Banner Health

Title: **Banner Health System Quality and Safety Plan**	
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Approved by: Banner Health Board of Directors Quality Committee, Administrative Policy Committee, Chief Clinical Officer, Clinical Leadership Team, PolicyTech Administrators	

Discrete Operating Unit/Facility:
Banner Baywood Medical Center
Banner Behavioral Health Hospital
Banner Boswell Medical Center
Banner Casa Grande Medical Center
Banner Churchill Community Hospital
Banner Del E Webb Medical Center
Banner Desert Medical Center
Banner Estrella Medical Center
Banner Fort Collins Medical Center
Banner Gateway Medical Center
Banner Goldfield Medical Center
Banner Heart Hospital
Banner Ironwood Medical Center
Banner Lassen Medical Center
Banner McKee Medical Center
Banner North Colorado Medical Center
Banner Ocotillo Medical Center
Banner Payson Medical Center
Banner Thunderbird Medical Center
Banner--University Medical Center Phoenix
Banner--University Medical Center South
Banner--University Medical Center Tucson
East Morgan County Hospital
Ogallala Community Hospital
Page Hospital
Platte County Memorial Hospital
Sterling Regional Medical Center
Torrington Community Hospital
Washakie Medical Center
Wyoming Medical Center

Post Acute Services
Banner Home Health Services
Banner Hospice Services

Banner Corporate

Ambulatory Services
Banner Health Clinics
Banner Imaging Services
Banner MD Anderson Cancer Center
Banner Urgent Care Centers
Occupational Health/Employee Services
Rural Health Clinics

Banner Pharmacy Services

Research

I. Purpose/Population:

A. The Banner Health Quality and Safety Plan outlines Banner Health's commitment and systematic approach to quality and patient safety at all levels of the organization consistent with its Mission, Values, and Purpose. Banner Health's quality and safety goal is to create a culture of safety through continuous improvement and increased reliability for the safety and betterment of our patients and their loved ones, our team members, and our communities.

B. **Population**: All Team Members.

C. **Mission:** Making health care easier, so life can be better.

D. **Values:**
1. Customer Obsessed:
   a. We put the needs of customers and patients first by delivering high quality experiences.
2. Relentless Improvement:
   a. We examine successes and setbacks to continuously learn and improve.
3. Courageously Innovate:
   a. We embrace new solutions with openness, curiosity, and without fear of failure.
4. Disciplined Focus:
   a. We achieve exceptional results through experience, insight, and data analysis.
5. Foster Accountability:
   a. We honor our commitments, collaborate for solutions, and hold each other accountable.
6. Continuously Earn Trust:
   a. We cultivate authentic relationships by demonstrating empathy, honesty, and integrity.

E. Purpose:
1. Banner can and will create a new model that answers America's health care challenges today and in the future.
2. Inspired to change the health care landscape in our communities – big and small – our talented and passionate teams care deeply about individuals who are responsible for the needs of their extended families.
3. Taking access and delivery from complex to easy, from costly to affordable and from unpredictable to reliable, we give every individual we serve confidence in their health care experience and its outcome.

II. Definitions:

A. Facility/Entity– Any Banner Health hospital, physician/provider office, home health, hospice, clinic, urgent care, imaging center where care is provided which Banner wholly owns or partially owns in which Banner Health is responsible by agreement to provide quality management oversight.

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 Management – For the purpose of this plan, "Quality Management" includes activities and/or programs such as Quality Assurance, Quality Improvement, Clinical Process Improvement intended to improve the delivery of care and services provided by Banner Health.

E. Quality Assurance Process Improvement (QAPI) – A sub-section of the CMS Conditions of Participation (CoP) defining Quality Improvement oversight and activities for healthcare entities.

III. Policy:

A. Banner Health bases its decisions on its values and applies these 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:
   The Banner Health Board of Directors has the ultimate responsibility and accountability for quality of care and services provided by Banner Health.
   a. The Care Management and Quality Committee of the Board and the Clinical Leadership Team 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 service 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. Review reports regarding the quality of care provided throughout the enterprise.
      vii. Perform such other duties and responsibilities as the Board may assign to the Committee from time to time.
   b. The Care Management and Quality Committee and the Medical Staff Subcommittee of the Care Management and Quality Committee serve as the oversight bodies for quality management activities pertaining to the acute care hospital medical staffs and have the following duties and delegated responsibilities.
      i. 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 corporation's institutions as to such policies which require the involvement of the Board of Directors.
      ii. 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.
      iii. 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.
      iv. Review reports regarding the quality of care being provided in respective Facilities.
      v. Perform such other duties and responsibilities as the Board may assign to the Committee from time to time.
   c. 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, values, and purpose, including annual and long-term initiatives. These are turned into actions through 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 the safety management system. The Clinical Oversight Team (COT), 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/Entity activities related to quality of services and patient safety is directed by Facility/Entity administrative teams working with leaders under the oversight of the Quality and Safety Council (QSC) structure (**See *Figure 2: Banner Facility/Entity Quality and Safety Council Structure Template***).
d. Quality and Safety Councils (QSC) are responsible for the oversight of:
   i. Quality Leadership:
      (i) Development and prioritization of Facility quality and patient safety initiatives in an annual Quality and Safety 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) Engage and empower workforce in quality and safety activities
   ii. Quality Management:
      (i) Identification of patient and customer needs
      (ii) Identification of key processes; standardization and simplification
      (iii) Establishment of key performance 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) Celebrations of success
   iv. Evaluation
      (i) Evaluation of this plan occurs at the local and system levels. Locally, each Facility/Entity reviews its progress towards goals identified in the annual Quality and Safety 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 sustained. Additionally, leaders evaluate their own performance in supporting sustained improvement. Measures failing to meet target 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 processes to appropriately reduce variation and waste, measure relevant indicators, and use this data to determine suitable improvement actions based on the organization's goals.

4. Employees, Contracted Staff, Vendors, 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 quality, safety, and 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 skill development training and opportunities for meaningful involvement in improving care delivery and operations
      iv. Recognize the need to work together to meet patient and other customer needs
      v. Know how to identify and report events impacting quality and safety

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 and Safety Councils. In addition, providers serve in various capacities as team members, collaborating with other members of the health care team, to monitor and improve care 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.

6. Risk Management
   a. Risk Management conducts activities intended to improve the quality of care and reduce errors and omissions. Risk Management may report trends and concerns relating to individual physicians and allied health providers to the appropriate Medical Staffs to determine whether peer review is warranted. Risk Management may report other trends and concerns to the appropriate subcommittee of the Clinical Leadership Team.

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 best practices, subject matter expertise, and internal and/or external benchmarks. Areas identified for improvement and for achievement of the vision are referenced as annual or long-term 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 core harms, high-risk environments, customer and team member satisfaction, strategic direction, financial sustainability, regulatory and accreditation compliance, resource utilization, high volume, 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 sustainability, 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 data over time, utilizing principles of variation. Process owners are responsible for proactively recognizing and implementing proven or evidence-based practices for existing processes, referencing current literature sources, leveraging knowledge from subject matter experts, and benchmarking performance internally and externally, when appropriate.

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, it is 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 chartered. In these cases, teams, formal and informal, apply improvement processes that systematically move through the following five steps (DMAIC):
   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 and new processes or practices are reported throughout the organization via 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, team members, payers, and others, along with current external peer comparatives when available.

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

L. 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 federal and state laws. Meetings will be held in confidence and minutes will be maintained separately. Dedicated portals with restricted access will be created to allow the sharing of confidential information.

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

N. New committees and new organization structures may be formed from time to time and the work performed by these groups is intended to be covered under the auspices of the Quality and Safety Plan and the protections afforded by federal and state law.

IV. Procedure/Interventions:

A. N/A

V. Procedural Documentation:

A. N/A

VI. Additional Information:

A. N/A

VII. References:

A. Arizona Statutes: A.R.S. § 36-441 et seq. A.R.S. § 36-2401 et seq., A.R.S. § 36-445 et seq.
B. California Statues: Cal. Health & Safety Code § 101848.9D. §§ 43.7, 43.8 and Cal. Evid. Code §§ 809, 1156, 1157
C. Colorado Statutes: C.R.S.A. § 25-3-109, 12.36.5-101 et seq**.**
D. Nebraska Statutes: Title 172 NAC, Chapter 5, §§ 71-7904 et seq., 25-12,123 and 44-32,127.
E. Nevada Statutes: NRS 439.865, § 49.117 et seq.
F. Wyoming Statutes: §§ 35-2-910, 35-17-103 et seq
G. CMS Conditions of Participation
H. The Joint Commission

VIII. Other Related Policies/Procedures:

A. Banner Health Annual and Long-Term Initiatives
B. Entity/Facility Quality and Safety Work Plans
C. Event Reporting (#911)
D. Event Reporting Post-Acute (#7080)
E. Patient Complaint Escalation and Post Discharge Patient Complaint and Grievance (#1341)
F. Peer Review, Medical Staff (#760)

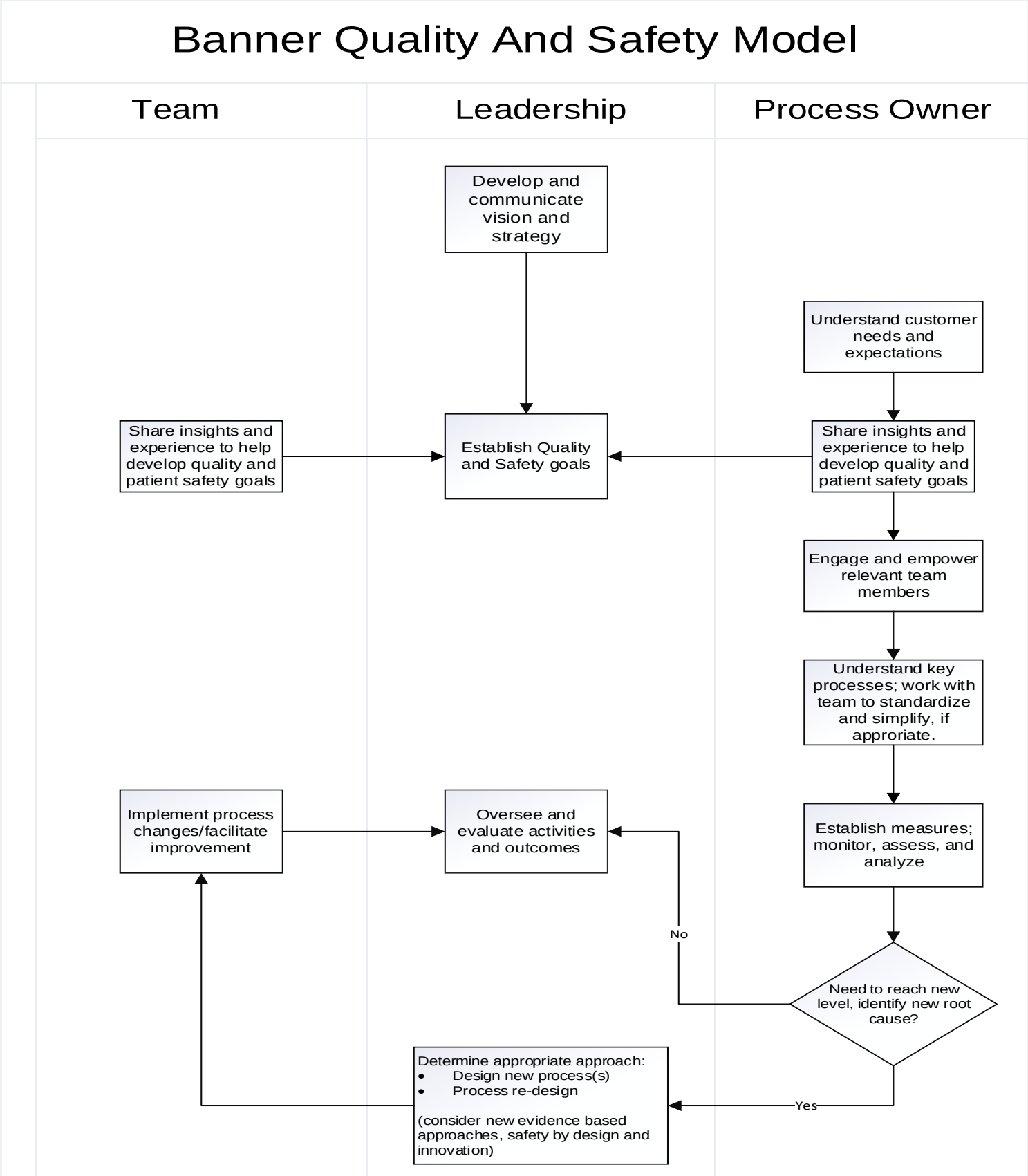
IX. Keywords and Keyword Phrases:

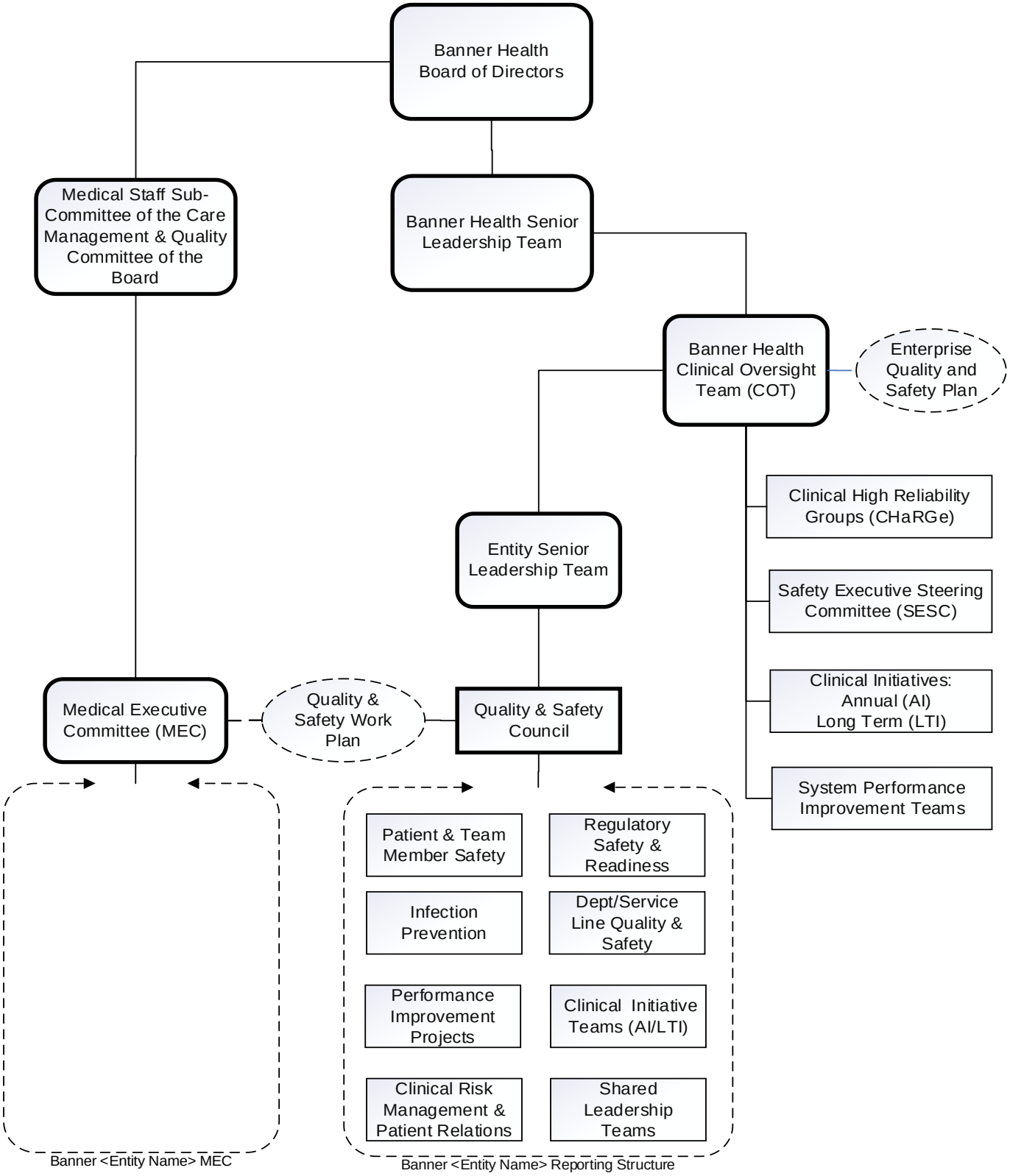
A. Banner Board
B. Care Management
C. Mission
D. Quality Management
E. QAPI
F. Quality Plan
G. Quality and Safety Work Plan
H. Vision
I. Safety Plan
J. Patient Safety Plan

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 Quality And Safety Model
Team
Leadership
Process Owner
Develop and communicate vision and strategy
Understand customer needs and expectations
Share insights and experience to help develop quality and patient safety goals
Establish Quality and Safety goals
Share insights and experience to help develop quality and patient safety goals
Engage and empower relevant team members
Understand key processes; work with team to standardize and simplify, if approriate.
Implement process changes/facilitate improvement
Oversee and evaluate activities and outcomes
Establish measures; monitor, assess, and analyze
No
Need to reach new level, identify new root cause?
Determine appropriate approach:
• Design new process(s)
• Process re-design
(consider new evidence based approaches, safety by design and innovation)
Yes

(Figure 2.)

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