Banner Health

POLICY and PROCEDURE

TITLE: Banner Health Quality and Safety Plan			
Number: 2878		Version: 2878.13	
Type: Administrative - Improving Organizational Performance		Author: Mikaela Mackey (Care Management Performance Improvement Team)	
Effective Date: 12/9/2015	Original Date: 9/19/2002	Approval Date: 12/4/2015	Deactivation Date:
Facility: System			
Population (Define): All Employees			
Replaces: Patient Safety Plan (#5800)			
Approved by: Care Management Council, Senior Operations Team, BH Board of Directors Quality Committee, BH Board of Directors			

TITLE: *Banner Health Quality and Safety Plan*

I. Purpose/Expected Outcome:

A. The purpose of the Banner Health Quality and Safety Plan is by design to outline Banner Health's commitment and systematic approach to quality and patient safety at all levels of the organization consistent with its Mission, Values, Core Behaviors and Vision. Banner Health's quality goal is to continuously improve and increase reliability of our processes and outcomes for the safety and betterment of our patients and other customers, our physicians, our communities and ourselves.

B. Mission: The mission of Banner Health is to make a difference in people's lives through excellent patient care.

C. Values and Core Behaviors: Banner's Values define the culture of Banner Health and how these values are demonstrated through actions and behaviors:
   1. People Above All: We treat those we serve and each other with compassion, dignity and respect.
      a. Patient Centered
         i. Compassionate
         ii. Respectful
         iii. Responsive
      b. Collaboration
         i. Promotes Teamwork
         ii. Fosters Cross Departmental Coordination
         iii. Effectively Communicates
   2. Excellence: We act with integrity and strive for the highest quality and service.
      a. Ownership
         i. Proactive
         ii. Resourceful
         iii. Responsible
      b. Continuous Improvement
         i. Safe and Reliable
         ii. Shares Knowledge
         iii. Continual Learner
   3. Results: We meet the expectations of the people we serve and the expectations we set for ourselves.
      a. Outcome Focused

b. Performance Driven
c. Agile
d. Accountable

D. Vision: We will be a national leader recognized for clinical excellence and innovation, preferred for a highly coordinated patient experience, and distinguished by the quality of our people.

E. Guiding Principles: Banner Health's approach to quality and patient safety is based on the following principles:
1. Patient/Customer Focus
   a. We are committed to meeting and exceeding the expectations of those we serve and engaging patients and their families in their care and services provided.
2. Leadership
   a. Our quality and patient safety commitment is established and demonstrated by our leaders.
3. Teamwork
   a. We actively encourage and involve everyone in the organization to communicate and work together to meet the needs of those we serve.
4. Continuous Improvement
   a. We understand that our outcomes are a result of our processes and that improving outcomes requires improving processes.
5. Evidence-based decision-making
   a. We rely on data from our own sources as well as credible research done elsewhere as the basis for our decisions.
6. Clinical Innovation
   a. We utilize the rapid identification and deployment of strategies leveraging Banner's operating model and the science of care delivery to ensure an extraordinary patient experience, which is safe, efficient and effective.
7. Values and Core Behaviors
   a. Our values and core behaviors set us apart as a leader in health care delivery and are essential to deliver an excellent care experience.
8. Culture of Safety
   a. Quality and patient safety is a core responsibility for all staff. We promote a culture of safety which encourages, instills and inspires accountability and responsibility.
   b. Banner Leadership support staff involved in medical incidents.
9. Learning
   a. We encourage organizational learning and support sharing knowledge within Banner Health and other health care organizations to improve quality and patient safety.

II. Definitions:

A. Facility – Any Banner Health hospital, ambulatory surgery center, physician/provider office, home health, hospice, skilled nursing facility, clinic or other setting where care is provided.

B. Process Owner – A process owner is an individual responsible for their respective level of business operations. A level of business operation could include a whole Facility, a department or a specific service within a department or across a Facility or the organization.

C. Process Improvement (PI) – Process Improvement is a series of actions taken to identify, analyze and improve existing processes to meet new goals and objectives.

D. Quality Assurance/Quality Improvement/Clinical Process Improvement/Quality Management Program Activities – For the purpose of this plan, "Quality Assurance/Quality Improvement/Clinical Process Improvement/Quality Management Program" means activities designed and implemented to improve the delivery of care and services.

III. Policy:

A. Banner Health bases its decisions on its values and applies the Guiding Principles throughout the organization in its Quality Management Model. (See ***Figure 1: Banner Quality and Safety Management Model***)

B. Quality Authority/Responsibility
   1. Governance.
      a. The Banner Health Board of Directors has the ultimate responsibility and accountability for quality of care and services provided by Banner Health. The Care Management Council and the Care Management and Quality Committee of the Board serve as the oversight bodies for quality management and have the following duties and delegated responsibilities:
         i. Monitor non-financial measures of organizational quality performance.
         ii. Ensure use of a systematic approach to quality management and assess ongoing improvement in the quality of services delivered by the corporation.
         iii. Review and make recommendations to the Board regarding a system-wide quality plan.
         iv. Evaluate and make recommendations to the Board concerning healthcare technologies including, but not limited to, genomics, biotechnology, future clinical services delivery and therapeutics.
         v. Evaluate and make recommendations to the Board with respect to ethical implications relating to the activities and services of the corporation, including quality and clinical innovation.
         vi. Act for the Board with respect to proposals of management and the local institutions and their medical staffs concerning medical staff policies, patient care policies, and compliance with standards of government and accreditation agencies having jurisdiction over the corporations' institutions as to such policies which require the involvement of the Board of Directors.
         vii. Act for the Board of Directors on matters and activities pertaining to the medical staffs of each local institution operated by the corporation to the extent permitted by law and applicable accreditation standards, including any matter which requires action by the Board of Directors, including the adoption, amendment or repeal of medical staff bylaws, rules and regulations, and medical credentialing criteria.
         viii. Act for the Board of Directors to the extent permitted by law and applicable accreditation standards, and otherwise make recommendations to the Board of Directors on any matter affecting medical staff membership or privileges, including application for appointment to the medical staff; application for reappointment to a medical staff; request for delineated clinical privileges; and denial, curtailment, limitation or revocation of any of the foregoing.
         ix. Review reports regarding the quality of care being provided in respective Facilities.
         x. Perform such other duties and responsibilities as the Board may assign to the Committee from time to time.
      b. In some communities, Advisory Boards provide advice and counsel to management and medical staff leadership on a variety of issues, including quality and safety activities and outcomes.

2. Leadership.
   a. Leadership is responsible for setting organizational direction and does this through the establishment of mission, vision, and goals, including annual initiatives. These are turned into actions though the development and execution of the strategic and operational plans that include quality of services and patient safety. Senior leadership communicates organizational direction, reviews and approves plans, provides resources and structure for the execution of the plans, and reviews performance to meet the goals of the plan.
   b. At Banner Health, Care Management provides oversight for improvement of clinical care and patient safety coordinated across the system. The Care Management Council, a group of Banner Health Leaders representing patient care and supporting functions, makes decisions related to system-wide quality and safety goals and activities to achieve those goals.
   c. Leadership for Facility activities related to quality of services and patient safety is directed by Facility administrative teams working with leaders under the oversight of the Quality Council structure. (See ***Figure 2: Banner Facility Quality and Safety Structure Template***)
   d. Quality Councils are responsible for the oversight of:
      i. Quality leadership:
         (i) Development and prioritization of Facility quality and patient safety goals and targets in an annual work plan.
         (ii) Facilitation of ongoing quality and patient safety education
         (iii) Communication of the quality and patient safety commitment, goals, targets and performance.
         (iv) Alignment of policies with quality and patient safety commitment.
         (v) Establishment of an engaged workforce.
      ii. Quality management:
         (i) Identification of patients and other customer needs.
         (ii) Identification of key processes; standardization and simplification.
         (iii) Establishment of measures and monitoring.
         (iv) Assessment and analysis of processes and outcomes.
         (v) Identification of improvement opportunities.
      iii. Performance improvement:
         (i) Evaluation and prioritization of improvement opportunities.
         (ii) Identification and replication of proven or evidence-based practices.
         (iii) Clinical Innovation through the rapid identification and deployment of strategies based on the science of care delivery.
         (iv) Allocation of resources for improvement.
         (v) Celebration of success.
      iv. Evaluation
         (i) Evaluation of this plan occurs at the local and system levels. Locally, each Facility reviews its progress towards goals identified in the annual work plan using data that measures clinical, financial, resource utilization, and service performance. To assure sustained improvement, this process includes a review of how improvements have been made and will be maintained. Additionally, leaders evaluate their own performance in supporting sustained improvement. Areas failing to meet targets become areas of focused improvement activities. At the system level, performance information is regularly aggregated for review by leadership and governance.

3. Process Owner/Department Managers.
   a. Process owners, individuals who serve in a leadership role in the performance of a process, are responsible for understanding patient and other customer needs, analyzing the processes used to meet those needs, standardizing and simplifying them to reduce variation and waste,

measuring important indicators, and using this data to determine appropriate improvement actions based on the organization's goals.

4. Employees, Contacted Staff and Volunteers.
   a. To assure that the organization meets the needs of its patients and other customers as they interact with nursing and other clinical staff as well as support staff, leadership has committed to developing an engaged workforce (staff, contracted staff and volunteers) who:
      i. Understand job expectations and responsibilities, including service standards;
      ii. Have access to information to determine if patient and other customer needs are being met, and understand how to respond quickly to resolve problems.
      iii. Are provided opportunities and skills for meaningful involvement in improving operations;
      iv. Recognize the need to work together to meet patient and other customer needs; and
      v. Know how to identify and report incidents.

5. Medical Staff
   a. Providers fulfill their Medical Staff delegated peer review responsibilities and take a leadership role in quality and patient safety activities. Medical Staff Departments and Committees routinely review clinical performance measures and identify improvement opportunities. Medical Staff leaders partner with administration in the leadership of quality management though routine interaction with administrative leaders and also serve on Quality Councils. In addition, providers serve in various capacities as team members, collaborating with other members of the health care team, to monitor and improve processes.
   b. The Board of Directors has delegated responsibility for review of professional practices to the medical staffs as set forth in the Medical Staff Bylaws. The Medical Executive Committees report on their performance of these responsibilities to the Board through the Medical Staff Subcommittee of the Care Management and Quality Committee of the Banner Health Board.

C. Quality management is initiated as leadership sets organizational direction by planning and developing goals, including quality, patient safety and risk priorities that are based on continuous efforts to understand the needs of those we serve as well as improving current levels of performance, utilizing evidence-based and best practices and industry benchmarks. Areas identified for improvement and for achievement of the vision are called strategic initiatives. Strategic and operational planning processes as well as proactive risk assessment and gap analyses are used to identify desired outcomes and actions to achieve those goals at various levels of the organization. Criteria used for establishing priorities may include, but are not limited to, clinical quality, patient safety, customer satisfactions, strategic direction, financial outcome, regulatory and accreditation compliance, resource utilization, high volume, high risk, or problem prone areas and external forces.

D. Process owners are expected to identify patient and other customer needs and expectations, understand key processes and safe practices, and establish performance measures for their areas of responsibility. Performance measures encompass different dimensions, including clinical outcomes, patient safety, evidence-based practice, utilization management, and patient satisfaction as well as financial results, and are aligned from the system level (e.g., quarterly patient satisfaction with inpatient care) to the process level (e.g., daily feedback from patients in a nursing unit).

E. Appropriate improvement action is determined by analyzing and interpreting these data over time, using an understanding of variation principles. Process owners are responsible for continuously standardizing and simplifying processes to increase reliability through the reduction of variation and waste. They are also responsible for proactively recognizing and implementing proven or evidence-

based practices for existing processes, using current literature sources and benchmarking activities internally as well as externally.

F. If processes are unstable, process owners investigate and work to remove the cause of the variation. If the variation results in a significant event, they are analyzed and acted on according to policy.

G. When data indicates a need to identify and correct the root cause of a problem, or there is an opportunity to move to a new level of performance, improvement projects are established. In these cases, teams, formal and informal, apply improvement processes that systematically move through the following five steps:
   1. Define the project
   2. Measure current performance
   3. Analyze to identify causes
   4. Improve
   5. Control

H. To assure that the changes required for improvement are successful, the human aspects of change are also addressed using a change model that addresses the need for effective change leadership, creating a shared need, shaping a shared vision, mobilizing commitment, implementing the change monitoring results, and anchoring the change in systems and structure.

I. Communication of improvement opportunities, new processes or practices are reported up and down the organization through defined reporting structures which include department, Facility and system-wide councils.

J. When current processes are not able to achieve customer expectations and/or established performance goals, new processes and services are designed and implemented utilizing evidence-based and innovative practices. A systematic approach involves multiple departments and disciplines working collaboratively, using information from patients, staff, payors, and others, along with current comparative information/data from other organizations.

K. Data for monitoring the effectiveness and safety of services and the quality of care at each Facility, including clinical outcomes, patient safety, evidence-based practice, utilization management, safety surveys and patient satisfaction, are collected and evaluated on an ongoing basis and reported up to governance for recommendations and actions on at least a quarterly basis.

L. When performance issues may be related to the professional practice of an individual medical staff member, medical staff committees review such professional practices and determine appropriate action, if any.

M. All proceedings, records, and materials related to Quality Assurance/Quality Improvement/Clinical Process Improvement/Quality Management and peer review activities are confidential in accordance with appropriate federal and state statutes.

N. When performance issues may be related to the performance of a staff member, they will be handled through the appropriate Banner Health Human Resources policies and/or procedures.

IV. Procedure/Interventions:

A. N/A

V. Procedural Documentation:

A. N/A

VI. Additional Information:

A. N/A

VII. References:

A. Alaska Statutes: § 18.23.030
B. Arizona Statutes: A.R.S. § 36-401 et seq. A.R.S. § 36-2401 et seq.
C. California Statues: Cal.Health & Safety Code § 101848.9D.
D. Colorado Statutes: C.R.S.A. § 25-3-109
E. Nebraska Statutes: Title 172 NAC, Chapter 5
F. Nevada Statutes: NRS 439.865
G. Wyoming Statutes: W.S. 35-2-910
H. CMS Conditions of Participation
I. The Joint Commission

VIII. Other Related Policies/Procedures:

A. Banner Health Strategic Initiatives/Plan
B. Facility Work Plans
C. Event Reporting Policy (#9062)
D. Patient Complaint, Discrimination and Grievance (#2865)

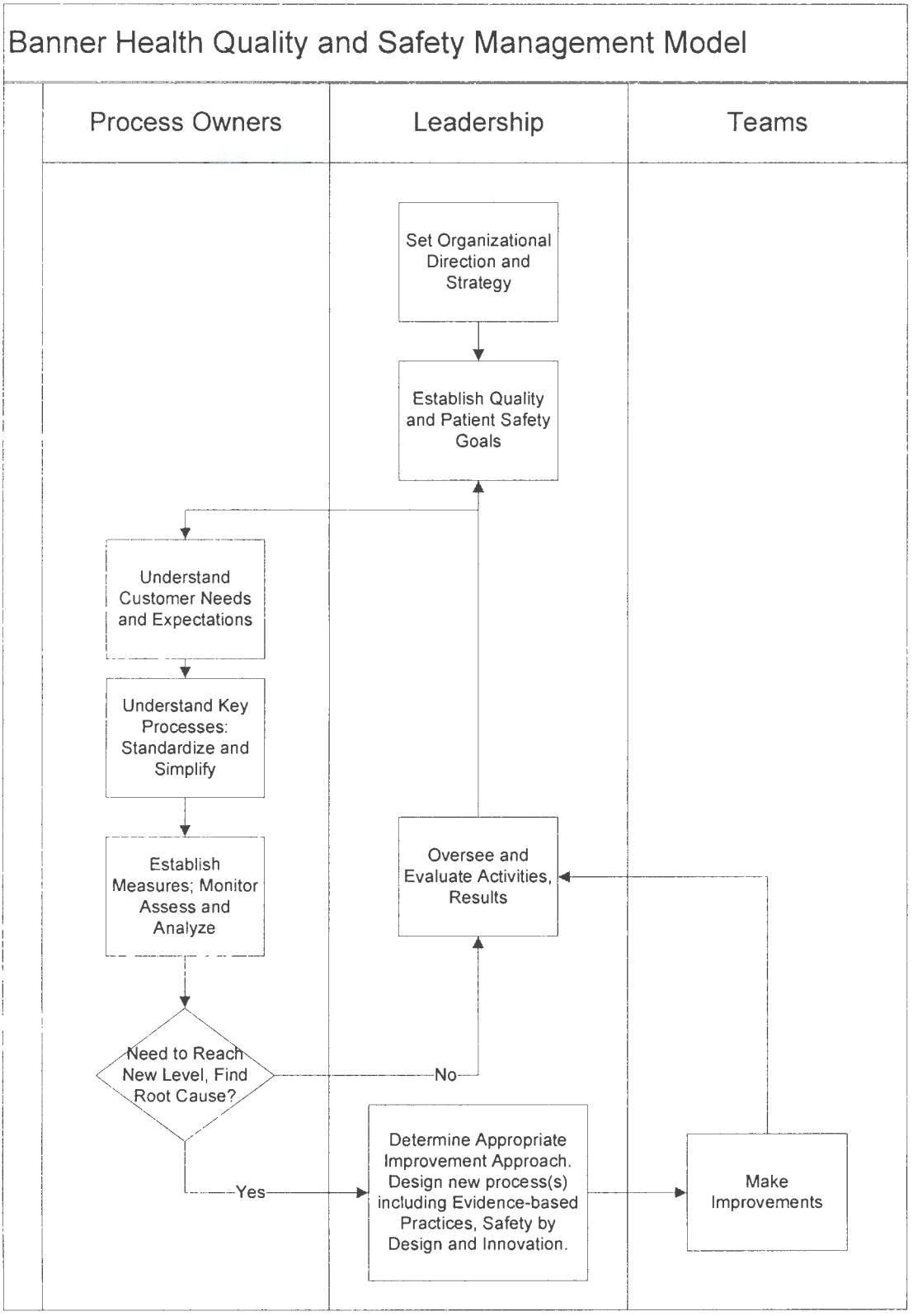
IX. Keywords and Keyword Phrases:

A. Board
B. Care Management
C. Mission
D. Quality Management
E. Quality Plan
F. Vision
G. Safety Plan
H. Patient Safety Plan

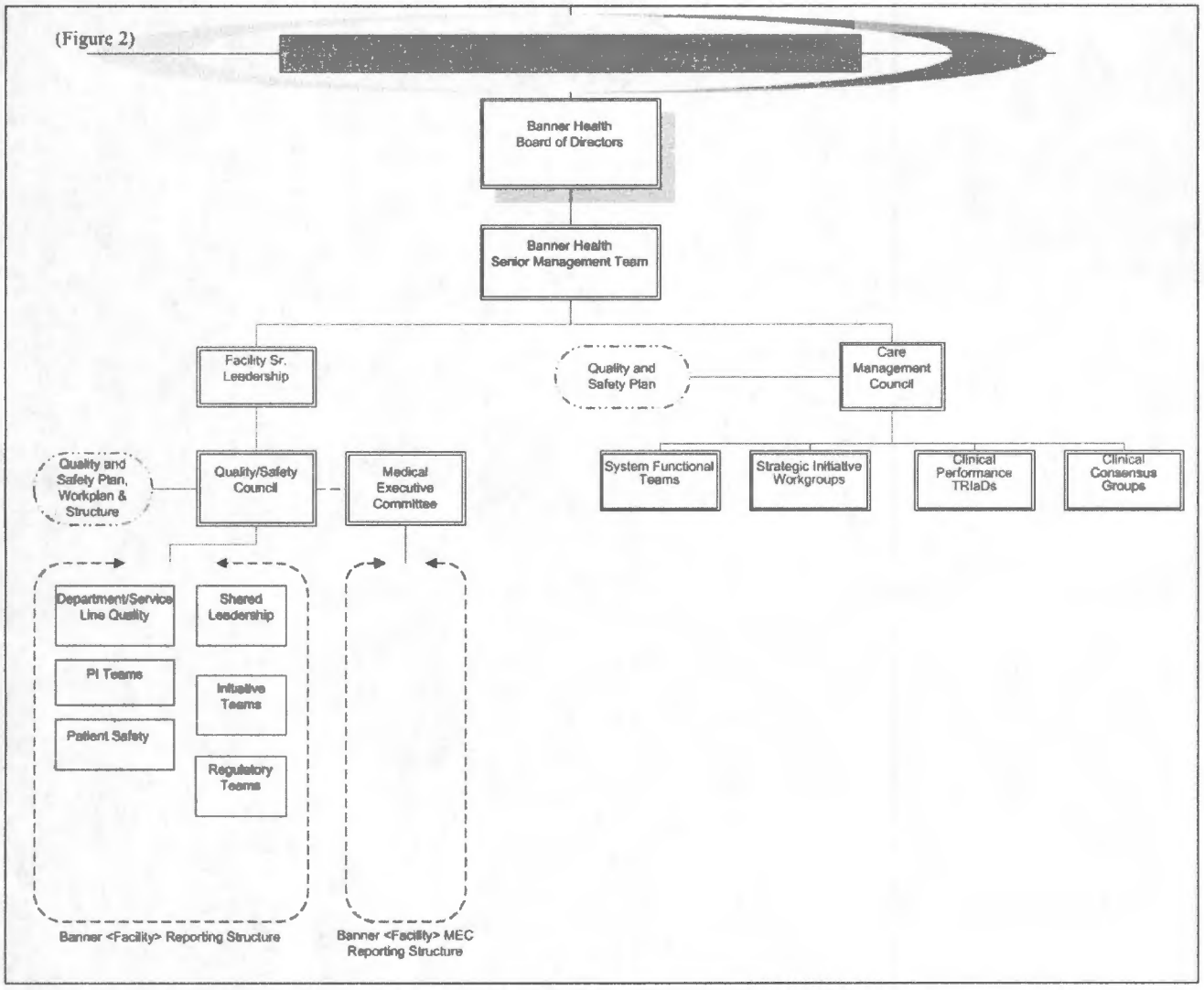
X. Appendix:

A. Figure 1: Banner Quality and Safety Management Model (See Section III.A: Appendix below)
B. Figure 2: Banner Facility Quality and Safety Structure Template (See Section III.B.2: Appendix below)

(Figure 1)


Banner Health Quality and Safety Management Model
Process Owners
Leadership
Teams
Set Organizational Direction and Strategy
Establish Quality and Patient Safety Goals
Understand Customer Needs and Expectations
Understand Key Processes: Standardize and Simplify
Establish Measures; Monitor Assess and Analyze
Oversee and Evaluate Activities, Results
Need to Reach New Level, Find Root Cause?
No
Yes
Determine Appropriate Improvement Approach. Design new process(s) including Evidence-based Practices, Safety by Design and Innovation.
Make Improvements

(Figure 2)


Banner Health
Board of Directors
Banner Health
Senior Management Team
Facility Sr.
Leadership
Quality and
Safety Plan
Care
Management
Council
Quality and
Safety Plan,
Workplan &
Structure
Quality/Safety
Council
Medical
Executive
Committee
System Functional
Teams
Strategic Initiative
Workgroups
Clinical
Performance
TRIaDs
Clinical
Consensus
Groups
Department/Service
Line Quality
PI Teams
Patient Safety
Shared
Leadership
Initiative
Teams
Regulatory
Teams
Banner <Facility> Reporting Structure
Banner <Facility> MEC
Reporting Structure