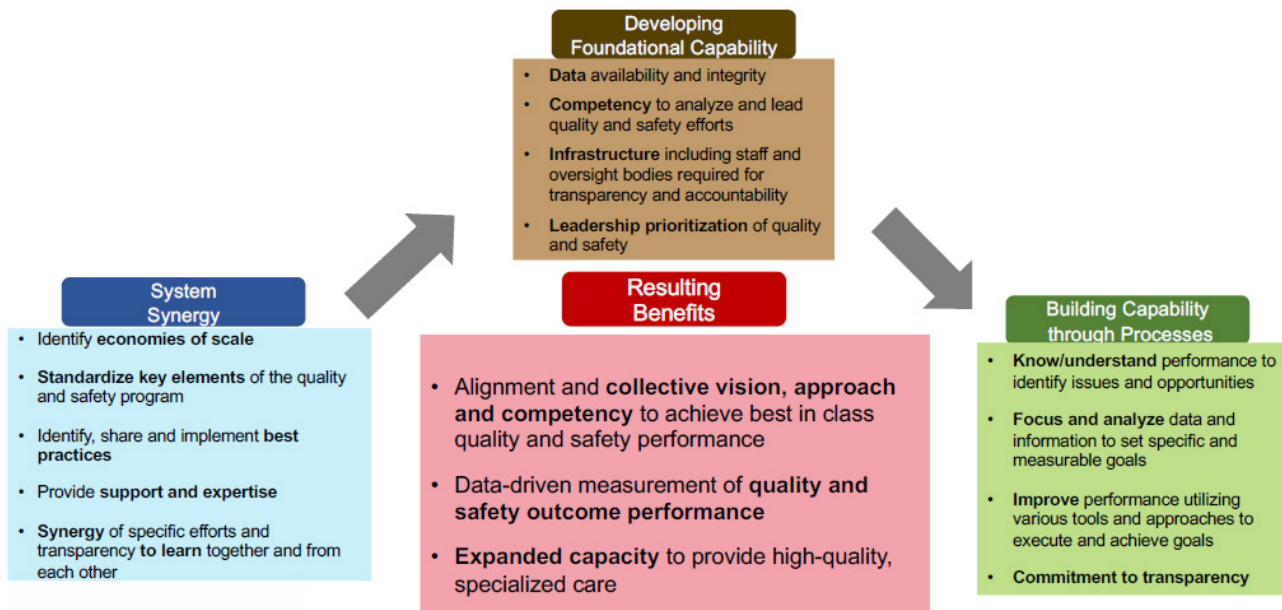
Aligning Goals

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.

Exhibit 2: Quality Philosophy | System Benefits



©Cedars Sinai Medical Center—All rights reserved
 Joyelle Sudbury, M.P.H., Chief Quality Officer

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.)

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 meet 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 STEEEP 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.

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.

“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.”

*–Thomas Priselac,
CEO*

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 subsidiary boards and senior leaders to help apply lessons from Cedars-Sinai's quality story:

1. How can we better work with our system to ensure quality metrics, goals, and targets are aligned with system priorities, yet still take into account our unique market concerns and opportunities?
2. Do we continually collaborate with our system leaders, as well as leadership at other hospitals within our system, to learn together and share best practices?
3. Do we need (more) buy-in from our leaders, boards, committees, and medical staffs around the importance of system-wide collaboration? If so, what actions can we take at the subsidiary board level to achieve that buy in and accelerate single-direction movement towards standardization, clinical integration, and aligned metrics?
4. Do we have the technical capability to stratify data and make it action-oriented? Do we know where we have disparities in care locally, and are we taking actions to close those gaps?
5. How are we driving the quality conversation at the board level to include outpatient metrics to the same degree as the inpatient focus?

