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CEO EXCHANGE

Insights Report

March 2015 | Report 2 of 2

DAVID HARTIG

QUALITY UNBOUND

Analysis and in-depth discussion from healthcare leaders at the 2014 HealthLeaders Media CEO Exchange

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Analysis

What Does Success in Quality Look Like?

JIM MOLPUS
Leadership Programs Director
HealthLeaders Media

It's encoded into the cultural tissue of hospital and health system teams to be driven to perform at higher levels. The common denominator of any team built with nurses and physicians is that they are scientists who identify problems through data, and use evidence to find a solution.

While the skills for constant improvement in healthcare quality may be present, a barrier to execution has been a lack of consensus regarding what success looks like. Health system CEOs and their partners in clinical leadership have been forced to sort through a conflicting collection of quality priorities thrust upon them through the hammer of regulation and the carrot of reimbursement.

The quality team staff and infrastructures that have been created since the Institute of Medicine's *To Err Is Human* report in 1999 have largely been left to administer a whack-a-mole of metrics, often without adequate information technology infrastructure to gather robust data, or the analytics to make sense of it and translate it into practice. In fact, when participants of the 2014 HealthLeaders Media CEO Exchange were asked their greatest challenge in clinical quality improvements, 43% listed full use of data analytics for clinical decision-making at the top, followed by 26% who named ensuring care along the continuum.

In four separate roundtables with the 40 invitation-only attendees of the HealthLeaders CEO Exchange, the leaders found some common threads, including:

- Despite an unclear path and competing metrics, the CEOs and their health systems are undaunted in shifting their organizations toward value-based healthcare
- With few exceptions, the provider CEOs at the forum expressed that their local payers are reluctant to enter into substantive discussions on risk-based contracts
- The CEOs still largely see their role as guiding the cultural transformation of the enterprise and setting the investments and operational foundation for clinical transformation

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Discussion

Defining and Delivering Quality

JIM MOLPUS

What does quality in healthcare delivery even mean today? In an era with competing definitions of quality, and the spread into other parts of the care continuum, it's up to the health system's board, the medical staff, and particularly the CEO to choose a course of quality that fits the organization's mission, vision, and marketplace.

More than 40 chief executives from across the country participated in the HealthLeaders Media CEO Exchange dialogue "Quality Unbound," where they considered a common theme: They embrace the idea that quality is evolving into a much broader set of goals that are beneficial for the patient and community, but they are frustrated that the broader set of players—health plans, external ratings organizations, and other providers—are at crossed paths in the journey.

TAKEAWAYS

- **Shifting definitions**
- **Foundation of quality**
- **Reducing variability**

Shifting definitions

Henry Ford Health System has a history of quality that any health system would envy, from the 2011 Malcolm Baldrige National Quality Award to a host of other national recognitions for its work in patient safety. Detroit-based Henry Ford's "No Harm" campaign aimed to reduce preventable and non-preventable harm to patients by half. Even with so much direction in quality, the system finds itself surrounded by different definitions.

"You can focus on quality the way you think it is best for patients, but then you have multiple organizations measuring quality in multiple ways and broadcasting their rankings. This is incredibly confusing for consumers," says Lynn Torossian, president and CEO of Henry Ford West Bloomfield (Michigan) Hospital. "We know we deliver amazing, exceptional care and quality to our patients, but often it is difficult to get that message noticed when every hospital is touting their quality award."

Kimberly Boynton, CEO of Crouse Hospital in Syracuse, New York, took the helm of the health system after a decade as its CFO. In finance, she was used to looking at numbers that were straightforward, but quality metrics are more difficult to pin down to evidence.

"It's challenging," Boynton says. "With so many quality metrics to track, we have spent the past year honing in and putting a dedicated focus on those key areas where we can have the most impact. We are still feeling our way a bit, but it helps provide clarity and consistency to the process."

The hospital is committed to delivering evidence-based healthcare, but measuring that depends on whose evidence is being used, Boynton says.

"With our physicians, we'll share what the measurements are for sepsis with them, for example," Boynton says. "But they may say this measurement or that measurement is not the right thing to do for the patient. So there may be times when we're at odds on some of the things we're trying to do that are evidence-based, but these

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> "With so many quality metrics to track, we have spent the past year honing in and putting a dedicated focus on those key areas where we can have the most impact."
> KIMBERLY BOYNTON, CEO OF CROUSE HOSPITAL, SYRACUSE, NEW YORK

are good and important conversations to have."

Bruce Elegant, president and CEO of Rush Oak Park Hospital in Chicago, says it is important to look at numbers and goals with some perspective.

"We did have a statistic that was eye-opening regarding falls with injury," says Elegant. "A few years ago we had 50 such incidents and made a concerted effort to lower that number considerably. Last year the number was 32, so we set an even lower goal this year. But then I read an article that said the Cleveland Clinic had 25 falls with injury last year. Now, the Cleveland Clinic is approximately a 1,000-bed medical center and we're a 150-bed hospital. I realized that we needed a much more strategic goal in place to continue to significantly reduce or eliminate these occurrences. It really opened my eyes to look at what's possible.

"Now we post the quality and safety dashboards on each nursing unit, keeping everyone informed," Elegant continues. "We've gone 190 days without a CAUTI [catheter-associated urinary tract infection] and 300 days without a CLABSI [central line–associated bloodstream infection]."

Foundation of quality

Charles Hart, MD, who retired at the end of 2014, but attended the exchange as president and CEO of Regional Health in Rapid City, South Dakota, says the organization emphasizes being a safe system as the foundation of quality from which all other success is built. He agrees Regional Health is struggling with ways to measure quality more effectively, but has made a point of not forgetting to include the staff when

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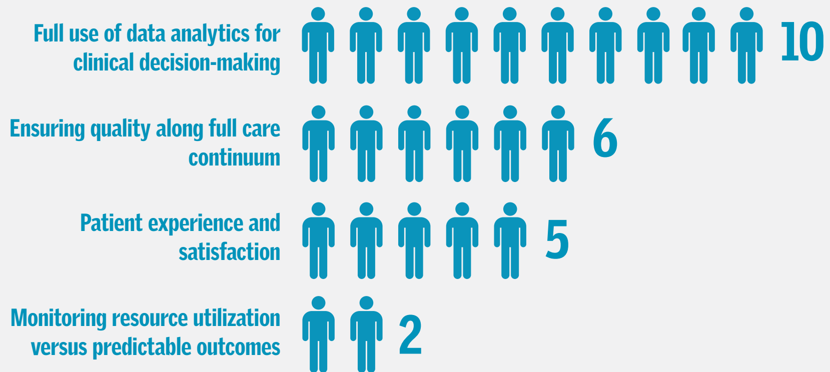
CLINICAL QUALITY CHALLENGES

With regard to clinical quality improvements, which of the following areas represents the greatest challenge for your organization?



SOURCE: HealthLeaders Media 2014 CEO Exchange Pre-Event Survey

defining what quality means.

"We want to include the caregiver's perception of the quality and the whole experience for them also," Hart says. "That perception is a way to get our physicians more engaged and our nurses more engaged. We consider these a quality measure. If we can create a quality experience for them also, it will help us get to our goals faster."

Michael Ugwueke, president and

> "We want to include the caregiver's perception of the quality and the whole experience for them also."
> CHARLES HART, MD, PRESIDENT AND CEO OF REGIONAL HEALTH, RAPID CITY, SOUTH DAKOTA (RETIRED)

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chief operating officer of Methodist Le Bonheur Healthcare in Memphis, Tennessee, says his health system board has an active quality committee that has been moving the organization toward outcomes measures over process measures in recent years. Last year the system elected to switch from all eight hospitals having the same quality targets to measurements that allow specific areas of improvement for particular hospitals.

"We changed it to give each hospital three outcomes-based quality measures based on their areas and opportunities for improvement," Ugwueke says. "So it varied a little bit. There were some that are consistent within the whole system, such as the catheter-associated urinary tract infection rate. Then some of the other hospitals are looking at sepsis because they were higher than the other hospitals."

Mark Solazzo, executive vice president and chief operating officer for North Shore-LIJ Health System in Great Neck, New York, says a few years ago the system's quality measurements were so myriad that the reports were difficult to track with any predictability.

"We measured a ton of different things, but it looked like a heartbeat," Solazzo says. "Some things would move up, some would move down. You'd have no steady movement. We then tried to focus the organization on a handful of things that we wanted to really focus on, and that helped a nice progression in those measures."

Working with quality-focused organizations such as Dartmouth-Hitchcock and the Institute for Healthcare Improvement has helped the organization focus on a few key areas, Solazzo says.

"We're really trying to redesign the

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> "We've been able to cut our sepsis deaths by 50% over the last number of years. Now we're looking at advanced illness in our ICUs and how we treat those patients."
>
> MARK SOLAZZO, EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER, NORTH SHORE-LIJ HEALTH SYSTEM, GREAT NECK, NEW YORK

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ASSESSING PERFORMANCE

How would you rate your organization's current performance in the following functions?

	Very strong	Strong	Neutral	Weak	Very weak
Care coordination	10%	44%	32%	13%	1%
Clinical analytics	1%	22%	42%	31%	4%
Clinical quality and patient safety	40%	50%	9%	1%	0%
Cost control	14%	55%	19%	12%	0%
Dedication to mission	54%	36%	9%	1%	0%
Financial/business analytics	12%	46%	26%	14%	3%
Healthcare IT	10%	45%	37%	6%	1%
Patient experience	22%	41%	32%	5%	0%
Population health management	5%	21%	38%	27%	9%

NOTE: This chart includes CEO data segmentation from the Premium edition of the report.
SOURCE: *HealthLeaders Media Industry Survey 2015: Succeeding in the Risk Era: How to Accelerate Progress Toward a Value-Based Future,* January 2015

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clinical process and do it in such a way that creates some sustainable change," Solazzo says. "We've been able to cut our sepsis deaths by 50% over the last number of years. Now we're looking at advanced illness in our ICUs and how we treat those patients."

Amy Perry, president of Sinai Hospital of Baltimore and executive vice president of its parent health system, LifeBridge Health, says looking at quality in three layers has helped system leaders agree on priorities and the evolving definitions.

"I would say that the primary layer of quality is health outcomes, and how well you do from the foundation of first doing no harm," Perry says. "Our most basic responsibility is to ensure no hospital-acquired conditions. Let's not do something to make the person worse than when they came in. Then the second level would be the patient experience or providing excellent service. And the third level would be a prevention indicator: Is there something we could

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"I would say that the primary layer of quality is health outcomes, and how well you do from the foundation of first doing no harm."

AMY PERRY, PRESIDENT, SINAI HOSPITAL, EXECUTIVE VICE PRESIDENT, LIFEBRIDGE HEALTH, BALTIMORE

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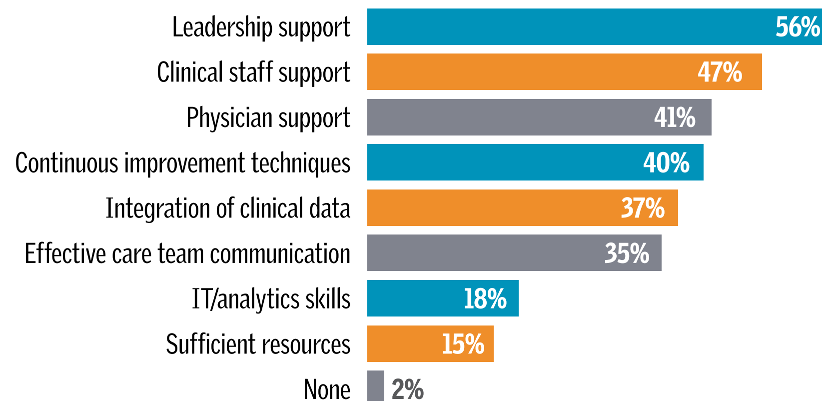
do to avoid a readmission and keep patients healthier on the outside of the hospital? I know most of us are working on new initiatives for that final health outcome to be improved in our population."

Patrick Charmel, president and CEO of Griffin Health in Derby, Connecticut, says the mission of his community health system has been to view definitions of quality "in their broadest context." On traditional measures of patient safety, Griffin has set its goal to be in the top decile nationally. Griffin has also taken tangible steps toward quality in population health, including the creation of a federally funded prevention research center, and a preventive medicine training program in cooperation with the Yale School of Public Health, Charmel says. Griffin is also well-known throughout the industry for Planetree, its not-for-profit subsidiary organization dedicated to advancement and education for patient-centered care.

"If you look at that broader definition of quality, we think that the core is patient-centeredness," Charmel says. "But it is only one aspect. So we talk about efficiency. We talk about the effectiveness of care. And we try to align the incentives to reward us for pursuing and achieving those aims. That's a challenge. Not everybody is willing to go there, payers included, but I think that's part of it. We are not willing to just wait for things to tip but actually try to influence the environment, and create those incentives so we can do the right things."

CLINICAL QUALITY SUCCESSES

What are the three biggest contributors to the success your organization has experienced to date in achieving clinical quality?



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SOURCE: HealthLeaders Media Intelligence Report, *The New Quality Equation: Measuring Success and Eliminating Waste,* July 2014

Reducing variability

Becky Kuhn, president of the Arizona East Region for Phoenix-based Banner Health, with responsibility for six acute care and specialty hospitals, says Banner has been looking at reducing variability in a systematic way. To that end, Banner has been investing heavily in its information technology and clinical staff infrastructure for the past decade or more.

"We're really transitioning now that we've got a strong infrastructure in place. We are now focusing more on high reliability so that we can produce the same result over and over and over again," Kuhn says. With that baseline in place, the team is able to identify areas for driving quality.

"Our infrastructure is designed for that," Kuhn says. "We have clinical consensus groups where physicians across the system come together, look at the data, and design clinical practices. Then the expectation is that those practices are implemented throughout every one of the hospitals. Now we're up to 13 clinical consensus groups on different specialties."

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At the same time, Banner also developed "ground up" clinical performance triads throughout the system, where a physician, nurse, and process engineer scour the data to identify areas for improvement.

"So it's a little bit of a ground-up approach to say, 'here's where we have the most variation' and then they hand off to a clinical consensus group to develop a solution," says Kuhn.

Michael Rowan, president of health system delivery and chief operating officer for Colorado-based Catholic Health Initiatives, with 105 hospitals in 18 states, says CHI has been focused on following a "true north" vision of where quality is heading.

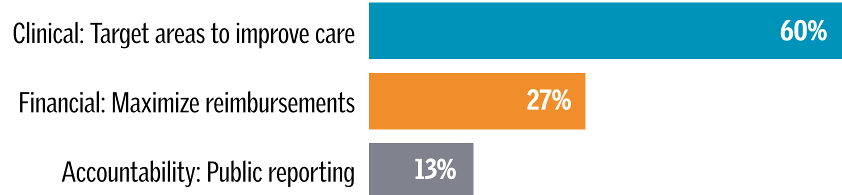
"We're really trying to focus on this idea of how to create a system which is focused on value instead of focused on volume," Rowan says. "In doing that, it's about the idea that it probably may not be about individual physicians or individual practices, but it's probably about how do we develop a care model that makes sense."

Rowan says part of that focus is to look at primary care redesign, where the primary care provider is working at the top of his or her license managing a team of providers. Likewise, the system is studying how to better manage patients with chronic illness based on evidence. Service lines are being studied to see where standardization can drive higher quality. What ties all of the programs together is the drive toward value, Rowan says.

"It's probably not so much about the specific metrics, and it's not so much about individual practitioners and their work as [it is about] how do we really put that care model together, because we believe that in putting the new care model together, the spinoff of that will be higher quality," Rowan says.

QUALITY MOTIVATION

Of the following motivations for pursuing improvements in clinical quality, please rank them by priority.



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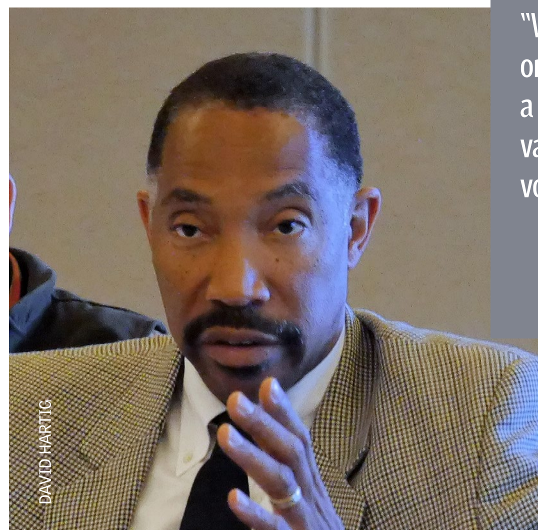

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"We're really trying to focus on this idea of how to create a system which is focused on value instead of focused on volume."

MICHAEL ROWAN, PRESIDENT, HEALTH SYSTEM DELIVERY AND CHIEF OPERATING OFFICER, CATHOLIC HEALTH INITIATIVES, ENGLEWOOD, COLORADO

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