THE OHIO STATE UNIVERSITY

OFFICIAL PROCEEDINGS OF THE

NINETH MEETING OF THE

WEXNER MEDICAL CENTER BOARD

Columbus, Ohio, December 12, 2014

The Wexner Medical Center Board met on Friday, December 12 at the Richard M. Ross Heart Hospital, Columbus, Ohio, pursuant to adjournment.

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Minutes of the last meeting were approved.

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Mr. Wexner called the meeting of the Wexner Medical Center Board to order on Friday, December 12, 2014 at 10:03am.

Present: Leslie A. Wexner, Chairman, William G. Jurgensen, Abigail S. Wexner, Stephen D. Steinour, John F. Wolfe, Michael V. Drake, Steven G. Gabbe, Geoffrey S. Chatas, E. Christopher Ellison, and Michael A. Caligiuri. Janet B. Reid was late.

Mr. Wexner:

Good morning. I would like to convene the meeting of the Wexner Medical Center Board and ask Blake to note the attendance.

The minutes of the November meeting have been circulated. If there are no additions or corrections, the minutes are approved as distributed.

Dr. Gabbe, you are first.

Dr. Gabbe:

Thank you. Welcome everyone. This is a very exciting and a very monumental day for the Wexner Medical Center because early this morning, the first patients moved into the new James Cancer Hospital and Solove Research Institute and Critical Care Center. I will emphasize, in the case of this morning, it was the Critical Care Center. Many of us were here around 4:30 this morning to gather with the teams that have been working on this move for over two years. The move today was for the Critical Care Patients, approximately 40, were moved an hour and 15 minutes ahead of schedule. It was done smoothly and without incident. Remember that these are the sickest patients we have. Many on ventilators. This is a tribute to the staff and the teams for organizing this.

As it turns out, John Chrisman, who is the head of Critical Care here, had done this twice before, once at the Nashville VA, and another time at Vermont. For him it was a bigger move but something that he's accomplished in the past.

I'd ask Dave Schuler, Jeff Walker, others who were there this morning if they would like to comment. We are so pleased and breathing a sigh of relief that it went as smoothly as it did. Mike.

Dr. Caligiuri:

I think today has been fantastic. We completed the 40 patients. Kudos, as Steve said, to everyone. Sunday will be the 200 patient move. We were going to move in four phases, started at 8:30 in the morning, patients will be moved at 6 minute intervals, this should be done by 6:30 in the evening.

There will be 500 volunteers. We closed the doors at the number of people that wanted to volunteer for this. They are going to be phenomenally important and helpful. We've got an ascending command center that is as the patients are sent out of the "old" James, two physicians at each bed. There is a center set up, very much like a room here, staffed with about 15 people, everything is monitored live, visually as well as over the phone lines. We have a receiving center in the new James that was activated this morning, receiving all of the calls and any issues that come up during this move. It'll be very complex. Two physicians stabilize the patient, bring them over, and then two physicians receive each patient, as I said, at every six minute intervals, 200 patients over the course of a day, a lot to do. We're going to hope for the best. We expect it to go well of course it's a million square feet, a billion things that could go wrong. We're on top of it. We will keep people notified.

Dr. Gabbe:

Thank you, Mike. I think how well this has gone today reflects what you see in front of you which was something that appeared in The Dispatch and other media announcing one of the safest places on earth,

The Wexner Medical Center. We're very proud of this, as you can imagine, for our recognition by the University Health Systems Consortium to be third among all of the academic Medical Centers that make up this important organization, superior performance, high quality, safe, efficient, and patient centered. I know we all take great pride in that.

I'd also like to recognize one of our outstanding nursing staff, Rochelle Santos, who is a staff nurse in our post-anesthesia care unit, who was recognized this year by the March of Dimes as the nurse of the year in surgical services in the state of Ohio. Congratulations to Rochelle. I think she represents the outstanding nursing team that we have here at the Wexner Medical Center.

We have up on the screen and in front of you, our medical center performance scorecard. This is through October. The first item under quality and service is inpatient mortality and it is green as it has been in the past as we have one of the lowest observed to expected mortalities in the country and that continues. Overall patient satisfaction is red. This is the percent of our patients who give us the highest ratings, a nine or a 10. For inpatients this was at the 74 percent mark and for outpatients the 90.6 percent mark. This has improved going into November, which we were pleased to see. Still not at the 90th percentile and we are working toward that. I'd say that generally, July, August, September, and October have been months where we have scored lower perhaps because we're bringing on many new staff, residents, faculty, and fellows.

This first quarter, third, of the year was the best we've had and should put us in a much better position to reach 90 percent as the year goes along. I do remember Mr. Jurgensen telling us that we should accept nothing less than the 100 percent but we're working towards the 90 percent right now. *US News and World Report* will not be available for Best Hospitals until July. I won't comment much on the financial metrics because Mr. Geier will.

Mr. Jurgensen:

This is an overall satisfaction metric. But underneath it, I am going to guess, are some number of important areas that lead to the impression. I think what would be helpful is, not necessarily for today, if you break it down into the five or six and then say, here is the real issue that's embedded in this. What I am really fishing for at the end is if there are things that are part of an academic medical center where teaching and other things are going on that might not be present in a pure clinical operation. For instance, you get visited by more than one person at a time.

Dr. Gabbe:

I know exactly what issue you are raising. I was going to mention that through the first four months of the year, the Ross Heart Hospital was at the 96 percent and the James is generally right around 90 percent. They are our best performing hospitals. I think we can come back at our next meeting and give you that break down and can focus on several of the areas that you're pointing to.

Mr. Jurgensen:

Yes because I think this is something we're going to need to do.

Dr. Moffatt-Bruce:

There are domains like doctor communication. Is that affected by an academic medical center where you have medical students, residents, fellows, and attendings. Cleanliness, critical test results, those are all different domains and we can certainly bring you back where those opportunities are and how we have improved yet we still have more opportunities.

Mr. Jurgensen:

You know my last comment is that satisfaction measures, at least in our corporate world, actually as a lagging indicator. Sometimes it's called net promotor score. The real question is, would you recommend and do we ask that question?

Dr. Gabbe:

Yes.

Mr. Jurgensen:

And do we score that?

Dr. Gabbe:

That is the outpatient question. Would you recommend?

We can bring that data back to you. I agree this is a lagging indicator and we should bring that back. We will at our next meeting.

President Drake:

We were visiting University Hospital East earlier this week and University Hospital East Orthopedics, I believe, does well.

One of the things that I think is interesting is that different units within our enterprise do better or worse depending on things that might not be intuitive. Quality of care, the way the people interact, all those kind of things, are really important. To say that University Hospital East, which has less investment in other things than many other places, performs really well in the patient satisfaction. I think there are things that we ourselves can learn from ourselves as we move forward.

Dr. Gabbe:

University Hospital East has been making excellent progress in this area. We can bring that back and show that to you.

In terms of the financial metrics, Pete will cover the days cash on hand, our revenue for adjusted admission, and our expenses per adjusted admission.

Looking at development dollars, we were red through October and you can see at $25.7 million. We did receive just recently a large gift from the Frick family of $2 million to support our electrophysiology program. The break down, if you're interested in that $25.7 million, I can tell you that the largest component is, as you'd expect, the James at just over $19 million, followed by neurosciences at just over $4 million, and the medical center itself at about $3 million. We know December is usually a big month for development and we would expect to see that number increase and improve.

Patty, are there any comments you want to make.

Ms. Hill-Callahan:

Yes, actually to date we're at $32 million and we're expecting another $16 to $18 million before the end of the calendar year.

Dr. Gabbe:

Excellent, thank you.

An area we are concerned about and you can see under research excellence is our NIH awards; in the red, at $28.9 million through October. Through November, we were just above $32 million. We had a very good fiscal year 2014 with several large awards early that year. We're actually 28 percent off where we were last year. In part, this reflects those large grants we received last year. It also reflects the funding climate in the NIH. We would hope that by December, which is when they have another funding cycle, we would see improvement. We're optimistic because our submissions to the NIH are up 32 percent and our funding success has also been higher this year. We have more proposals going in. We're getting funded at a higher rate. We hope that that will improve but that is an area we are focusing on; working with Dean Ellison and our Vice Dean for Research, Dr. Groden. Chris is here, I don't know if you would like to add.

Dr. Ellison:

I would say that we have submitted 33 proposals, I think, this year as compared to 26 last year. We are ahead of number of proposals for funding and funding rate is greater. We are optimistic that this will turn the corner.

Dr. Gabbe:

Thank you. The other two areas on the scorecard are yellow. We are awaiting data for both *US News and World Report* medical schools report, which will come out in April, and our workforce engagement survey.

That's the scorecard to date. I would be happy to answer any questions about it that we haven't addressed.

Mr. Wexner:

Questions? Thank you very much.

Dr. Gabbe:

We will be back with the data on patient satisfaction at our next meeting.

Mr. Wexner:

Pete?

Mr. Geier:

Good morning. When we sent the book out, we had only October closed but we've set at everybody's place, November year-to-date which is the slide that we have up.

Many of the trends I reported on continue. All the hospitals are significantly above a year ago and better than budget. Next time I will bring a hospital-by-hospital break down.

A couple of comments on the financials that you see. We were above budget on admissions through October. We were off a bit in November. Our length of stay was up, mostly in hospital medicine but it looks like this month we're back green through the early part of December.

Surgical volume has continued to be a good story on the inpatient side, Ross, University Hospital, and University Hospital East are all over budget and on outpatient, and all of the hospitals and the surgery

center are over budget for the year. Some of the services that have been particularly strong are open heart and vascular service in the Ross, neurosurgery, our transplant program. With the lung transplant program being reinstated, we're actually over budget for the first time in many years, urology and surgical oncology.

Our outpatient volume continues to grow across the board. The bariatric program is seeing significant growth in weight management, respiratory therapy, and radiation oncology at the Stephanie Spelman. We opened an endoscopy suite at University Hospital East, which is quite busy and our cardiac rehab.

Emergency department visits. We talked a little bit about that last week and the fact that we have been full and getting patients in and obviously opening the new hospitals will help with this. For the first five months of the year, we were on divert in the emergency room. When you translate the days, we were actually on divert a total of 15 days during that period of time. When you're on divert, you let Central Ohio Trauma and other ambulance services know you're full. Our emergency room is essentially shut down for those periods of time. Now it doesn't happen on days, it happens on hours during the day but if that was just open you'd probably have about another 2,800 visits to the emergency room and more admissions. This issue of getting our capacity opened up so that we can get patients through and into the new beds is very real.

With the surgical volume being above budget and the outpatient, you can see, operating revenues are over budget and over last year. Expenses continue to be a good story. Actually, in the month of November, our total expenses were lower than they were in November a year ago. Seventy-five percent of our expenses are in three categories: salaries and benefits, supplies, and services. That's about 75 percent and all three of those categories are under budget and under last year. We're making some headway on the work we have reported on the supply chain and a lot of issues on our staffing models and our span of control and management positions. Those are going to be on going for the rest of the year and into next year.

All that translates into the EBIDA margins. You can see our days cash is over budget and that equates to about $30 million higher than budget in terms of reserves and year over year from a year ago about $80 million in cash higher. All in all we are continuing on a good start.

I always try to throw a little bit of caution on this. We still have to open the building. I fully expect these numbers to move around a lot over the next couple of months. As we move into the building, new expenses will be coming on. I think in this report in December, January, and February, we will see some volatility in the numbers until we get to a new normal in the later part of the fiscal year.

I'd be happy to answer any questions.

President Drake:

Pete, how would these numbers look compared to other hospitals in the region. Our numbers are all up. I know that's a trend nationally. How do we compare relative to others in the region?

Mr. Geier:

From what I take from UHC, which is the national group I am associated with, not so much. I think all local hospitals are doing well. I think for a lot of hospitals the inpatient admissions are a mixed bag. Activities are good but I think some places are experiencing declines in admissions, struggling with admissions, locally and in some parts of the country, and even some of the rural areas around Ohio, they have particular struggles.

President Drake:

One of the things I am interested in is the impact of Medicaid expansion. That is one of the trends that impacts all these things strongly.

Mr. Geier:

We are obviously seeing the impact from a positive standpoint on Medicaid expansion. We have been very proactive about setting up programs to sign people up; you can actually go back a year and sign people up. Obviously one of the big populations has been at University Hospital East in terms of volume and we've seen it there. The hospital is very full of activity. A year ago at this period of time for these five months, University Hospital East, and this is fully loaded expenses, was losing $2.2 million for the first five months of the year, they're making $6 million. A lot of that is volume. We added services to University Hospital East, but it tends to be a population where we see that in University Hospital and both.

Mr. Steinour:

Are any of the startup numbers for the new James reflected in November or are they going to be in the future?

Mr. Geier:

They will be mostly in the future. We've been ramping up. The expenses are up in the James and they are down in other areas. We're beginning to see it. The real interest decrease starts this second half of the year and we'll get a full load next year in some of the staffing. Yes, we'll probably see more of that in the second half of the year, I don't think we'll keep expenses lower than a year ago flat but we're certainly trying to control them.

Mr. Steinour:

You had an expense exercise that you went through. We will lose visibility to the success of that by the one-time expense of the opening of the new hospital. It would be helpful to be able to more clearly see that.

Mr. Geier:

Ok. I can break that out next time. As I mentioned, hospital by hospital probably shows that a little better because you do see increases in the James relative to the ramp up and then other areas declines where we've instituted things.

Mr. Steinour:

Great.

Mr. Jurgensen:

We can also recognize it in individual line items, right?

Mr. Geier:

Yes.

Dr. Gabbe:

I think in response to President Drake's question, we've seen at University Hospital East, our uninsured fall from 11 or 12 percent to 1 or 2 percent; that has helped.

Mr. Geier:

We've seen that at University Hospital too which sends out a large Medicaid population.

President Drake:

Those two experiments: one is to see the impact of Medicaid expansion on things like the uninsured population and on the uncompensated care that we give and how those factors come together at the end of the day.

Another thing for us to look at, that I am interested in, is the impact of decompressing the enterprise. You mentioned 15 days of diversion. That we should see also this next month or two; pretty rapidly when we open the new hospital. That will be an interesting trend to follow as well.

Mr. Geier:

It will be. To comment, and I'd let Susan, Andy, and others comment, I think we will see it. I don't think it will immediately take care of the issue. We have some significant workflow, reengineering, and redesign work going on right now and our transfer process and our bed placement. The other half of that is capacity but I think we all recognize we've got some workflow issues, some information and data systems that we're putting in place in our transfer center in the ED to help better with the patient placement; I do think it will help.

President Drake:

It will be interesting to follow over the next few months as well.

Mr. Wexner:

I have a question. I think some members may remember and some may not have been here, but we had a significant increase in cash, 62 days to 78 days. First question is, of about $16 million pick up, what are the sources of it and what does it look like a year out?

Mr. Geier:

The sources are two-fold. One, we're exceeding the revenue number and the expense base is lowered down; it comes out the end in cash. I set our target for the end of this fiscal year, I would love to be able to end the year over 80 days. I haven't done a projection. I can do that and what the following year looks like.

Mr. Wexner:

Any range of outcome?

Mr. Geier:

We are talking about fiscal year 2016 and fiscal year 2016 gets even a little trickier with the budget because we have the full year of expenses for the James. I would hope we could continue to grow it, you know, three to six days a year which has been our range. We obviously have picked up. I think if we can end this fiscal year above 80 days and get into a range of 85 days for fiscal year 2017.

Mr. Wexner:

That's an easy number to remember. So much of what we do depends on building the cash reserves so then we can do other things. A lot of this speaks to efficiencies, really being an efficient organization. I've been thinking about it and on a go forward basis have you pondered efficiency as a strategy; and that's something nice to do. It is a strategy in and of itself. I think that will be a lot of the work in the progress we've made and progress that we will make going forward, not putting aside effectiveness but we have to be efficient.

Mr. Jurgensen:

There was some conversations that took place recently; spurred in part by your note. I think one of the things that we can do a better job of, and we need to do to break this down, is to take the expense structure and put it in different kinds of buckets. In other words, under the theory that all expenses are variable over a really long period of time but in the short run a lot of expenses aren't. They can be in the long run but not the short run. If we have over $5 billion of expense, how much of it is actionable within what periods of time, in bigger buckets, and then break the bigger buckets down. I know Geoff and others in finance are working on that to give us a better depiction. I think when you look at the gross number and you say in corporate land ten percent of expenses is almost always within reach, some of that is true here but there are some differences. Geoff and I are trying to figure out how to demonstrate that because I think it needs a little more light on it.

Did you want to say anything?

Mr. Chatas:

We're working on it and breaking it up with the university and medical center in different pools and classifying the expenses that are addressable. I think what Jerry is talking about on the university side, as an example, is the tenured faculty bucket and what time that would take to address versus the significant ramp up in supplies or staff cost that we've experienced.

Mr. Jurgensen:

It was interesting. There was an article in *The Lantern* about a month or two months ago. It talked about the staffing of overall university. I think the number was something on the order of 44,000 staff of about 6,700 to 6,800 being faculty. The student author was making the point where we are rapidly approaching having one staff or faculty member per student; which is kind of a staggering thing to think about. That's one area for sure that needs to be exploded.

President Drake:

Let me say though, not to be critical or to be in the minutes, that we have an enterprise that is a huge enterprise with lots of employees that are not related to the undergraduate educational mission.

Mr. Jurgensen:

I agree with you and that's why we need to go below the aggregate.

President Drake:

And that number also is head count and not FTE; it's just about 50 percent inflated over the FTE. Not to discuss that.

Mr. Wexner:

I will resist the temptation. Any other questions on the finances? We are making progress and I think we're all committed to make continued progress and accelerate.

I think we've taken out of the run rate about $100 million. Tim what does it look like the next year in terms of potential to take out.

Mr. Chapman:

If we stay at the $18,000 per adjusted admissions, the target was 18.7 million that would have been $100 million. If you take the $700 per adjusted admission, we're running $170 million.

If we hold the line at $18,000 per adjusted admission. I would be saying we're well on our way towards a $200 million trajectory into fiscal year 2016. But one important question that we all need to really understand a little bit better is all of our payer contracts are up for renegotiation. What we're doing right now is trying to run as hard as we can on efficiency with an uncertain outcome of what would happen on the end of the Aetna and United Healthcare contracts. I would say that a $200 million run rate is where we're headed. We're bending the curve. We really are bending the curve.

Mr. Wexner:

I will make one comment on efficiency. You can unpack it a lot of different ways, at the end of the day, from the operations of the hospital, we're in a competitive market with other hospitals that are efficient or maybe become more efficient to get a larger share of market based on the changes in payers. It's kind of march or die on efficiency and we have to be efficient to maintain market share and that market share maintenance, or gain of market share actually which I would hope for, is absolutely connected to the success of the whole medical center. The notion of us being efficient in every way possible and just a culture of efficiency. People are figuring out and being creative and entrepreneurial about efficiency is what we should be doing. I give the same advice to the whole university because if, my metaphor would be, if I believe I am overweight and I ought to lose about 10 percent of my weight or 10 pounds then I would begin to think about how to do it. If I believe I have to rationalize my bone density and muscle density and all this, I delay the beginning of the beginning.

I think this is a cultural issue of being efficient. Efficient in time, efficient in spans, efficient in how we buy things, efficient in how we sell things. Big organizations find it difficult to be entrepreneurial to change. That's the task that lies ahead and we're forced to be efficient. One because of judgment but more importantly and more immediately is the market. It just is what it is.

We're making progress and hopefully we can hold that line and in holding the line, maintain or gain market share because that would be a keyed measure of our success; gaining market share. That's just how I think about things offline; we can have the debate.

Dr. Moffatt-Bruce:

I will just take but a minute.

Obviously, every year we have to plan for the next year around quality and patient safety. I feel that we are making some in-roads. However, everybody is continuing to get better at the national level. Every year we tend to set our goals high.

This is a plan that has been put in place every year for as long as I have been in this role and every year we review it, not only with our quality committees, but also with our patient advisory committee. This is a fairly lengthy plan, there's almost 32 pages but just for your orientation, it does speak to who is here to support this around the medical directors, the CQO (chief quality officer), the physician in chief, and the CMO (chief medical officer). It also speaks to the confidentiality and as well where the data is collected. I think most importantly, it outlines what we're going to be doing every year.

On page 24, it actually speaks to our targets; what we want to do this year in order to achieve the success that we have achieved this past year. For instance, we want to continue to improve around mortality. We want to continue to improve around our value based purchasing, which is our pay for performance; when the government says how good we are, we want to be really good. We want to continue in our compliance around providing safe care to our patients. This is, for the first time, an integrated quality plan. This is all of the hospitals working with our different hospitals to assure that we've met our special populations as well. The cancer indicators are also in here and Dr. Goldberg and I worked on that together to meet the needs of all our patients across the medical center. This really is for your approval today if you see it meets that. It is somewhat of a living document; every year we tend to increase our expectations ourselves, but we set the expectations herein.

Mr. Wexner:

Thank you. I really appreciated the moving up in the ranking. I'm sensing that culturally, across the various practices and hospitals, there's been a buy-in on us being one of the safest places and best places on earth.

Dr. Moffatt-Bruce:

I appreciate your support.

Mr. Wexner:

Thank you.

Mr. Steinour:

As a lay person, I want to look at page 24, I don't know how to think about it in terms of upper index, best of breed performance by looking at the improvement. Could you give us some way of thinking about where this might position us?

Dr. Moffatt-Bruce:

It would depend on which ranking system you want us to look at.

These infections, if we were to reduce just these particular infections, it would put us into the top quartile for all of the hospitals that have Medicare patients. It would also continue to allow us to be in the top 10 for UHC. There is some consistency but we set these metrics based on where we feel, considering our past performance and trying to predict what others are going to do this year, where we would get to to be in the top 10 for rankings in UHC and the top quartile for CMS (Centers for Medicare and Medicaid Services), which is what we need to get back the money for our value-based purchasing programs.

Mr. Steinour:

Is there a long-term set of objectives we're trying to get to tap this out, number one, or how do you, how does this track to what we aspire to accomplish?

Dr. Moffatt-Bruce:

Every year, I would say that as people continuously get better across the nation, we are always trying to be in the top percentile around our quality indicators. We'd love to be number one in UHC and we will continue to aspire to that and hopefully track to that. Around the value-based purchasing, which is the CMS Medicare reimbursement, every year the metrics change and it is a little bit difficult to predict exactly where we can get to but we aspire to be in that top 10 percentile.

President Drake:

Two comments. One goes to Steve's questions.

The range of hospitals that are evaluated, it's a very large range, very small hospitals, to huge ones and the patient mix is entirely different. Part of this is predicting the likely outcomes of very different populations of people but that's something to chase. A very good thing about this is as we have begun to compare information unit to unit, region to region, now instead of thinking you're doing a pretty good job, you can now see how everyone is doing. It actually has motivated the entire enterprise to do better and so everyone gets better every year and then the bar becomes higher and that's a wonderful, that's a very good thing broadly.

To Dr. Moffatt-Bruce, let me say that, in some of the places we are interested in getting to the top decile and others we want to get to the median. I am sure you do this but I would be more concerned if we had places that really lagged. I would focus more on the lagers then going from 11th to 10th. I worry more about places where we were lagging with the caveat that it could be that we were lagging in something that wasn't particularly meaningful.

Dr. Moffatt-Bruce:

I think that is an important point and remembering too that we're only going into our third year with the value-based purchasing, where we're actually setting standards to improve going forward in comparison to all others, whether or not it's 5,000 hospitals or its 100 hospitals. This is a fairly new, I would say, science, although we have to use a little bit of art in it as well.

Mr. Wexner:

Thank you.

Dr. Moffatt-Bruce:

I do need a motion for approval if you see it so fits.

CLINICAL QUALITY MANAGEMENT, PATIENT SAFETY AND SERVICE PLAN

Resolution No. 2015-84

Synopsis: Approval of the annual review of the Clinical Quality Management, Patient Safety and Service Plan for The Ohio State University Hospital, Richard M. Ross Heart Hospital, Harding Hospital, and University Hospital East and the Arthur G. James Cancer Hospital, is proposed.

WHEREAS the mission of the Wexner Medical Center is to improve people's lives through the provision of high quality patient care; and

WHEREAS the clinical quality management, patient safety and service plan outlines assessment and improvement of processes in order to deliver safe, effective, optimal patient care and services in an environment of minimal risk for inpatients and outpatients of The Ohio State University Hospital, Richard M. Ross Heart Hospital, Harding Hospital, University Hospital East, and the Arthur G. James Cancer Hospital:

WHEREAS the proposed Clinical Quality Management, Patient Safety and Service Plan was approved by the Quality and Professional Affairs Committee of the Wexner Medical Center Board on November 19, 2014:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board approves the Clinical Quality Management, Patient Safety and Service Plan for The Ohio State University Hospital, Richard M. Ross Heart Hospital, Harding Hospital, University Hospital East, and the Arthur G. James Cancer Hospital.

(See Appendix X for background information, page 245)

Mr. Wexner:

Can I have a motion?

Upon motion of Dr. Reid, seconded by Mrs. Wexner, the Wexner Medical Center Board members adopted the foregoing motion by unanimous roll call vote, cast of board members Mr. Chatas, Dr. Gabbe, Dr. Drake, Mrs. Wexner, Mr. Jurgensen, and Dr. Reid.

Dr. Thompson:

Please note that community members do not vote on accreditation items.

I will note that a quorum is present and the motion carries Mr. Chairman.

Mr. Wexner:

Thank you very much. I think the next order of business is a pleasure for Dr. Caliguri.

Dr. Caligiuri:

Thank you very much. Good morning everyone. Thanks to all of you for joining us. For those of you that do not know, I am Mike Caliguri, the CEO of the James and the Director of the Comprehensive Cancer Center.

It is a pleasure for me to take a moment to recognize all of you today for being here as well as some of our past award winners. We're going to present the James Hope Award today to two very distinguished individuals, Scott Oeslager and Bob Massie.

I'm pleased and honored to be able to present the award to these two individuals who've made enormous impact on our cancer program by extension to our university, our community, and the lives of the patients and families that we serve. Before I introduce you, I want to tell a little bit about the award itself.

The James Hope Award is presented annually to one or two individuals or organizations that have demonstrated exceptional commitment to advancing the highest quality patient care, education, and research in cancer or improving healthcare access for cancer patients in Ohio and beyond. James Hope Award winners are advocates, collaborators, innovators, and certainly leaders.

When I am with a group of people that don't work in health care, I am often asked isn't it depressing to work in a cancer hospital or to be researching such a formidable and life threatening disease. I am always quick to answer "no not at all". As many of my colleagues here know, we devote our lives to studying cancer and caring for those who struggle against it. We tell them about the enormous gains we've made in understanding the causes of cancer, about the amazing new therapies, and the growth in them are people successfully treated and cured of cancer. We tell them about the extraordinary people we meet each day in our work. So rather than depress us, the environment energizes us, rather than bringing out the worst in people, we see the very best in people here and in our colleagues, in our community, and especially in our patients and their families. All of this giving us great hope and inspiration for the future.

In the front lawn of the main entrance of our new James Cancer Hospital and Solove Research Institute is a beautiful life sized bronze statue that depicts a woman reaching into the air to release three shimmering gold birds. It's graceful, it's elegant, and it's named "The Statue of Hope". I want to spend just a minute here with the artist who created this lovely sculpture.

(Video)

"I am a Holocaust Survivor. If we do not have hope, we don't have a future." Alfred Tibor believes in hope. Hope sustained him in the gulag and the message of hope is the essence in the works of art he creates.

In the early 1990s, Dr. Arthur G. James was looking for an artist to create an inspirational work to grace the front of the new cancer hospital that was named for him. He met Alfred Tibor, saw his work, and the project was born. Dr. James saw a particular statue of a woman releasing a bird from her hands. It represented the message he wanted to convey and it inspired the title he wanted the piece to have.

He said, "Why don't you give a title of the piece 'Hope' because we are working for the hope every day." Alfred Tibor went to work, inspired by his life experience and the vision of Dr. Arthur G. James. He

sculpted a woman in bronze. Moving forward, looking ahead, he added three birds to represent freedom. I wanted to express that time, living figure who is walking. Walking off and letting the birds fly because she became healthy, she could give life and let the birds fly. It is expressing freedom and health.

Since 1993, thousands of people have walked by the statue of hope as they enter and leave the James. What each of those people feels and thinks when they see it is known to them alone. For Alfred Tibor, creating the statue was a simple act of giving.

"It's going to give support for those people who are hit by that sickness and I am giving them support to survive."

Dr. Caligiuri:

Today we have our two winners of the award. They are going to receive a beautiful miniature replica of the Hope statue created for them by the original sculpture, Alfred Tibor.

Our first honoree today couldn't be here because he is recovering from surgery but his Chief of Staff, Gina Wilt is here receive the award on his behalf. He is certainly one of Ohio's most respected Senators and a strong voice of the cancer community at our State's capitol. Senator Scott Oeslager has 27 years of legislative experience, representing the residents of Stark County. He currently serves as the chair of the influential Senate Finance committee which develops the State's two-year operating budget and significant issues such as medical education funding and Medicaid. He is also the former chairman and current member of the Senate Medicaid Health and Human Services Committee which oversees healthcare policy in our state.

We are honoring Senator Oeslager today because of a cause he took up a few years ago on our behalf and on behalf of really all cancer patients to ensure that individuals traveling this challenging journey of cancer have access to the most advanced and complex cancer therapies without facing significant personal financial challenges. Chairman Oeslager worked closely with our government affairs team, the administration, and his colleagues to bring about a state law change, that this year through the enactment of Bill 99, to ensure oral chemotherapy agents have parody in insurance coverage with intravenous chemotherapy agents.

I can't overstate the importance of this change because of the way insurance plans were previously covered for these two types of treatments. A patient could be required to pay thousands of dollars monthly for chemotherapy delivered through a pill versus a much smaller copay for intravenous therapies. Some patients chose to discontinue the best treatment simply because they could not afford it while others depleted their savings to acquire the medications. The new law that Senator Oeslager authored will allow physicians and patients to make care determinations based on only the most appropriate treatment rather than on the cost. In addition, Senator Oeslager coauthored legislation Bill 230, also signed into law this year which ends the practice in Ohio of sending cancer medications that cannot be self-administered and must be injected directly to the patients. These delicate therapies are not meant to be in the hands of the patients and must always be in a controlled environment to ensure their efficacy. Ending this practice, which has typically been called, "brown bagging" is a significant step forward in patient safety for our cancer patients.

For these achievements and for demonstrating every day at the Statehouse the attributes we seek in our James Hope Award recipients, those being advocacy, collaboration, innovation, and leadership, I am honored to give the 2014 James Hope Award to Chairman Scott Oeslager.

Ms. Wilt:

Thank you. I am sorry Senator Oeslager could not be here. I am trying to think what he might say.

I think he would first be thinking, I probably can't take this home because of ethics. He's humbled, he's honored. It was definitely a team effort, the oral chemo and the brown bagging bill, they seem like common

sense initiatives to us. Things are not always that easy at the Statehouse; it took us a while to get some things done. Jenny is great to work with and she's feisty when she needs to be and friendly to everyone. It's been great to have her there with Stephanie and Katie. It was a team effort.

He is definitely a collaborator. Thank you. He is honored.

Dr. Caligiuri:

Thank you. Our second James Hope Award is one of central Ohio's most respected business and community leaders, Robert or Bob Massie, retired from Chemical Abstracts Service this past spring where he had served 21 years as President and CEO and director.

Many people in Columbus knew the Northwest side lawn of Chemical Abstracts Service for the Picnic with the Pops concerts for almost three decades. Bob extended the best and the highest use of the lawn by hosting Cancer Survivors' Day for many years and literally launching Pelotonia from that site for the first three years of the grassroots bike ride that has now raised over $82 million for cancer research in its first six years.

Bob's contributions to Columbus and to the James only begin with Chemical Abstracts. His keen intellect and his acumen have been highly valued and sought after by several entities. He most recently served as secretary and director at Tech Columbus, a project he spearheaded in 2005 which united the business technology center, a business incubator on Kinnear Road, the Ohio State Affiliated Science and Technology Campus Corporation, commonly called SciTech, and the Columbus Technology Council and Advocacy group.

Bob has been Chair of the James Cancer Hospital Board and Chair of the University Medical Center Partners, a non-profit corporation to develop commercial enterprises for research coming out of Ohio State's Wexner Medical Center. Among the many things Bob has done for the James and the Comprehensive Cancer Center, he's been instrumental in helping us develop the plan for our new cancer hospital and the operations of our facility. I am proud to say that today, as I mentioned earlier, we moved the first 40 patients from the intensive care unit into the new James.

What is so special about Bob is that he embraces our vision to create something extraordinary at Ohio State, a place that will not only offer the best cancer care in the nation but will be an inspiring environment in which our physicians, our scientists, and our staff will work together each day and will attract the best and brightest people in healthcare, research, and teaching in an environment of collaboration against a common enemy, cancer.

On a personal note, Bob has been a mentor and an inspiration to me, providing his wisdom, experience, and careful council to help me be a better leader for the James and the cancer center and for the university and for this I will be forever grateful to him.

For his extraordinary leadership, collaboration, advocacy, and his guidance and vision in moving the new James forward, I am proud to present the 2014 James Hope Award to Mr. Bob Massie.

Mr. Massie:

Thank you so much Dr. Caliguri, members of the Board. I think this award is going in wrong direction. When I was this tall, my father walked into the living room or wherever the TV was, he was a surgeon, Chief of Surgery at several hospitals, a member of the greatest generation, and officer in World War II. He said, "I don't know what you're doing but you're coming with me." He took me around to make the rounds with him and I basically grew on this stuff, to the point where I began to hallucinate that I could simply look after people. I learned over time, especially through law school that that actually was illegal.

The message I would like to leave with you, if I may, is that I do believe that we need to reflect back on the fact that this extraordinary leadership at the James and the Wexner Medical Center has a track record

of reaching out to the community and allowing people like myself, where appropriate and when possible, to hopefully add some value and maybe be useful. It is this incredible connection between this medical center and the James, of course, and the community that I think is unusual. It certainly was unusual when I was growing up.

My father was a classic surgeon. He was in charge all the time, certainly in the operating room, but all the time. But the sense you get, the sense I've gotten certainly from this institution is that if you can help, if you can collaborate, if you can bring value, you're welcome.

I would like to say, first, thank you for this extraordinary award, it means more to me than you know, if only my father could see it. And second of all, in my 22 years in this town, there is no work that I have been involved in that has meant more to me than the work I have been privileged to share with the leadership of the James. I wish I had brought some award for them and for you. It is great to see all of you again by the way; I've been out of the game a little bit with a health issue myself and I miss it.

Thank you for all you're doing and President Drake, welcome to you sir. I hope you get over to Chemical Abstracts sometime. All the chemistry you need is right over there.

Thank you very much.

Mr. Wexner:

I think we're ready now to move into executive session. Blake?

Dr. Thompson:

I simply need a motion to recess into executive session.

Upon motion of Mr. Wolfe, seconded by Dr. Drake, the Wexner Medical Center Board members adopted the foregoing motion by unanimous roll call vote, cast of board members Mr. Chatas, Dr. Gabbe, Dr. Drake, Mr. Wolfe, Mr. Steinour, Mr. Fischer, Mrs. Wexner, Mr. Jurgensen, Dr. Reid and Mr. Wexner.

Dr. Thompson:

Mr. Chairman, the motion carries to recess into executive session to discuss business sensitive trade secrets.

Mr. Wexner:

Thank you.

Attest:

Leslie H. Wexner	Blake Thompson
Chairman	Secretary

(APPENDIX X)

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

LEADERSHIP COUNCIL

FOR CLINICAL QUALITY, SAFETY AND SERVICE

The Ohio State University Wexner Medical Center

Clinical Quality Management, Patient Safety, & Service Plan

FY 2014 -2015

Clinical Quality Management, Patient Safety, & Service Plan

ATTACHMENTS

Clinical Quality Management, Patient Safety, & Service Plan

Definition

The Clinical Quality Management, Patient Safety and Service Plan is the organization-wide approach to the systematic assessment and improvement of process design and performance aimed at improving in areas of quality of care, patient safety, and patient experience . It integrates all activities defined in the Clinical Quality Management, Patient Safety & Service Plan to deliver safe, effective, optimal patient care and services in an environment of minimal risk.

Program Scope

The Clinical Quality Management, Patient Safety & Service Plan include all inpatient and outpatient facilities in The OSU Wexner Medical Center (OSUWMC) and appropriate entities across the continuum of care.

Program Purpose

The purpose of the Clinical Quality Management, Patient Safety & Service Plan is to show measurable improvements in areas for which there is evidence they will improve health outcomes and value of patient care provided within The OSUWMC. The OSUWMC recognizes the importance of creating and maintaining a safe environment for all patients, visitors, employees, and others within the organization.

Objectives

1) Continuously monitor, evaluate, and improve outcomes and sustain improved performance.

2) Recommend reliable system changes that will improve patient care and safety by assessing, identifying, and reducing risks within the organization and responding accordingly when undesirable patterns or trends in performance are identified, or when events requiring intensive analysis occur.

3) Assure optimal compliance with accreditation standards, state, federal and licensure regulations.

4) Develop, implement, and monitor adherence to evidenced-based practice guidelines and companion documents in accordance with best practice to standardize clinical care and reduce practice variation.

5) Improve patient experience and their perception of treatment, care and services by identifying, evaluating, and improving performance based on their needs, expectations, and satisfaction.

6) Improve value by providing the best quality of care at the minimum cost possible.

7) Provide a mechanism by which the governance, medical staff and health system staff members are educated in quality management principles and processes.

8) Provide appropriate levels of data transparency to both internal and external customers.

9) Assure processes involve an interdisciplinary teamwork approach.

Structure for Quality Oversight

The Leadership Council for Clinical Quality, Safety & Service serves as the single, multidisciplinary quality and safety oversight committee for the OSUWMC. The Leadership Council (Attachment I and II) determines annual goals for the health system.

Roles and responsibilities

Clinical quality management, patient safety & service excellence are the responsibilities of all staff members, volunteers, visitors, patients and their families.

Medical Center Board

The Medical Center Board is accountable to The Ohio State University Board of Trustees and the Quality and Professional Affairs Committee through the President and SVP for Health Sciences and is responsible for overseeing the quality of patient care throughout the Medical Center including the delivery of patient services, quality assessment, improvement mechanisms, and monitoring achievement of quality standards and goals.

The Medical Center Board receives clinical quality management, patient safety and service quality reports as scheduled, and provides resources and support systems for clinical quality management, patient safety and service quality functions, including medical/health care error occurrences and actions taken to improve patient safety and service. Board members receive information regarding the responsibility for quality care delivery or provision, and the Hospital's Clinical Quality Management, Patient Safety and Service Plan. The Medical Center Board ensures all caregivers are competent to provide services.

Chief Executive Officer (CEO)

The CEO for the Medical Center is responsible for providing leadership and oversight for the overall Clinical Quality Management and Patient Safety Plan across the OSUWMC.

OSUCCC – James Physician-in-Chief

The OSUCCC-James Physician-in-Chief reports to the CEO of The James Cancer Hospital and Solove Research Institute and the Director of the Comprehensive Cancer Center. The Physician-in-Chief provides leadership and strategic direction to ensure the delivery of high quality, cost-effective health care consistent with the OSUCCC-James mission. The physician-in-chief has chosen to additionally

delegate these responsibilities to the Oncology Medical Director of Quality, who will report to the Physician-in-Chief.

Chief Quality Officer (CQO)
The CQO reports to the Medical Center CEO and provides oversight and leadership for the OSUWMC in the conceptualization, development, implementation and measurement of OSUWMC approach to quality, patient safety and adverse event reduction.

Chief Medical Officer (CMO)
The CMO for the Medical Center is responsible for ensuring the implementation of the overall Clinical Quality Management and Patient Safety Plan at OSUWMC. The CMO is responsible for implementing the recommendations approved by the various committees under the Leadership Council for Clinical Quality, Safety & Service.

Medical Director
Each business unit Medical Director (University Hospital, Ross Heart Hospital and University Hospital East) are responsible to the Chief Quality and Patient Safety officer for the implementation and oversight of the Clinical Quality Management and Patient Safety Plan **within their business unit**. Each Medical Director is also responsible for reviewing the recommendations from the Clinical Quality Management and Patient Safety Plan.

Associate Medical Directors
The Associate Medical Directors assist the CQO in the oversight, development, and implementation of the Quality & Safety Plan as it relates to the areas of quality, safety, evidence based medicine, clinical resource utilization and service.

Health System Chief Executive Officer (CEO)
The OSUWMC CEO is responsible to the Board for implementation of the Clinical Quality Management and Patient Safety Plan.

Business Unit Associate Executive Directors
The OSU Health System staff, under the direction of the Health System CEO and Hospital Administration, implements the program throughout the organization. Hospital Administration provides authority and supports corrective actions within its realm for clinical quality management and patient safety activities.

Clinical Department Chief and Division Directors:
Each department chairperson and division director is responsible for ensuring the standards of care and service are maintained within their department/division. In addition, department chairpersons/division director may be asked to implement recommendations from the Clinical Quality Management and Patient Safety Plan, or participate in corrective action plans for individual physicians, or the division/department as a whole.

Medical Staff

Medical staff members are responsible for achieving the highest standard of care and services within their scope of practice. As a requirement for membership on the medical staff, members are expected and must participate in the functions and expectations set forth in the Clinical

Quality Management, Patient Safety, & Service Plan. In addition members may be asked to serve on quality management committees and/or quality improvement teams.

A house staff quality forum with representatives from each ACGME accredited program has dedicated one medical resident who will be the quality liaison to the overall Quality Program. This committee will report to the Health System Clinical Quality & Patient Safety committee.

A senior quality council with representation from each medical staff department through a faculty quality liaison will support the overall Quality Program reporting to the Leadership Council for Clinical Quality, Safety & Service.

Nursing Quality

The Chief Nursing Executive (CNE) provides leadership and oversight for the Nursing Quality Plan and the integration of this plan into the overall Clinical Quality Management & Patient Safety Plan. Nursing leadership and staff are active participants in the Leadership Council for Clinical Quality, Safety and Service and all other associated Committees outlined in this plan. Nursing staff are responsible for ensuring the delivery of world class personalized nursing care to patients and families. Nursing-related quality activities are integrated and aligned with the goals and tactics established by the LCCQSS.

Hospital Department Directors

Each department director is responsible for ensuring the standards of care and service are maintained or exceeded within their department. Department directors are responsible for implementing, monitoring, and evaluating activities in their respective areas and assisting medical staff members in developing appropriate mechanisms for data collection and evaluation. In addition, department directors may be asked to implement recommendations from the Clinical Quality Management and Patient Safety Plan or participate in corrective action plans for individual employees or the department as a whole. Department directors provide input regarding committee memberships, and serve as participants on quality management committees and/or quality improvement teams.

Health System Staff

Health System staff members are responsible for ensuring the standards of care and services are maintained or exceeded within their scope of responsibility. The staff is involved through formal and informal processes related to clinical quality improvement, patient safety and service quality efforts, including but not limited to:

- Suggesting improvements and reporting medical/health care errors
- Monitoring activities and processes, such as patient complaints and patient satisfaction participating in focus groups
- Attending staff meetings
- Participating in efforts to improve quality and safety

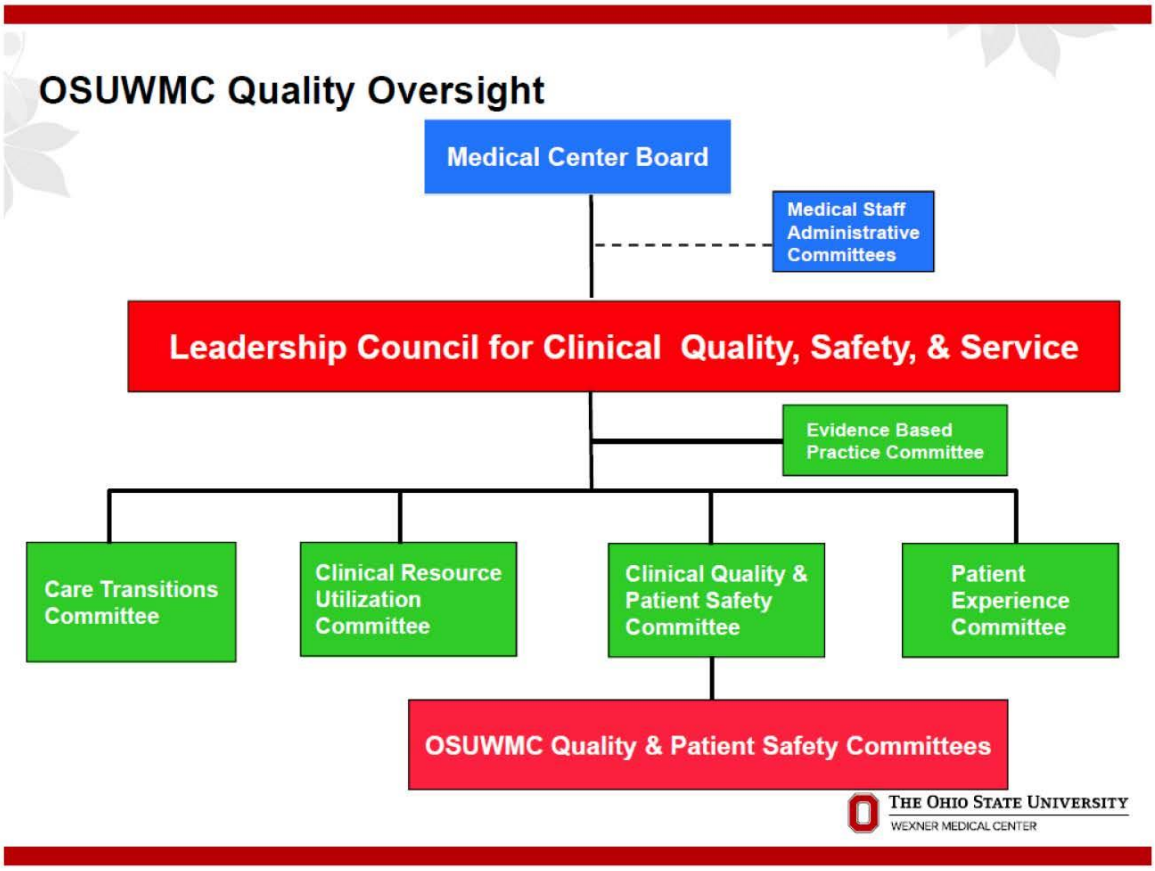
Quality and Operations Improvement Department:

The primary responsibility of the Quality and Operations Improvement (Q&OI) Department is to coordinate and facilitate clinical quality management and patient safety activities throughout the Health

System. The primary responsibility for the implementation and evaluation of clinical quality management and patient safety activities resides in each department/program; however, the Q&OI staff also serves as an internal consultant for the development and evaluation of quality management and patient safety activities. The Q&OI Department maintains human and technical resources for team facilitation, use of performance improvement tools, data collection, statistical analysis, and reporting.

Patient Experience Department

The primary responsibility of the Patient Experience Department is to coordinate and facilitate a service oriented approach to providing healthcare throughout the Health System. This is accomplished through both strategic and program development as well as through managing operational functions within the Health System. The primary responsibility for the implementation and evaluation of service-related activities resides in each department/program; however, the Patient Experience staff also serves as an internal consultant for the development and evaluation of service quality activities. The Patient Experience Department maintains human and technical resources for interpreter services, information desks, patient relations, team facilitation, and use of performance improvement tools, data collection, statistical analysis, and reporting. The Department also oversees the Patient/Family Advisor Program which is a group of current/former patients, or their primary caregivers, who have had experiences at any OSU Health System facility. These individuals are volunteers who serve on committees and workgroups, as Advisory Council members, complete public speaking engagements and review materials.



COMMITTEES:

Medical Staff Administrative Committees (MSACs) (James and UH)

Composition: Refer to Medical Staff Bylaws and Rules and Regulations
Function: Refer to Medical Staff Bylaws and Rules and Regulations

The organized medical staff, under the direction of the Medical Directors, Chief Medical Officer and Physician-in-Chief and the MSAC(s) for each institution, helps to implement the Clinical Quality Management and Patient Safety Plan throughout the clinical departments.

This committee has overall responsibility for evaluating the quality and appropriateness of clinical performance and service quality of all individuals with clinical privileges, after the credentials committee and the OPPE processes have evaluated every practitioner. The MSAC(s) reviews corrective actions and provides authority within their realm of responsibility related to clinical quality management and service.

Leadership Council for Clinical Quality, Safety and Service (LCCQSS):

Composition: Refer to Medical Staff Bylaws and Rules and Regulations
Function: Refer to Medical Staff Bylaws and Rules and Regulations

The LCCQSS is responsible for designing and implementing systems and initiatives to enhance clinical care, outcomes and the patient experience throughout the integrated health care delivery system. The LCCQSS serves as the oversight council for the Clinical Quality Management and Patient Safety Plan as well as the goals and tactics set forth by the Patient Experience Council.

Evidence-Based Practice Committee (EBPC)

Composition:

The EBPC consists of multidisciplinary representatives from Hospital Administration, Medical Staff, Information Technology, Pharmacy, and Nursing. An active member of the medical staff chairs the committee. The EBPC reports to LCCQSS and shares pertinent information with the Medical Staff Administrative Committees. The EBPC provides guidance and support to all committees under the LCCQSS for the delivery of high quality, safe efficient, effective patient centered care.

Function:

1. Develop and update evidence-based guidelines and best practices to support the delivery of patient care that promotes high quality, safe, efficient, effective patient centered care.

2. Develop and implement Health System-specific resources and tools to support evidence-based guideline recommendations and best practices to improve patient care processes, reduce variation in practice, and support health care education.

3. Develop processes to measure and evaluate use of guidelines and outcomes of care.

Clinical Quality and Patient Safety Committee (CQPSC)

Composition:

The CQPSC consists of multidisciplinary representatives from Hospital Administration, Medical Staff, Information Technology, Nursing, Pharmacy, Laboratory, Respiratory Therapy, Diagnostic Testing and Risk Management. An active member of the Medical Staff chairs the Committee. The committee reports to Leadership Council and additional committees as deemed applicable.

Function:

1. Create a safe environment, which promotes organizational learning related to patient safety and minimizes individual blame or retribution for involvement in a medical/health care error
2. Assure optimal compliance with patient safety-related accreditation standards.
3. Proactively identifies risks to patient safety and initiates actions to reduce risk with a focus on process and system improvement.
4. Oversees completion of proactive risk assessment as required by TJC.
5. Oversees education & risk reduction strategies as they relate to Sentinel Event Alerts from TJC.
6. Provides oversight for clinical quality management committees.
7. Evaluates and, when indicated, provides recommendations to improve clinical care and outcomes.
8. Ensures actions are taken to improve performance whenever an undesirable pattern or trend is identified.
9. Receive reports from committees that have a potential impact on the quality & safety in delivering patient care such as, but not limited to, Environment of Care committee, Health Safety Committee, Clinical IHIS Steering Committee, Value Based Clinical Transformation Committee, and Infection Prevention Committee

Patient Experience Council

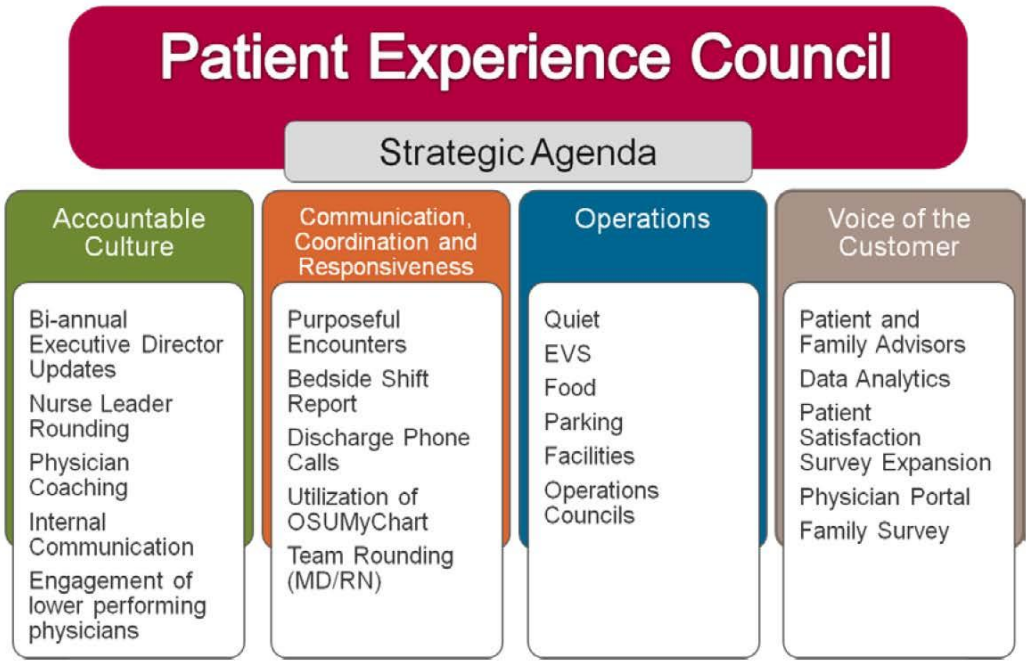
Composition:

The Patient Experience Council consists of multidisciplinary representatives from across all settings. The Council is co-chaired by the Chief Nurse Executive for the Health System and a physician leader. The committee reports to the Leadership Council and reports out to additional committees as applicable. One of the goals of the Patient Experience Council is to ensure the organization maintains a patient- and family-centered approach.

Function:

1. Create a culture and environment that delivers an exceptional patient experience consistent with the OSU Medical Center's mission, vision and values focusing largely on service quality.
2. Measure and review voice of the customer information in the form of Patient and Family Experience Advisor program and related councils, patient satisfaction, comments, letters and related measures.
3. Monitor publicly reported and other metrics used by various payers to ensure optimal reimbursement.

4. Recommends system goals and expectations for a consistent patient experience.
5. Collaborates with other departments to reward and recognize faculty and staff for service excellence performance.
6. Provides guidance and oversight on patient experience improvement efforts ensuring effective deployment and accountability throughout the system.
7. Serves as a communication hub reporting out objectives and performance to the system.
8. Serves as a coordinating body for subcommittees working on specific aspects of the patient experience.



Care Transitions Committee (CTC)

Composition:

The CTC committee consists of multidisciplinary representatives from Hospital Administration, Medical Staff, Case Management, Financial Services, Information Technology, and Nursing. The assistant chief operating officer for the Health System chairs the committee. CTC reports to LCCQSS, Health System Committee, and shares pertinent information with the Medical Staff Administrative Committees.

Function:

1. Promote the efficient and effective patient care transitions processes while assuring the highest quality of care.
2. Serves to facilitate optimal capacity management related to patient care settings across the care continuum
3. Direct the development of action plans to address identified areas of improvement.
4. Resolve or escalate barriers related to effective and efficient care transition processes in the health care delivery system, which impede efficient and effective care transition processes.

Key areas of focus:

- Capacity Management/Transitions
- Readmission management
- Targeted early discharge processes
- LOS management
- Transfer Center Processes

Clinical Resource Utilization Committee (CRU)

Composition:

The CRU committee consists of multidisciplinary representatives from Hospital Administration, Medical Staff, Patient Care Resource Management, Financial Services, Information Technology, and Nursing. The Utilization Management Medical Director chairs the committee. CRU reports to LCCQSS, Health System Committee, and shares pertinent information with the Medical Staff Administrative Committees.

Function:

1. Promote the efficient utilization of resources for patients while assuring the highest quality of care.
2. Direct the development of action plans to address identified areas of improvement.
3. Resolve or escalate barriers related to clinical practice patterns in the health care delivery system, which impede the efficient, appropriate utilization of resources.
4. Review patients for appropriate level of care (e.g., inpatient, observation, outpatient, extended care facility, etc.) and for the efficiency and effectiveness of professional services rendered (physician, nursing, lab, therapists)
5. Ensure compliance with regulatory requirements related to utilization management (ie: RAC Audits, denial management, etc).

6. Administration of the Utilization Management Plan

Key areas of focus:

- Availability and appropriateness of clinical resources and services
  - OP/IP beds appropriateness
  - Post-acute partnerships
  - Availability of necessary services
  - Timeliness of necessary services
  - Appropriate use of necessary services
- LOS management
- Medical necessity and appropriateness of level of care and related denial management.
- Readmission management

Technology Assessment Committee (TAC)

Composition:

The TAC is composed of multi-disciplinary representatives from the medical staff, hospital administration, Biomedical Clinical Engineering and Strategic Sourcing. TAC is chaired by the Director of Peri-operative Services and reports to the Clinical Resource Utilization Committee.

Function:

Evaluate and make decisions regarding the appropriate use and acquisition of new and existing technologies across The Ohio State University Health System.

Key areas of focus:

- Clinical benefits
- Financial impact
- Alignment with strategic plan

Practitioner Evaluation Committee (PEC)

Composition:

The Practitioner Evaluation Committee (PEC) is the PEER review committee that provides medical leadership in overseeing the PEER review process. The PEC is composed of the Chief Quality and Patient Safety Officer, physicians, and advanced practice licensed health care providers from various business units & clinical areas as appointed by the CMO & Physician-in-Chief. The Medical Center CMO & Physician-in-Chief at the James serve Ex- Officio.

Function:

1. Provide leadership for the clinical quality improvement processes within The OSU Health System.
2. Provide clinical expertise to the practitioner peer review process within The OSU Health System by thorough and timely review of clinical care and/or patient safety issues referred to the Practitioner Evaluation Committee.
3. Advise the CMO & Director of Medical Affairs at the James regarding action plans to improve the quality and safety of clinical care at the Health system.
4. Develop follow up plans to ensure action is successful in improving quality and safety.

Health System Information Systems Steering Team (HSISST)

Composition:
The HSISST is a multi-disciplinary group chaired by the Chief Medical Information Officer of The Ohio Sate University Health System.

Function:
The HSISST shall oversee Information Technology technologies on behalf of The Ohio State University Health System. The committee will be responsible for overseeing technologies and related processes currently in place, as well as reviewing and overseeing the replacement and/or introduction of new systems as well as related policies and procedures. The individual members of the committee are also charged with the responsibility to communicate and receive input from their various communities of interest on relevant topics discussed at committee meetings.

Sentinel Event Team

Composition:
The OSU Health System Sentinel Event Team (SET) includes an Administrator, the Chief Quality Officer, the Associate Executive Director for Quality & Patient Safety, a member of the Physician Executive Council, representatives from Quality and Operations Improvement and Risk Management and other areas as necessary.

The Sentinel Event Determination Group (SEDG)
The SEDG is a sub-group of the Sentinel Event Team and determines whether an event will be considered a sentinel event or near miss, assigns the Root Cause Analysis (RCA) Executive Sponsor, RCA Workgroup Leader, RCA Workgroup Facilitator, and recommends the Workgroup membership to the Executive Sponsor. The Sentinel Event Team facilitator will attend to support the members.
The SEDG membership includes the CMO or designee, Director of Risk Management, and Quality Director of respective business unit for where the event occurred (or their designee).

Sentinel Event Team Function:

1. Approves & makes recommendations on sentinel event determinations and teams, and action plans as received from the Sentinel Event Determination Group
2. Evaluates findings, recommendations, and approves action plans of all root cause analyses.

The documentation created as a result of a sentinel event or near miss is not externally reported or released.

Clinical Quality & Patient Safety Sub-Committees

Composition:
For the purposes of this plan, Quality & Patient Safety Sub-Committees will refer to any standing committee or sub-committee functioning under the Quality Oversight Structure. Membership on these committees will represent the major clinical and support services throughout the hospitals and/or clinical departments. These committees report, as needed, to the appropriate oversight committee(s) defined in this Plan.

Function:
Serve as the central resource and interdisciplinary work group for the continuous process of monitoring and evaluating the quality and services provided throughout a hospital, clinical department, and/or a group of similar clinical departments.

Process Improvement Teams

Composition:

For the purposes of this plan, Process Improvement Teams are any ad-hoc committee, workgroup, team, taskforce etc. that function under the Quality Oversight Structure and are generally time-limited in nature. Process Improvement Teams are comprised of owners or participants in the process under study. The process may be clinical (e.g. prophylactic antibiotic administration or not clinical (e.g. appointment availability). Generally, the members fill the following roles: team leader, facilitator, physician advisor, administrative sponsor, and technical expert.

Function:

Improve current processes using traditional QI tools and by focusing on customer needs.

Approach to Quality, Safety & Service Management

The OSU Health System approach to clinical quality management, patient safety, and service is leadership-driven and involves significant staff and physician participation. Clinical quality management and patient safety activities within the Health System are multi-disciplinary and based on the Health System's mission, vision, values, and strategic plan. It embodies a culture of continuously measuring, assessing, and initiating changes including education in order to improve outcomes. The Health System employs the following principles of continuous quality improvement in its approach to quality management and patient safety:

Principles

The principles of providing high quality, safe care support the Institute of Medicines Six Aims of Care:

Safe
Timely
Effective
Efficient
Equitable
Patient-centered

These principles are:

Customer Focus: Knowledge and understanding of internal and external customer needs and expectations.

Leadership & Governance: Dedication to continuous improvement instilled by leadership and the Board.

Education: Ongoing development and implementation of a curriculum for quality, safety & service for of all staff, employees, clinicians, patients, and students.

Everyone is involved: All members have mutual respect for the dignity, knowledge, and potential contributions of others. Everyone is engaged in improving the processes in which they work.

Data Driven: Decisions are based on knowledge derived from data. Both data as numerator only as well as ratios will be used to gauge performance

Process Improvement: Analysis of processes for redesign and variance reduction using a scientific approach.

Continuous: Measurement and improvement are ongoing.

Just Culture: A culture that is open, honest, transparent, collegial, team-oriented, accountable and non-punitive when system failures occur.

Personalized Health Care: Incorporate evidence based medicine in patient centric care that considers the patient's health status, genetics, cultural traditions, personal preferences, values family situations and lifestyles.

Model

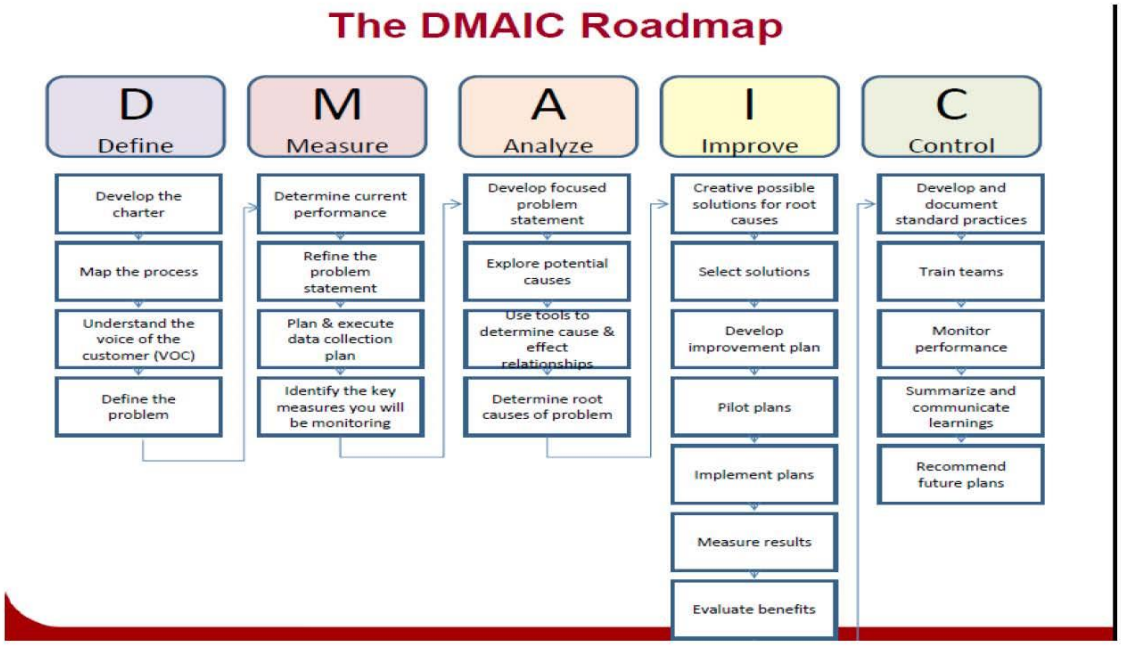
Systematic Approach/Model to Process Improvement

The OSU Medical Center embraces change and innovation as one of its core values. Organizational focus on process improvement and innovation is embedded within the culture through the use of a general Process Improvement Model that includes 1) an organizational expectation that the entire workforce is responsible for enhancing organizational performance, 2) active involvement of multidisciplinary teams and committees focused on improving processes and 3) a toolkit* of process improvement methodologies and expert resources that provide the appropriate level of structure and support to assure the deliverables of the project are met with longer term sustainability.

***The Process Improvement Toolkit**

Methodology
PDCA
Rapid Cycle Improvement
DMAIC
Lean Principles

Recognizing the need for a systematic approach for process improvement, the health system has traditionally utilized the PDCA methodology. While PDCA has the advantage of being easily understood and applied as a systematic approach, it also has the limitation of not including a "control step" to help assure longer term sustainability of the process improvement. To address this need for additional structure at the end of the project, the DMAIC model was added to the toolkit. With the increased organizational emphasis on utilizing metric-driven approaches to reducing unintended medical errors, eliminating rework, and enhancing the efficiency/effectiveness of our work processes, the DMAIC methodology will be instrumental as a tool to help focus our process improvement efforts.



Consistent Level of Care

Certain elements of The OSU Health System Clinical Quality Management, Patient Safety, & Service Plan assure that patient care standards for the same or similar services are comparable in all areas throughout the health system:

- Policies and procedures and services provided are not payer driven.
- Application of a single standard for physician credentialing.
- Health system monitoring tools to measure like processes in areas of the Health System.
- Standardize and unify health system policies and procedures that promote high quality, safe care.

Performance Transparency

The Health System Medical and Administrative leadership, working with the Board has a strong commitment to transparency of performance as it relates to clinical, safety and service performance. Clinical outcome, service and safety data are shared on the external OSUMC website for community viewing. The purpose of sharing this information is to be open and honest about OSUMC performance and to provide patients and families with information they can use to help make informed decisions about care and services.

Performance data are also shared internally with faculty and staff through a variety of methods. The purpose of providing data internally is to assist faculty and staff in having real-time performance results and to use those results to drive change and improve performance when applicable. On-line

performance scorecards have been developed to cover a variety of clinical quality, safety and service metrics. When applicable, on-line scorecards provide the ability to "drilldown" on the data by signature program, discharge service, department and nursing unit. In some cases, password authentication also allows for practitioner-specific data to be viewed by Department Chairs and various Quality and Administrative staff. Transparency of information will be provided within the limits of the Ohio law that protects attorney –client privilege, quality inquiries and reviews, as well as peer review.

Confidentiality

Confidentiality is essential to the quality management and patient safety process. All records and proceedings are confidential and are to be marked as such. Written reports, data, and meeting minutes are to be maintained in secure files. Access to these records is limited to appropriate administrative personnel and others as deemed appropriate by legal counsel. As a condition of staff privilege and peer review, it is agreed that no record, document, or proceeding of this program is to be presented in any hearing, claim for damages, or any legal cause of action. This information is to be treated for all legal purposes as privileged information. This is in keeping with the Ohio Revised Code 121.22 (G)-(5) and Ohio Revised Code 2305.251.

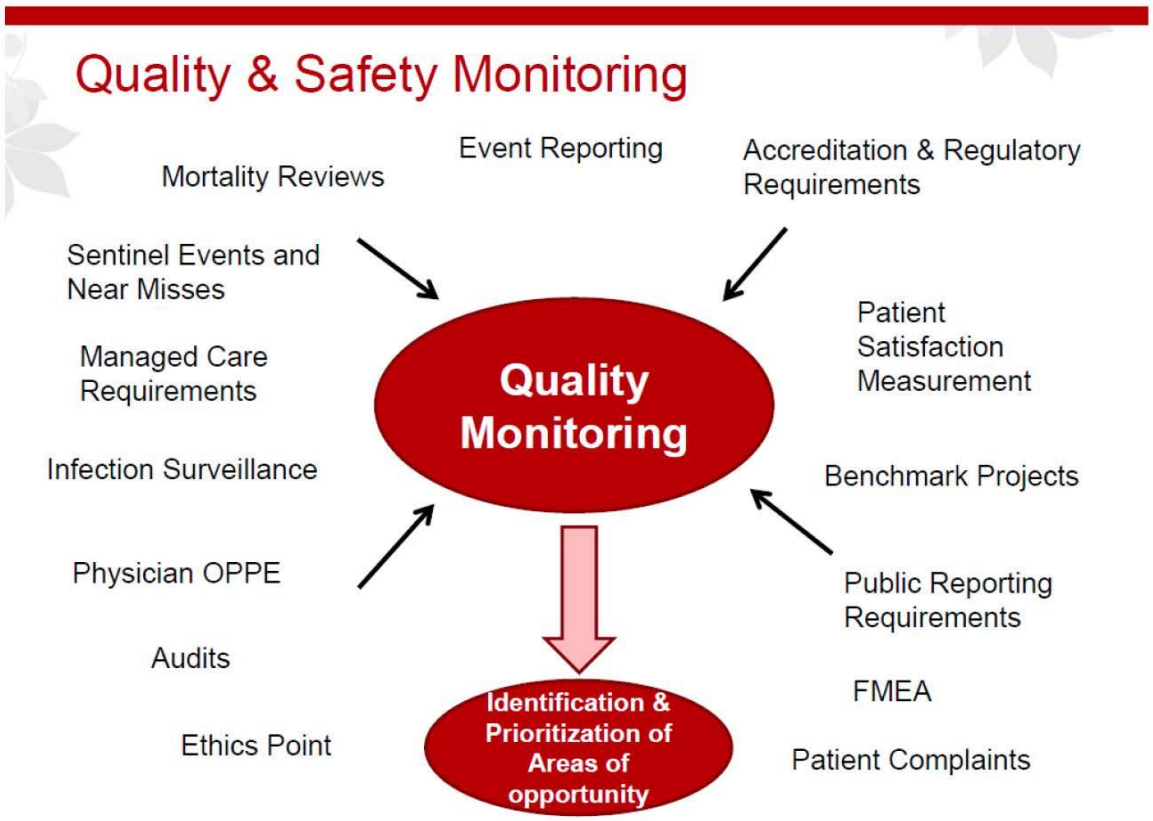
Conflict of Interest

Any person, who is professionally involved in the care of a patient being reviewed, should not participate in peer review deliberations and voting. A person is professionally involved if they are responsible for patient care decision making either as a primary or consulting professional and/or have a financial interest (as determined by legal counsel) in the case under review. Persons who are professionally involved in the care under review are to refrain from participation except as requested by the appropriate administrative or medical leader. During peer review evaluations, deliberations, or voting, the chairperson will take steps to avoid the presence of any person, including committee members, professionally involved in the care under review. The chairperson of a committee should resolve all questions concerning whether a person is professionally involved. In cases where a committee member is professionally involved, the respective chairperson may appoint a replacement member to the committee. Participants and committee members are encouraged to recognize and disclose, as appropriate, a personal interest or relationship they may have concerning any action under peer review.

Determining Priorities

The OSU Health System has a process in place to identify and direct resources toward quality management, patient safety, and service activities. The Health System's criteria are approved and reviewed by the Leadership Council and the Medical Center Board. The prioritization criteria are reevaluated annually according to the mission and strategic plan of the Health System. The leaders set performance improvement priorities and reevaluate annually in response to unusual or urgent events.

Data Measurement and Assessment



Determination of data needs

Health system data needs are determined according to improvement priorities and surveillance needs. The Health System collects data for monitoring important processes and outcomes related to patient care and the Health System's functions. In addition, each department is responsible to identify quality indicators specific to their area of service. The quality management committee of each area is responsible for monitoring and assessment of the data collected.

External reporting requirements

There are a number of external reporting requirements related to quality, safety, and service. These include regulatory, governmental, payer, and specialty certification organizations. Attachment V displays some examples of external organizations where quality, safety, and service data are reported.

Collection of data
Data, including patient demographic and diagnosis, are systematically collected throughout the Health System through various mechanisms including:

- Administrative and clinical databases
- Retrospective and concurrent medical record review
- Reporting systems (e.g., patient satisfaction)
- Surveys (i.e. patients, families, and staff).

Assessment of data
Statistical methods such as control charts, g-charts, confidence intervals, and trend analysis are used to identify undesirable variance, trends, and opportunities for improvement. The data is compared to the Health System's previous performance, external benchmarks, and accepted standards of care are used to establish goals and targets. Annual goals are established as a means to evaluate performance.

Surveillance system
The Health System systematically collects and assesses data in different areas to monitor and evaluate the quality and safety of services, including measures related to accreditation and other requirements. Data collection also functions as a surveillance system for timely identification of undesired variations or trends in quality indicators.

Quality & Safety Scorecard
The Quality and Safety Scorecard is a set of health system-wide indicators related to those events considered potentially preventable. The Quality & Safety Scorecard covers the areas such as never events, sentinel events, hospital-acquired conditions, falls, medication events, and several other categories. The information is shared in various Quality forums with staff, clinicians, administration, and the Boards. The indicators to be included in the scorecard are reviewed each year to represent the priorities of the quality and patient safety program (Attachment VI).

Patient Satisfaction Dashboard
The Patient Satisfaction dashboard is a set of health system-wide patient experience indicators gathered from surveys after discharge or visit to a system based clinic or hospital. The dashboard covers performance in areas such as physician communication, nursing responsiveness, pain management, admitting and discharging speed and quality. It also measures process indicators, such as discharge phone calls and nurse leader rounding, as well as serves as a resource for best practices. The information is shared forums with staff, clinicians, administration, including the Boards. Performances on many of these indicators serve as annual goals for leaders and members of clinical and patient facing teams.

Quality, Patient Safety, and Service Educational Information

Education is identified as a key principle for providing safe, high quality care, and excellent service for our patients. There is on-going development and implementation of a curriculum for quality, safety & service of all staff, employees, clinicians, patients, and students (Attachment IV). There are a variety of forums and venues utilized to enhance the education surrounding quality and patient safety including, but not limited to:

- On line videos
- Quality & Patient Safety Simulcasts
- News Letters
- Classroom forums
- Simulation Training
- Computerized Based Learning Modules
- Partnerships with IHI Open School
- Curriculum Development within College of Medicine
- Websites (internal OneSource and external OSUMC)

Benchmark data

Both internal and external benchmarking provides value to evaluating performance (Attachment V).

Internal Benchmarking

Internal benchmarking uses processes and data to compare OSUMCs performance to itself overtime. Internal benchmarking provides a gauge of improvement strategies within the organization.

External Benchmarking

The OSU Health System participates in various database systems, clinical registries and focused benchmarking projects to compare performance with that of peer institutions. The University HealthSystem Consortium, The US News Report, and The Society of Thoracic Surgery are examples of several external organizations that provide benchmarking opportunities.

Design and evaluation of new processes

- New processes are designed and evaluated according to the Health System's mission, vision, values, priorities, and are consistent with sound business practices.
- The design or re-design of a process may be initiated by:
- Surveillance data indicating undesirable variance
- Patients, staff, or payers perceive the need to change a process

- Information from within the organization and from other organizations about potential risks to patient safety, including the occurrence of sentinel events
- Review and assessment of data and/or review of available literature confirm the need

Performance Based Physician Quality & Credentialing

Performance-based credentialing ensures processes that assist to promote the delivery of quality and safe care by physicians and advanced practice licensed health care providers. Both Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) occur. Focused Professional Practice Evaluation (FPPE) is utilized on 3 occasions: initial appointment, when a Privileged Practitioner requests a new privilege, and for cause when questions arise regarding the practitioner's ability to provide safe, high quality patient care. Ongoing Professional Practice Evaluation (OPPE) is performed on an ongoing basis (every 6 months).

Profiling Process:

- Data gathering from multiple sources
- Report generation and indicator analysis
- Profile review meetings with department chairs
- Discussion at Credentialing Committee
- Final Recommendation & Approval:
    - Medical Staff Administrative Committees
    - Medical Director
    - Hospital Board

Service-Specific Indicators

Several of the indicators are used to profile each physician's performance. The results are included in a physician profile (Attachment III), which is reviewed with the department chair as part of credentialing process.

The definition of service/department specific indicators is the responsibility of the director/chair of each unit. The performance in these indicators is used as evidence of competence to grant privileges in the re-appointment process. The clinical departments/divisions are required to collect the performance information as necessary related to these indicators and report that information to the Department of Quality & Operations Improvement.

Purpose of Medical Staff Evaluation

- To appoint quality medical staff
- To monitor and evaluate medical staff performance

- To integrate medical staff performance data into the reappointment process and create the foundation for high quality care
- To provide periodic feedback and inform clinical department chairs of the comparative performance of individual medical staff
- To identify opportunities for improving quality of care

Annual Evaluation

The Clinical Quality Management, Patient Safety & Service Plan is approved by the Leadership Council, the Medical Staff Administrative Committees, and the Medical Center Board on an annual basis. The annual evaluation includes a review of the program activities and an evaluation of the effectiveness of the structure.

Attachment I: LCCQSS Priorities 2014-2015

Key Result Area: Quality

- Achieve all Infection Control Targets
  - Reduce Colon SSIs by 20%
  - Reduce Abdominal Hysterectomy SSIs by 30%
  - Reduce C-Section SSIs by 20%
  - Reduce CABG SSIs by 50%
  - Reduce Hip Replacement SSIs by 25%
  - Reduce Knee Replacement SSIs by 25%
  - Reduce Spinal Fusion SSIs by 10%
  - Reduce Ventilator Associated Events by 10%
  - Reduce CLABSIs by 10%
  - Reduce CAUTIs by 25%
  - Reduce C Diff by 10%
- Improve UHC risk adjusted mortality index to 0.61
- Achieve positive financial variance for all CMS quality based payment programs (i.e. Value Based Purchasing and Hospital Acquired Conditions)
- Hand Hygiene Compliance $\geq$ 95%

Key Result Area: Productivity and Efficiency

- Achieve the UHC Top Quartile for 30 day readmission rates in Heart Failure and Knee/Hip Replacements
- Achieve the UHC Median for 30 day readmission rates in AMI, Pneumonia, and COPD
- 10% reduction in overall readmission rate
- Improve UHC risk adjusted LOS index to 0.95

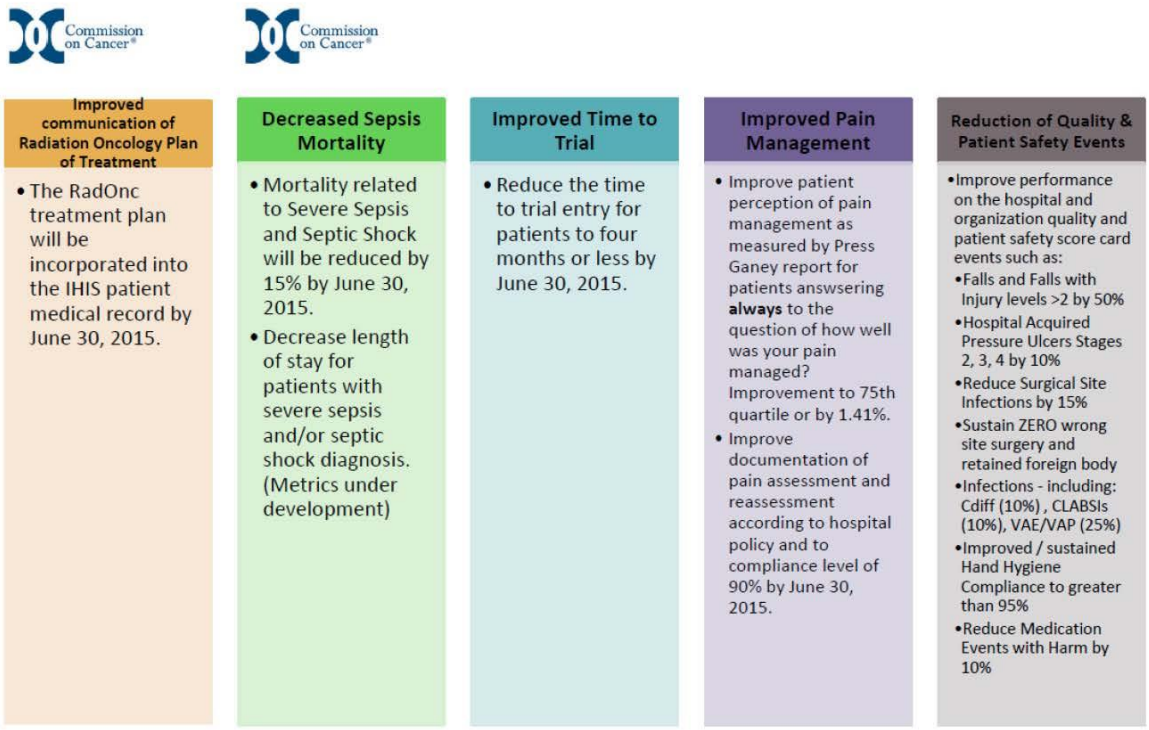
Key Result Area: Service and Reputation

- Achieve and sustain top decile status by FY2016 for patient satisfaction HCAHPS Score 79%

Key Result Area: Work Place of Choice

- Achieve 25% reduction in Employee Injuries

James Clinical Quality & Patient Safety Priorities 2014-2015

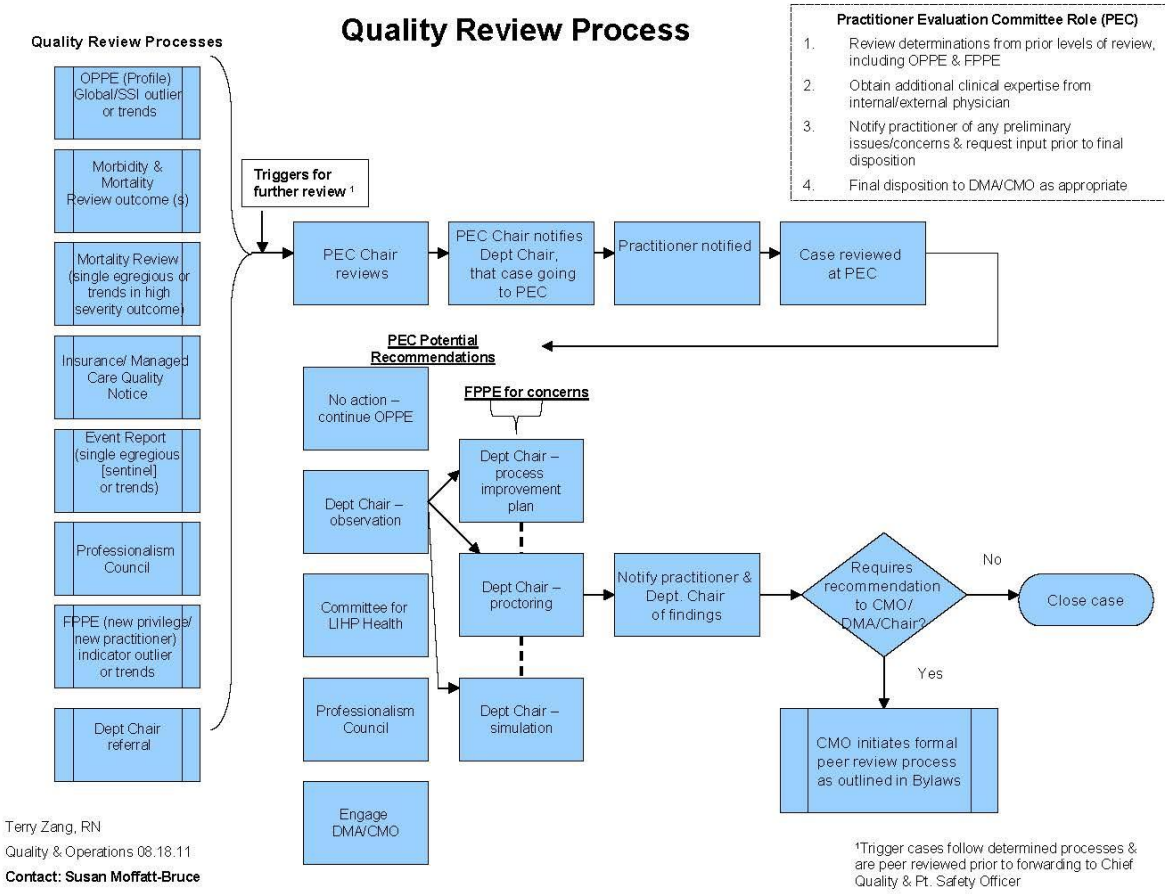


Attachment II: Priority Criteria

The following criteria are used to prioritize clinical value enhancement initiatives to ensure the appropriate allocation of resources.

1. Ties to strategic initiatives and is consistent with hospital's mission, vision, and values
2. Reflects areas for improvement in patient safety, appropriateness, quality, and/or medical necessity of patient care (e.g., high risk, serious events, problem-prone)
3. Has considerable impact on our community's health status (e.g., morbidity/mortality rate)
4. Addresses patient experience issues (e.g., access, communication, discharge)
5. Reflects divergence from benchmarks
6. Addresses variation in practice
7. Is a requirement of an external organization
8. Represents significant cost/economic implications (e.g., high volume)

Attachment III: Physician Performance Based Profile



Profile for <name>
SERVICE: INTERNAL MEDICINE-CARDIOVASCULAR MEDICINE
Profile last viewed by Provider: Never

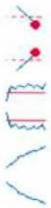
Status	Indicator	My Score	Peers Score	Target	SPC Alert	Current Period	6 Month Values: My Score	6 Month Values: Peer Score	6 Month Values: Start Month
A - Volume and Acuity									
	CMI	n/a	2.03	n/a		Q2 2013	No Data	1.97	Feb 2013
	IP Discharges	n/a	14.6	n/a		Q2 2013	No Data	14.0	Feb 2013
★ ▼	IP LOS Index (Obs_Exp Total Days)	0.83	1.06	1.00		Q1 2013	No Data	1.08	Feb 2013
▼	IP Procedures	4	42.7	n/a		Q2 2013	4	34.5	Mar 2013
▼	Observation Cases	0	1.85	n/a		Q2 2013	0	2.63	Feb 2013
▲	Outpatient Visits	189	107	n/a		Q2 2013	398	102	Feb 2013
B - Patient Care									
★ —	Autopsy Discrepancy	0	0.00	0		Q2 2013	0	1.00	Feb 2013
	Cath PCI Peri-procedure AMI	No Data	1.1%	n/a		Q2 2013	No Data	1.2%	Mar 2013
	Cath PCI Retro-perifoneal Bleed	No Data	0.3%	n/a		Q2 2013	No Data	0.2%	Mar 2013
	CM - AMI_2 Aspirin Prescribed at Discharge	n/a	91.2%	100.0%		Q4 2012	No Data	No Data	No Data
	CM - AMI_3 ACEI or ARB for LVSD	n/a	24.6%	100.0%		Q4 2012	No Data	No Data	No Data
	CM - AMI_5 Beta Blocker at Discharge	n/a	87.7%	100.0%		Q4 2012	No Data	No Data	No Data
	CM - AMI_9 Inpatient Mortality	n/a	0.0%	0.0%		Q4 2012	No Data	No Data	No Data
	CM - HF_2 Evaluation of LVS Function	n/a	95.7%	100.0%		Q4 2012	No Data	No Data	No Data
	CM - HF_3 ACEI or ARB for LVSD	n/a	46.8%	100.0%		Q4 2012	No Data	No Data	No Data
	ICD Registry CVA	No Data	0.0%	n/a		Q1 2013	No Data	0.0%	Mar 2013
★ ▼	IP Mort Index (Obs_Exp)	0.00	0.50	0.79		Q1 2013	No Data	0.47	Feb 2013
—	Mortalities Reviewed	1	0.44	n/a		Q2 2013	1	1.57	Mar 2013
★ —	Mortalities Sent for Peer Review	0	0.14	0		Q2 2013	0	1.07	Feb 2013
★ —	Mortality Peer Review #1 Score 4 or 5	0	0.00	0		Q2 2013	0	No Data	No Data
★ —	Quality Management Events - Standard of Care Not Met	0	0.04	0		Q2 2013	0	1.14	Mar 2013
—	Related ReAdmit 30 days	0.00%	3.34%	n/a		Q1 2013	No Data	3.19%	Feb 2013
	SSI CABG Procedures	No Data	0.0%	3.0%		Q2 2013	No Data	0.0%	May 2013
	SSI Pacemaker and AICD	No Data	0.0%	n/a		Q2 2013	No Data	0.0%	Apr 2013
C - Medical and Clinical Knowledge									
★ —	Formal Peer Reviews	0	0.00	0		Q2 2013	0	0.00	Feb 2013
E - Interpersonal and Communication									
★ —	Patient Complaints	0	0.02	0		Q2 2013	0	1.00	Mar 2013

Status	Indicator	My Score	Peers Score	Target	SPC Alert	Current Period	6 Month Values		
							My Score	Peer Score	Start Month
▼	Patient Satisfaction Ave Score	98.6%	91.9%	n/a		Q2 2013	99.3%	91.5%	Feb 2013
G - Practice Based Learning and Improvement									
★ —	Surgical Team Safety Checklist Variances	0	0.00	0		Q2 2013	0	0.00	Feb 2013

Profile Generated 09/04/2013 13:53:57
Next Review Due: Aug 13, 2013

	Reviewed By	Outcome	Notes
Jan 29, 2013	<name>	Maintain privileges without modification	The Provider's performance meets expectations.

SPC Alert Legend



Most recent period is below Lower Control Limit

Most recent period is above Upper Control Limit

Process shift: Most recent 8 periods are all above the Center Line

Process shift: Most recent 8 periods are all below the Center Line

Most recent 6 periods are all increasing

Most recent 6 periods are all decreasing

Green border: The alert is in a positive direction
Red border: The alert is in a negative direction
No border: There is no target direction for the indicator

Attachment IV: Patient Safety Program

Vision

To be the safest health system in the world.

Goals

- Improve patient safety with full integration of key safety initiatives as evidenced by the Quality and Patient Safety Scorecard.
- Improve the culture of patient safety as evidenced by culture of safety survey results

Our Culture of Patient Safety

- "Just Culture"
- Balance system/process issues with accountability for expected behaviors
- Responsible, Accountable and Fair
- Ownership and integrity
- Create a work environment that is open, honest and transparent

Patient Safety Program Components

The patient safety program is a comprehensive plan comprised of initiatives in the following domains:

- Culture of safety
- Performance monitoring and improvement
- Regulatory and accreditation
- Event reporting
- Sentinel events
- Education
- Innovation
- Recognition

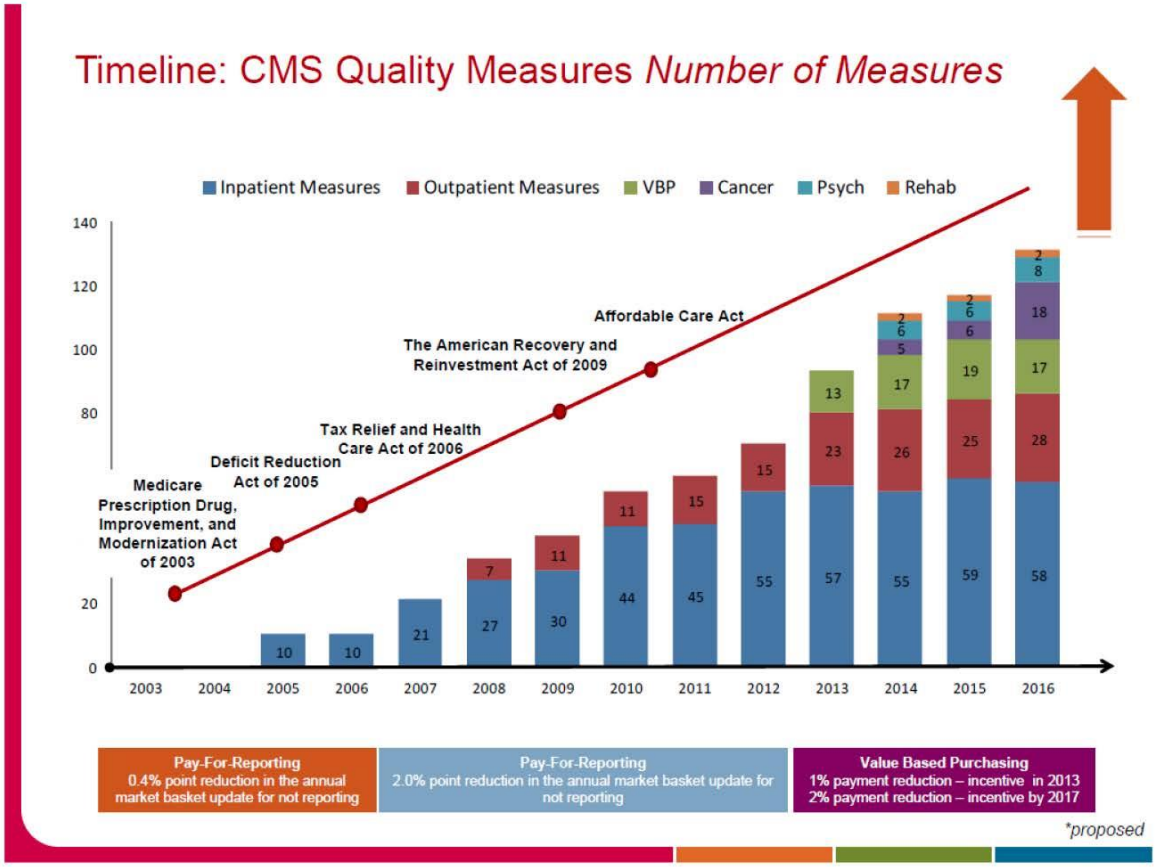
A Patient of Safety Culture Survey will be administered at a frequency determined by CQO and other Senior Leaders.

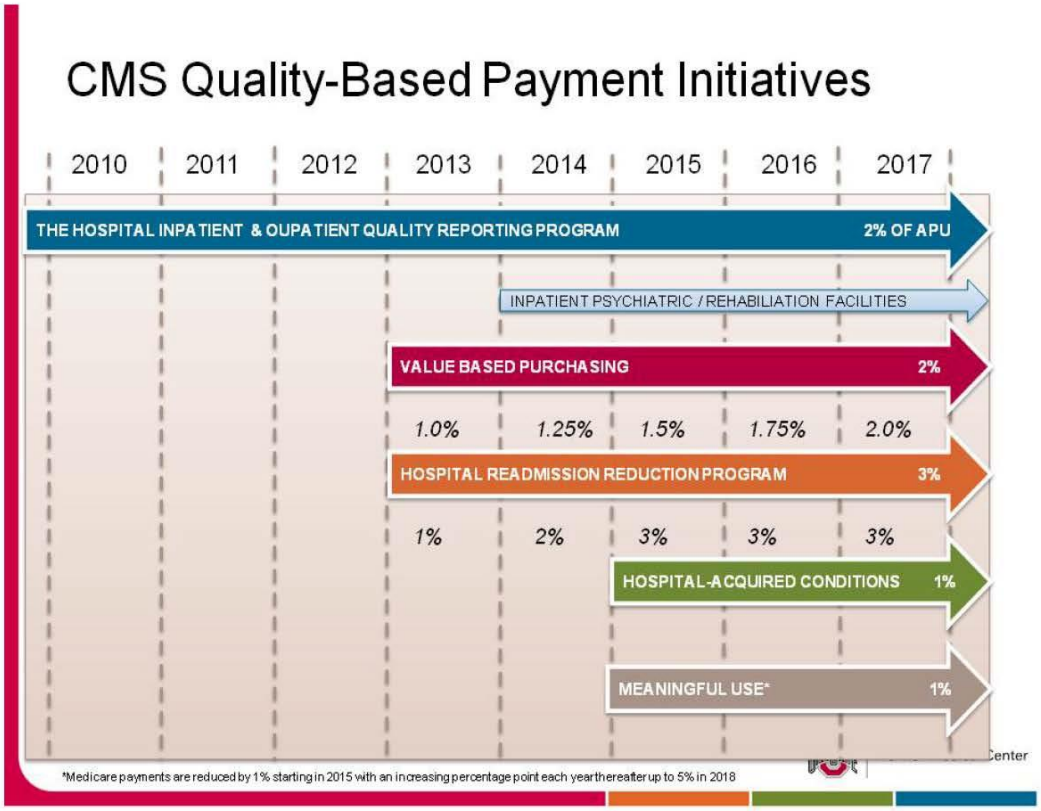
Attachment V: External Reporting

Quality Data & External Reporting

Regulatory/Public Data	Payers	Registries/ Benchmarking
CMS	Anthem	STS
ODH	United Healthcare	ACC
TJC	Aetna	GWTG
Leapfrog	Optum Health	Vermont Oxford
Franklin Co	MMO	NSQIP
NHSN/CDC	Cigna	UHC
Oryx		BOLD
CARF		eRehab
		Coverdell
		SVS
		INTERMACS
		ELSO

Red = Public Data


Timeline: CMS Quality Measures *Number of Measures*
Inpatient Measures
Outpatient Measures
VBP
Cancer
Psych
Rehab
140
120
100
80
20
0
Medicare Prescription Drug, Improvement, and Modernization Act of 2003
Deficit Reduction Act of 2005
Tax Relief and Health Care Act of 2006
The American Recovery and Reinvestment Act of 2009
Affordable Care Act
2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016
10 10 21 27 7 30 11 44 11 45 15 55 15 57 23 13 55 26 17 5 6 2 59 25 19 6 6 2 58 28 17 18 8 2
Pay-For-Reporting
0.4% point reduction in the annual market basket update for not reporting
Pay-For-Reporting
2.0% point reduction in the annual market basket update for not reporting
Value Based Purchasing
1% payment reduction – incentive in 2013
2% payment reduction – incentive by 2017
*proposed


CMS Quality-Based Payment Initiatives
2010
2011
2012
2013
2014
2015
2016
2017
THE HOSPITAL INPATIENT & OUPATIENT QUALITY REPORTING PROGRAM
2% OF APU
INPATIENT PSYCHIATRIC / REHABILIATION FACILITIES
VALUE BASED PURCHASING
2%
1.0%
1.25%
1.5%
1.75%
2.0%
HOSPITAL READMISSION REDUCTION PROGRAM
3%
1%
2%
3%
3%
3%
HOSPITAL-ACQUIRED CONDITIONS
1%
MEANINGFUL USE*
1%
*Medicare payments are reduced by 1% starting in 2015 with an increasing percentage point each year thereafter up to 5% in 2018

Attachment VI: Quality and Safety Scorecard

Type of Event
Retained Foreign Bodies
Wrong Site Events
Medication Events with Harm (Severity E-I)
Falls with Harm (Injury Level 2-4)
Hospital Acquired Pressure Ulcer
Central Line Blood Stream Infections
Ventilator Associated Pneumonia
Hospital Acquired Surgical Site Infections
Hospital Acquired Clostridium Difficile Infection
Total Potentially Avoidable Events