System Focus

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The Governance Institute

A System Perspective on Quality: St. Luke's University Health Network

Adapted from a January 2024 Leadership Conference session in Naples, FL, facilitated by Michael D. Pugh, President, MdP Associates, LLP

Panelists:

Robert Black, Board Chair, *St. Luke's University Health Network*

Joel D. Fagerstrom, Executive Vice President & COO, *St. Luke's University Health Network*

While improving quality in hospitals and health systems has been an industry focus for more than 20 years, progress has been slow but relatively steady. One of the primary goals of consolidating hospitals into health systems over the past decade has been to standardize care processes and protocols as a means to advancing efficiency, access, and outcomes. We have yet to see significant impacts of this consolidation in improving quality of care.

The consolidation of hospitals into local, regional, and national health systems will likely continue across most healthcare markets, especially given challenges that were exacerbated by the COVID-19 pandemic. The benefits of system membership and consolidation translate to potentially greater access to capital, ability to consolidate overhead and support functions, access to payer contracts, and improved or stabilized financial performance. While the financial benefits of system development and consolidation have been clearly demonstrated, the promise of improved quality across health systems has lagged.

Because of this, The Governance Institute wanted to find out how health systems that are able to perform highly across multiple care sites work to ensure and improve quality,

and who are the key leaders within these systems making an impact. Starting in 2021, we commenced research in partnership with Michael Pugh comparing CMS Value-Based Purchasing datasets with NRC Health's Market Insights consumer perception data to identify systems that demonstrate high scores system-wide.[1] This quantitative research helped us to identify the organizations that would move on to the qualitative stage of interviews and case studies so that we could learn directly from quality leaders, practitioners, and board members from these high-performing systems.

As part of this ongoing research, in January 2024 we learned from leaders at St. Luke's University Health Network how they maintain high quality system-wide.

St. Luke's University Health Network is a non-profit, regional, fully integrated health system providing services at 15 campuses and more than 300 sites across 10 counties in eastern Pennsylvania and western New Jersey. 15 years ago, the network had four hospitals; today it includes 12 acute care hospitals, one rehabilitation hospital, and one behavioral health hospital, with 20,000 employees, $3.6 billion in annual revenue, and over 2,000 employed providers. Medical education is a significant part of the organization and it operates the longest-running nursing school in the country. It was founded in 1872 in Bethlehem, PA.

The St. Luke's University Health Network (SLUHN) board sets quality priorities and goals for the network as a whole. "The network CEO, Richard Anderson, has established quality as the number one priority and it cascades down through the organization," said Robert Black, network board chair. "The vision statement says specifically that we will achieve and maintain top-decile performance in national quality standards. We are committed to that, it is our guidepost, and we reinforce it and talk about it every chance we get."

The board-level quality committee meets bimonthly to discuss the scorecard showing percentile performance across various measures; they discuss any quality issues or concerns that have arisen since the last meeting, along with their recommendations for improvements and prepare a report for the network board.

Five "entity" hospitals within the network also have boards as well as a local quality committee. The quality data from every hospital rolls up to the system-level quality committee.

Quality goals for the network are set at the beginning of the year, and for the most part, they are the same for all hospitals and entities. Senior leaders have individual goals as

1 For more information on this research and methodology, see "The Governance Institute Health System Quality Honor Roll 2022."

well, and 50 percent of their performance evaluation is based on those individual goals, most of which are quality related.

If an entity is doing very well in one of the focus areas, the system-level chief quality officer (CQO) helps them identify a different focus area. "It is relatively easy to identify what you need to improve. The harder part is executing, having alignment across goals, and holding your team accountable," said Joel Fagerstrom, Executive Vice President and COO.

"There is no doubt that better care leads to better financial outcomes. If you focus on your employees and your patients, the finances will come."
—Joel Fagerstrom, Executive Vice President & COO, SLUHN

Key Drivers of Quality

- **The CEO** must make quality the top priority, with board support/buy-in.
- The **management structure** must reflect the importance of quality with a strong chief quality officer reporting directly to the CEO and who works closely with other clinical leaders.
- A **culture of quality/safety** must be an everyday focus and become second nature; this includes transparency and communication.
- The board must spend as much time on **outpatient** quality metrics as it does on inpatient quality.

Management Structure for Accountability

The network has established a performance improvement committee that includes the CEO, CQO, and other senior executives, and meets every month for two hours. Every department reports on their own quality scorecard: 50th percentile or below shows up red; 50–90th percentile performance is yellow; and 90–100th percentile is green. During the meetings, participants discuss what they are doing to improve their scores and specific initiatives they are working on.

The CQO reports directly to the CEO and is highly respected across the staff. She works closely with the service line chiefs and a quality officer at every campus. The quality officers report to their entity president but have a dotted line reporting relationship with the CQO.

The CQO and CEO work closely with the network quality committee and board. The CQO is the main presenter to the board. Service line leaders attend board meetings on a rotated basis to support and answer questions; every service line has an opportunity to present at a board meeting each year. They compare SLUHN's performance against other organizations as well as what initiatives are coming forward for the next year that will help

improve scores. Having this structure supports quality improvement efforts and reinforces quality as a top priority for the organization, as well as motivating the board to engage.

Culture is another key driver of success. Staff and department chiefs on every floor hold a daily safety brief, which helps hardwire this focus on quality and safety every day. It creates an environment where everyone can learn from each other and it becomes second nature. Questions for discussion include how many patients are on the floor, which ones are new admissions, and any problems they are having including staffing, IT, supplies—anything that could affect safety or quality every day.

Board Oversight

The system-level balanced scorecard is dynamic and adjusted every other month. "If we have a metric we have done well on for several quarters we take it off and put something else in its place," said Fagerstrom. "We participate in 14 Blue Cross collaboratives. Those metrics are also included in the scorecard and discussed at the committee level. We have multiple groups of people looking at the data and it's great to see different perspectives. If we bring something to the full board, their diverse perspectives provide implicit experience and a wealth of information. A supply chain person can see a weak link that we might miss if we are in it every day."

SLUHN has a "strong quality staff" that looks for trends and brings those to the quality committee, including adverse outcomes and near misses. They will discuss and debate whether the concern is important enough to go to the network board, which happens only rarely for a serious safety incident. The majority of the course correction is done through the quality department and with the clinicians involved. For the board, most of the information shared regarding quality and safety is for education purposes. In addition, they are spending more time over the past few years focusing on improving outpatient metrics. "Five years ago, the board started asking about outpatient measures," said Fagerstrom. "At the time there weren't a lot of good comparisons, but there are now so we can do a much better job."

To learn more about other systems' quality drivers as part of our ongoing research, see St. Luke's Health System: Setting the Foundation for Continuous Quality Improvement, Cedars-Sinai: A Shared Vision for Systemwide Quality, and Main Line Health: Achieving Top Quality Performance Requires Equity for Every Patient.

> "Without good quality you aren't even in the game. I can't stress enough how important culture is to the success of any quality program. It's really all about the culture. It starts at the top for us, the CEO is committed to it. The board has to buy into it, and then it cascades down. Culture is everything, and you have to work at it every day."
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> *—Robert Black, Chair, SLUHN board*