THE OHIO STATE UNIVERSITY

OFFICIAL PROCEEDINGS OF THE

FOURTEENTH MEETING OF THE

WEXNER MEDICAL CENTER BOARD

Columbus, Ohio, November 4, 2015

The Wexner Medical Center Board met on Wednesday, November 4 at the Richard M. Ross Heart Hospital, Columbus, Ohio, pursuant to adjournment.

** ** **

Minutes of the last meeting were approved.

** ** **

November 4, 2015 meeting, Wexner Medical Center Board

Mr. Wexner called the meeting of the Wexner Medical Center Board to order on Wednesday, November 4, 2015 at 9:51am.

Present: Leslie H. Wexner, Jeffrey Wadsworth, Janet B. Reid, W.G. Jurgensen, Cheryl L. Krueger, Abigail S. Wexner, David B. Fischer, Stephen D. Steinour, John F. Wolfe, Michael V. Drake, Sheldon M. Retchin, Geoffrey S. Chatas, E. Christopher Ellison, Peter E. Geier, Michael A. Caligiuri, Amanda N. Lucas, Elizabeth O. Seely, and Martha C. Taylor. Corbett A. Price was absent.

Mr. Wexner:

Good Morning. The minutes of the August meeting have been distributed. If there are no additions or corrections, the minutes are approved as distributed.

We are beginning with hellos and goodbyes. First, I want to welcome Mark Larmore, our new chief financial officer to the medical center. We look forward to working with you over the years to come. At the last meeting of this board and the university board of trustees, the bylaws were amended to allow all hospital CEOs (chief executive officers) or executive directors to join as ex-officio, non-voting members of the board. Therefore, I want to welcome Amanda Lucas and Elizabeth Seely to their first meeting and to also recognize Marti Taylor and Mike Caligiuri.

We also approved the addition of the CEO of the OSU Health System as an ex-officio, member. Currently this position is held by Pete Geier.

Pete, as you know, will be leaving his position but has been with the medical center for 14 years. I would like to take this opportunity to recognize him and his contributions to the medical center. As the chief operating officer, beginning in 2001, Pete began to work with the organization to align it, change it, and improve it. Clearly, we've seen significant improvements in performance, which have been enabled by Pete's support: the construction of the $150 million biomedical research tower, which was opened on time and budget, and likewise, the James. He merged 32 physician practice businesses into a 600-member physician group with more than $200 million in annual revenue. He also standardized and created a consolidated financial statement that we have for six hospitals, 1,100 beds, primary care sites around the city, ambulatory surgery centers, affiliated hospitals, and, to remind everybody, more than 19,000 employees. This is a very big business. We have also had improved margins.

As Pete leaves, the financial state and other states of our health are very good. Pete I'd like to give you an opportunity to speak if you care to.

Mr. Geier:

Thank you, Mr. Wexner, for your kind words. This is a time of mixed emotion for me. This has been a fantastic personal and professional experience and I've been greatly honored to have the opportunity to serve The Ohio State University and the Wexner Medical Center. I am not going far, I'm staying in Columbus. I have some other things that I'm planning to do. I think most of all I'll miss the people and my great colleagues here at the medical center.

Thank you very much for your comments.

Mr. Wexner:

We have three things to do and then we get to vote on some things. First will be Dr. Retchin, then I'm going to ask Mark Larmore to present, and then Dr. Moffatt Bruce will talk about quality and safety.

First, Dr. Retchin.

Dr. Retchin:

Before I start, Les, I also want to add my thanks to Pete for everything that he's done.

First I want to mention the turnaround in the health system and the improvement in the margin. We all say "no margin, no mission." The opportunity he was given at this academic health center, which is as academic health centers go, these are and can be very difficult places. You have lots of, sometimes overlapping missions, difficult to separate out. Mr. Geier gave so much of his professional life to the institution and made several improvements: the movement of the enterprise into the 21st century in electronic medical records, with the installation of Epic was no easy task. Many places have abandoned that effort along the way and he had the prescient forethought to be able to get us there. With the opening of the Ross Heart Hospital and the new James; the list goes on.

On a personal level, Pete, I staked out an office so I could be across from him early on. He was a tutor in my early initiation here. He would come in once a day and give me some life lesson, always, following one of the Seinfeld episodes. It was sometimes difficult for me to make the leap.

Then there are those times when you find out something about somebody that you never knew. Pete Geier played football for Purdue. He played center, which he has maintained is the most skilled position. Who knew? But it's also one of course that has a lot head trauma.

Pete has been a great friend and so I have my own thanks for everything that you've done for the institution.

Please join me in another round of applause.

I'm going to go on to the CEO report make a couple of remarks on this Mr. Chair.

First, the inpatient mortality, as you see here, is slightly above target but certainly among the top of the UHC (University HealthSystem Consortium) hospitals as we have been before. I think the ranking now would be, if you were to run the numbers, 6th. A continued remarkable performance nationally, setting, I think, a mark for other academic health centers to follow and it's one to celebrate.

As I go down this list, you'll notice some new metrics that we have carefully tried to include on the scorecard. You will continue to see this develop in future years as we get more granularity to our performance. Some of these will be great and some of these not so great. Part of the opportunity for growth is to be sure that you have transparency.

The next is a patient safety index (PSI). This is a compilation of numbers and it's referenced on the sheet. Maybe to provide a little more granularity, Susan, will you talk a little bit about the PSI?

(See Attachment VIII for background information, page 95)

Dr. Moffatt-Bruce:

Absolutely. The PSIs are patient safety indicators that nationally we're ranked by and graded on our performance. They come from a number of different things including pressure ulcers, falls, and central line infections. It is the only way that the government and payers, as well as ranking systems like *US News and World Report*, can get our data. This one that we have to keep our eye on because everybody else is. It is one that we manage daily and one that our physicians and nurses and staff are highly invested in.

Dr. Retchin:

Thanks Susan. You see that we're still pushing the envelope on the target on the PSI and we'll be bringing that back to you.

The next one is our readmission rates. CMS (Centers for Medicare & Medicaid Services) decided a 30-day window after an acute patient admission is sort-of the sweet spot. If you go beyond 30 days, there are elements that are out of the hospitals control. They did extend post-acute admission in terms of readmission rights. Lower is better and we're at 13.2%, our target is 11.9%. This puts us, I believe, in the median, or maybe a little below.

Dr. Moffatt-Bruce:

When we are compared to our academic peers, we are worse than the median right now and that's something to be discussed.

Dr. Retchin:

We will be bringing that back to you again. We have efforts underway to improve this. Some of these are value based purchasing. That is one of the elements that CMS is looking at.

The next is CAUTI rates, catheter associated urinary tract infections. Urinary tract infections are one of the most common hospital acquired conditions that is preventable. About 75% of these infections are due or are in conjunction with having a catheter inserted. There is something you can do about it and that is to be sure when you do put a catheter in to take it out very quickly, as soon as it is medically indicated. We might discuss this a little bit Susan, in the context of having nurse decision making.

Dr. Moffatt-Bruce:

Absolutely. This is one of those indicators that requires an entire team to facilitate improvements. In particular, this one we have used at the medical center to really engage nurses and empower them to use evidence-based practice. As you can see, our results have improved dramatically. I think it's a good example of an indicator that now is not only in the ICUs (intensive care unit) where our critical care patients are, but it's across the entire medical center, regardless of what your disease is. Although it sounds like a minor or a smaller type of infection, the impact to the patient is huge and this one that leverages the entire teams engagement.

Mr. Jurgensen:

Is the level that we obtained in fiscal year 2016, .48, is that sustainable?

Dr. Moffatt-Bruce:

We anticipate that it will be with all of our ongoing efforts. Particularly at the bedside with the nurses being able to remove catheters based on protocols that have been derived by physician decision making.

Mr. Jurgensen:

This would be an example, potentially, of a place where you would reconsider your goal given what you've accomplished.

Dr. Moffatt-Bruce:

Yes. Part of the goals have been established also by looking at national benchmarks. We are constantly being compared to all hospitals across the nation. We receive more data on a quarterly and semi-annual basis and we will continue to push that envelope. We intend to get to the top percentile on this, and the goal will change.

Dr. Retchin:

Next is inpatient satisfaction where we've made gains in some areas and in other areas we have room to grow. Susan and Mary, can you comment on the patient satisfaction results?

Dr. Moffatt-Bruce:

Absolutely and we have some more granularity that Mary helped to put together around each of the hospitals performance. Mary do you want to speak briefly?

Dr. Nash:

I think Marti Taylor should be the one to speak on behalf of the University Hospitals.

Ms. Taylor:

Yes, certainly. University Hospital, as we just toured through and saw, has challenges from a patient experience standpoint, with 60% of the beds there being semiprivate. We continue to work on that.

We have some good improvements in the women and infants area; still room to go there, but that is another big focused area for us.

Dr. Moffatt-Bruce:

This is the data through to the end of August. We know that our most recent data is better than this, and we are continuing to see a sustainable improvement every month this year.

Dr. Retchin:

I want to congratulate the staff for their focus in terms of nursing and doctor communication continued efforts. The faculty are shoulder to the wheel in this and we will continue to bring this back as well.

Going on to the financial metrics. As you can see the net medical center operating margin has been changed, Mr. Chair. It includes the physician group, both on the college side and the practice plan. We feel this is integrated and it's important that we show all of the metrics combined. As you can see our target this year, net after distributions for academic missions, is 7%. We are at 6.7% operating margins so far. We are a little behind but after the first quarter I'm very pleased with the results. We will talk a little bit more about that as well.

Days cash on hand is ahead of target, remarkably so. As well now, you'll see day's cash on hand at the practice plan and college, again trying to be sure that we look at this in a comprehensive integrated fashion.

Stop me if you have any questions.

Mr. Wexner:

I do. The days of cash, just to remind me at 99, is how many dollars?

Mr. Larmore:

That's about $7 million a day in cash.

Mr. Wexner:

One hundred days is $700 million in reserves.

Mr. Larmore:

Total cash.

Mr. Wexner:

In cash reserves.

Dr. Retchin:

That includes the physician group and the college?

Mr. Larmore:

Just the hospital.

Dr. Retchin:

Oh yes, you are correct.

Dr. Ellison:

The physician's group is $100 million a day.

Mr. Wexner:

That is what I was trying to get to is days of cash and then days of cash in other places, so I can see what the total days of cash are?

Mr. Larmore:

The cash in the College of Medicine and the practice plan, as Chris said, is about $100 million because their amount per day is less. On the health system, if you look at just the health system, is about $7 million a day. Having 99 days is about $700 million, about $800 million in total.

Mr. Wexner:

Would that include reserves that are in the budget also? I'm trying to get to a kind of dooms day scenario. How much cash do we really have? We could have days of cash and then we could have reserves. The reserves may be legitimately reserved but are also part of the total pot.

Mr. Larmore:

This would include all cash except restricted cash, and then there's some cash that's set aside for capital projects that are planned. That would not be included.

Mr. Wexner:

That is what I'm trying to get to, the big number, the unrestricted.

If a spinach hit the fan, we'd have $800 million, we'd stop capital projects we'd do a bunch of stuff, so I'm trying to understand, no intention to go use unrestricted cash or do other things, what is the real gross number? If we had to stop right now, stop projects, and stop spending, my guess is it's close to a billion dollars.

Mr. Jurgensen:

You could answer the question if the spinach really hit the fan, the number is like $3 billion. This sits over a net of the university.

Mr. Wexner:

The university's got a big number too, I'm just trying to get to ours and then I'll let the university worry about theirs. I am guessing, and you don't have to answer, I think we should always be looking at that because you look at days of cash, there's not much difference between 9 days and a hundred. If in fact, from kind of a dooms day or extremist position, if we're sitting on or could mobilize a billion dollars, the world looks different; to me anyway. In your prior experience did people look at it that way in New York?

Mr. Larmore:

Yes. I would say a hundred days in cash is on the low side if you look at your ratings analysis. I think depending on where you are in a capital plan, often you have more money set aside for your capital project, finishing one and preparing another. There is not, I'd say, as much money set aside right now on the capital side.

Mr. Wexner:

From memory, if I went back 10 years, what would our days of cash been in days in dollars?

Mr. Geier:

Ten years ago? Forty days maybe. The spend was probably $4 million to $5 million a day at the time. Two hundred million dollars roughly, 10 years ago. Fifteen years ago it was negative and we were into the university at that time.

Dr. Drake:

Fifteen years ago nationally, many people were around zero, or measured cash in hours.

Dr. Retchin:

Moving on to the revenue enhancement and scale. Our operating revenue is slightly below target. You can see the development dollars. Patty, do you want to comment?

Ms. Hill-Callahan:

Yes. The number that's on the dashboard is as of the end of the first quarter. As of the end of October, we're up to about $35 million, which is slightly above where we were last fiscal year. We have great momentum and more gifts in the pipeline, hundred thousand plus, then we had before.

Dr. Retchin:

Thank you. On cost management you'll see the first is operating expenses per adjusted admission. We are below target there which is a good thing and indicates some continued efforts to ensure that we are as efficient as possible.

The next metric is a new one as well. This is in value based purchasing as CMS continues to focus in areas regarding outcomes. That is spending per Medicare beneficiary. We would have to be at .98 to get any points on the value based purchasing and that is our target. You can see we're above that and have a ways to go. We are continuing to focus on efficiency, which is what I talked about in my medical center address a few weeks ago.

Dr. Drake:

This is a new one for me. What would it look like to move from .99 to .98? What kinds of things would change?

Dr. Moffatt-Bruce:

This is a spend for every Medicare patient, regardless of what the disease is, three days before, during, and post-op. The post-op or the post-procedure or post-stay going to LTACH (long-term acute care hospital), that's where we're having our most amount of dollars spent and that's where we're going to focus our efforts. We need to move that down.

Dr. Retchin:

That post-acute, where you do lose some control, has been an issue for us and we're continuing to focus on that space.

Total NIH awards is about $24 million. This is also I believe at the end of the first quarter, but we've had some catch up there too, right Chris?

Dr. Ellison

Yes we have. October was a very good month.

Dr. Retchin:

On education, you can see our medical school ratings that were last year, and you see our target to move up. Best hospitals, the number of specialties that are ranked, and those in the top 20, will be reported in July.

The workforce engagement survey, which has impart been put on hold, but others we're moving ahead. That is my report, Mr. Chair.

Mr. Wexner:

Thank you. Questions, comments?

Dr. Wadsworth:

Was September not a good month compared to October?

Dr. Ellison:

I think there were some timing issues with receiving the award letters. We had an excellent October that puts us right on target to hit our goal for the year.

Dr. Wadsworth:

Yes, federal funding is often unloaded at the end of September. I was wondering if that was reflected in October.

Dr. Ellison:

We received a large number of grants in October. I can't explain it, but we were grateful for it.

Mrs. Wexner:

Just a question, Dr. Retchin. When we say we're 30th in medical school ranking and top 10 public, is 30 out of in the publics or is that in total.

Dr. Retchin:

That's in total.

Mrs. Wexner:

It's odd because they're measuring differently, right?

Dr. Retchin:

The top 30 would be public and private and number 10 would be 10th among publics.

Mrs. Wexner:

Where would we sit among the publics now?

Dr. Retchin:

We are 11th.

Dr. Drake:

We turn out to be pretty similar as it turns out. Ten and 30 turn out to be pretty similar numbers.

Dr. Reid:

I have a question as well, more of a reminder for me. In terms of days cash on hand, what would be a top percentile for academic medical centers versus not-for-profit hospitals versus for-profit?

Dr. Retchin:

I will take a stab at that, and then Mark if you want to. I would venture to say among the top 20 academic health centers, maybe even the top 30, you'd be looking at 210 to 220 days.

Mr. Larmore:

I would say somewhere within 200 to 300 days in cash.

Dr. Drake:

That is a whole lot of money too.

Mr. Jurgensen:

It also begs the question whether it's financially smart.

Dr. Reid:

That is for academic medical centers. What would you say, generally speaking for not for profits and for-profits, roughly? Days cash on hand, top quartile or for non-academic for-profits and then non-academic not-for-profits, roughly.

Dr. Retchin:

I don't think for-profits would be reporting days in cash would they?

Mr. Larmore:

No. The for-profits are looking more at how they're deploring their cash to grow their business. I'd say the not-for-profits, depending on which city you're in, has changed dramatically. The big academic, not-for-profits, in many states have seen their financial performance improve greatly over the last 10 years. We have seen big numbers of growth.

You know, in New York, I can speak to the best, if you had one day you were doing good. If you broke even you were doing well, but over the last 10 years all the big academics in the city have put a lot of cash and reserves on the books. And quite frankly, it's allowed them to enter the debt market on their own, where in the past they used to have to rely on the federal government to back their debt.

Mr. Wexner:

Is it your turn to jump in the tank?

Mr. Larmore:

Okay. I will try not to repeat what Dr. Retchin has gone through already. There is one slide and the first three lines talk about volume. From an admission or discharge standpoint we're slightly behind budget for the first quarter. Not an alarming percentage, but we've seen good growth year over year with inpatient volume growing about 2%. If you include the number of patients in observation beds, which are not considered an inpatient bed, growth of about 4%.

We are a little bit off budget but on the 4th line you can see that total surgeries are up almost 3%. We have seen our case mix run a little ahead of what we had budgeted and that's offsetting some of the volume shortfall.

Ambulatory volume is slightly behind, 1.6%. That is not a huge number and can be made up in a month. That is the budget, but still growth of 3% year over year. I think ED (emergency department) visits grow every year, no matter how packed the EDs are. We certainly put capacity on them here and, of course, the volume grew and filled the ED. When I toured through them last week, there are waiting areas that were not expected to be used because there were enough bays inside, and there were plenty of people waiting in there. I think if you build it, they come on the ED side.

Adjusted admission is a number where we conferred the inpatient volume and the ambulatory volume on a percentage of revenue. You can see we are a little behind our target by 1.8%, but again everything has grown year over year.

Revenue, as I said, is 1% off. I am not concerned about that but we've been conservative on the expense side by about .6%. Consequently, when you look at the bottom line,

we're only a couple million dollars off with the budget, and certainly about 8% ahead of last year. If you include investment returns, we're about 10% above last year. I have not seen the October numbers yet, but I'd say the amount we're trailing is not a big concern yet.

FTEs (full time equivalents), you can see, are slightly under budget but considerable growth over last year because of the opening of the James between the two years. There is an addition of about 1,100 FTEs at the institution now compared to last year and that was anticipated as the budget was built.

The case mix index doesn't seem huge, its 1.8 compared to 1.78, a very small movement in that number has a big financial impact on the institution. It is good to see that increase and that's a combination of the type of business that's coming though and then also some other initiatives that are going on in the health system to make sure that we're documenting and coding the complexity of the patients that do come though the health system.

The operating EBIDA (Earnings Before Interest, Taxes, Depreciation and Amortization) is 20.6% which is pretty much on budget and ahead of last year. Again, that number is prior to the distribution of the MCI or Medical Center Investment, that's recorded as a transfer below that. Without that, the number is about 13%.

We already talked about day's cash on hand.

In the four weeks I have been here, I think it's a good start. Pete has been a big help on opening his drawers and files and showing me what's here. He also agreed to take the blame for any miss on the budget for the next nine months. I do appreciate his help.

Other than the numbers, one thing I'd like to mention is on October 1, coincidental to my arrival, the ICD-10 (International Classification of Diseases) program, which you may have heard about for years, went live. When you look at the complexity with that, we went from about 18,000 codes to 140,000 codes. I think Phyllis Teater, the CIO (Chief Information Officer), sent out a few of them that are out there that are kind of interesting.

We watched and our concern was that we could drop bill code and drop bills that went well. The bigger concern was, as they went to the insurance companies, whether they would be ready for this and we would see payment. The good news was in October, I got an email from the rev cycle team and as of the 27th, and we had met the October cash goal. I think both the health system was prepared well for it and it seems like the payers were prepared for it. That is good news.

(See Attachment IX for background information, page 96)

Mr. Wexner:

I think I've always seen this information the same way, it just occurred to me. When I look at the summary financials, I'm looking at admissions like actual budget against last year, which are numbers, right? Number of admissions and then the variance to those numbers. I have no income or financial that matches those admissions.

What I'm guessing is, they can go through that whole line, and I know in our business sometimes people want to talk in percentages or numbers and I want to talk in numbers and percentages and dollars so I can see what's happening. The thought would be that if I were budgeting or planning for a department practice, there'd be numbers and percents and dollars attached so we could see what the average admission was in units and dollars.

I would like you to think about summarizing that so we can the numbers and the dollars and averages and percents and don't necessarily need the backup by all the practices

or by all the functions, but just the certainty that everyone is planning that way, if you would, in units and dollars. Because I think it would seem to me, from not a medical or hospital experience, that it's just better when you're looking at both, and reporting both.

Mr. Larmore:

That's fair. If you looked at my slide, I hand-wrote in the dollar piece of that next to it. We will modify the slide. One section that says operating revenue per adjusted, in the middle of the page and the expense per, looks at all the business in total. We look at that.

Mr. Wexner:

Would that make sense by practice plan or location that people are looking at, if it were patient numbers in numbers and percents and then matching dollars and expenses or revenue to those things?

Mr. Larmore:

Sure.

Mr. Wexner:

Is that a standard practice?

Mrs. Wexner:

If you wanted to really understand it, you'd have to understand the types of services being provided, because some are very different in terms of a bottom line.

Mr. Jurgensen:

You know Les, to build on your point, we've been looking at this sheet or some variation of this sheet, for a really long time. It is not our business, it's not intuitive to us; which measures matter most and why? You made a comment, halfway down the sheet, I'm not worried about that. I can't figure why you would be or wouldn't be, because it isn't intuitive. You know if this were an insurance company I'd know the seven things you really want to pay attention to, but I don't know the seven things you really want to pay attention to here. This ought to be prioritized in some way. The things that matter the most should be at the top and we should understand why it's something. You could have admission going up and it's a really bad thing if they're all the wrong kind of admissions, but if they're the right kind of surgery admissions, bring them in.

Mr. Larmore:

I take your point. We'll give some thought to that.

Ms. Krueger:

As I looked down halfway through the page, I looked at operating revenues and I see they're up 15% to last year. When I look at the expense side, I see we're at 16.4%. At what point do we start getting some leverage? It is like a rat in a wheel. If you go up 15% but your expenses go up you never gain any leverage or any economies of scale. It may not be a fair question now, but it's something we should look at. If your expenses are going up and your revenues twice as much let's say or three times as much and your expenses maybe only go up by like by a quarter of that. Then you're going to get some leverage out of it at some point. And I'm not dismissing, the numbers are terrific.

Mr. Larmore:

No, I agree.

Ms. Krueger:

Thank you.

Mr. Jurgensen:

Another question about the revenue cycle management. With respect to ICD-10, what level of maturity in coding would we say Ohio State is at?

Dr. Retchin:

I'll ask Mark and maybe Susan or Andy to comment, but to have gone through this now more than 30 days with no dramatic increase in receivables, is just extraordinary. This is like a Y2K perhaps, that was a bad metaphor, but it is profound. We went from, I think a fourfold increase in the number of diagnoses.

Mr. Larmore:

Eighteen thousand to 140,000. If your question was different, as if you're looking at the type of care we deliver here and then how well are we documenting coding that we're delivering that care, it's too early for me to tell that. I think there's always opportunity that's there and it's the whole revenue cycle process to look at.

Mr. Jurgensen:

As I have listened to people all around the country and listened to providers and doctors and people in my industry, this coding thing is a really big deal, and it's a very complicated deal. It isn't a matter of if my receivables are speeding up or slowing down, it also goes to what are receivables in the first place?

Ms. Marsh:

Mr. Jurgensen, that area of coding reports to Dr. Andy Thomas who stays on top of it. He might want to make a comment about the coders.

Dr. Thomas:

Thank you Gail. A couple of points Mr. Jurgensen to your question. We did bring on an extra group of coders last spring, they were student apprentices that we then hired over the summer to be prepared for the changes that were coming October 1st. Also, well over a year ago, we went out to the market and purchased a new computerized coding software system that will help us over time with that conversion.

The update that we've had towards the end of October was that on the outpatient side, on the hospital outpatient side, our coders have returned to near pre ICD-10 efficiency already, which was even surprising to our leadership team. On the inpatient side, it's been a little bit more difficult, but we're expecting to reach a new normal of productivity after January 1st. They feel we're ahead of the game compared to where we thought we'd be, but we're now here near the productivity we were before October 1st.

Mr. Jurgensen:

Andy, what's productivity mean?

Dr. Thomas:

The time it takes a coder to code a chart. Part of the issue with the time it takes to code a chart is we're doing more double checking because of the new coding system for the first few months to make sure we're doing it right. Plus with new coders that we brought on last spring, we are additionally double checking their work since they're more junior in their experience. We think by January, we'll be back up to that normal turnaround time, if not even sooner. I think we did, in the budget, set aside some contingency dollars from a cash flow perspective for this fiscal year, which at this point we don't feel that we're at risk of needing to draw down on.

I think to Mark's point, what we have been happy with is the turnaround time from insurers in terms of paying us so far. That's something that's well out of our control, but it has not been a worst case scenario by any point. I think at your next board meeting, we'll have a much better sense of three months of time to be able to give you a better update.

Mr. Wexner:

Everybody runs on budgets, but if you said we're going to catch up quickly, we can, you know just throw people at it, outsource it. You have a cost and then you've got how quickly you capture the cash, right? I'm not looking for the answer, I want you to think about that. Because I can catch up within budget, or I could accelerate in the greater value I'd need to be caught up sooner rather than later.

Mr. Larmore:

I would say the coding that Andy's talking about it not effecting our budget in performance numbers, it's just it affects your cash; how long it takes you to get a bill out and subsequently get paid. Sometimes it's not a speed thing. You would almost rather it be a little slower at a time like to this to make sure that you're coding everything that happened to the patient to get paid the maximum amount that you should and what you're entitled to. I'd say right now we're probably in that period where it's better to be a little bit slower and then as we go forward we'll pick up the pace.

Dr. Thomas:

I would agree with what Mark said, and that was our plan all along. Not until the spring will we be able to stay stable.

Mr. Wexner:

What was behind my thought was, if you're getting reimbursed fast, right, it doesn't mean you're going to be reimbursed fast. If there is a window of prompt reimbursement, and I don't want to compromise quality, but then I'd make sure that it's that way because in January, it could flip dramatically in terms of cycle times. It is something to think about.

Dr. Thomas:

Having to build a lot quickly, but go on incorrectly in the long run adds time to the cycle. I think your point is a good one, it's a balance between the two.

Mr. Wexner:

We could be accurate and fast, because we're being reimbursed quickly or we could be accurate and slow and then in January the cycle increased 60 days or whatever.

Mr. Jurgensen:

Productivity is a measure, speed of collection is a measure, but to me the question is, if I had a patient experience come through the place, and I asked a hundred different doctors how to code it, would I get the same answer a hundred times? Because how its coded matters to what you're ultimately going to get paid, whether you get paid it fast or slow. I have seen doctor practices that get squat in the marketplace traded at significantly different multiples as a function of how effective that physician was in the coding game. That's why, when I ask what level of maturation are we at, would we say on a scale of one to 10, that we're a 10 when it comes to coding, or are we a six, irrespective of how long it takes us or how fast we collect?

Dr. Thomas:

Also I think, Mr. Jurgensen, there's a difference between hospital coding and physician practice professional. Most of what I've been talking about is the hospital side, which is not done by physicians, it done based on physician documentation. Mark's point earlier, the better we can get doctors to document, the easier it is for the coders to do their jobs.

Mr. Jurgensen:

I get that that, that's what I'm asking.

Dr. Thomas:

We have a staff of folks that are clinical documentation improvement specialists that work on this every day, that are out imbedded with the teams and we can bring back a report on that program at our next meeting.

Mr. Chapman:

Jerry, I find there's five levels of insurance companies. United, Aetna, Sigma, and all of our major payers come through negotiations in what they pay us. I don't believe one of them brought up the issue of clean claims. Said another way, we are clean on claims. We don't cause them extra work.

Mr. Jurgensen:

Maybe we could take this offline because that aspect of it I'm relatively familiar with and sometimes there's a reason I'm real happy with the claims you're submitting.

Mr. Chapman:

Jerry, we got higher than average rates from our insurance companies.

Mr. Jurgensen:

That would matter a lot.

Mr. Chapman:

When looking at the outcome of the rate negotiations, we got higher than we expected, none of them brought up the fact that we're causing them extra time and cost on their claim process. I am just going to use that as evidence that we're probably at average or better than average on the revenue cycle.

Mr. Jurgensen:

Thanks.

Dr. Retchin:

In the interest of time, I'm going move quick, and ask those presenting in public session to move quickly as well. I'm going to move right into the accreditation requirement, Dr. Moffatt-Bruce.

Dr. Moffatt-Bruce:

Within your package there is a document that speaks to the Clinical Quality Management, Patient Safety and Service Plan. This a document that has been through the MSACs (Medical Staff Administrative Committee), both in the university hospital as well as in James. This gives us guidance as a recurring document that was here last year.

It is one that simply states how we approach quality and patient safety, what methodology we use, and what type of data we collect. It is a guide book if you like, for those of us working in quality across all of the hospitals and it certainly is simply just updated here with our most current initiatives and it has been endorsed by the entire medical center.

CLINICAL QUALITY MANAGEMENT, PATIENT SAFETY AND SERVICE PLAN
Resolution No. 2016-20

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; and

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 October 20, 2015:

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 Attachment X for background information, page 97)

Dr. Retchin:

I guess we take that as a motion?

Ms. Link:

Yes, we need a motion to approve it.

Dr. Reid:

I have read through this. I have a question here on health disparities. There is no question about whether they occur, it's what anyone is doing about them. What do we do about them and is that covered in here?

Dr. Moffatt-Bruce:

We benchmark ourselves and work with the collaboratives in the University Health System Consortium, which is our academic peers. That is part of our initiatives every year to continuously look at that. We are part of a collaborative with all our peers to look at this on a continuous basis and we get that data every quarter so that we can look at where our opportunities are; not only around payer mix, but socioeconomics, race, ethnicity, so that is continuous.

Dr. Reid:

English is a second language in all of that, so we look to make sure that the treatment of those types of individuals is equal to anybody else's.

Dr. Moffatt-Bruce:

Absolutely, and we benchmark ourselves with what we would call our peers.

Dr. Reid:

There is a measure for that. It's not covered in here

Dr. Moffatt-Bruce:

No. It is part of the University Health System Consortium ranking system that we are part of, one of their 114 hospitals.

Dr. Drake:

I will speak quickly even though our time is short. It is a very useful measure. You can measure outcomes and then stratify those outcomes based on different categories of patients and then compare those against peers. You can get really specific numbers and see where there's a gap and move towards closing that gap, and it's really, I think, helped them out to assist the community in eliminating disparities. It's been a very positive outcome.

Dr. Retchin:

That is a great question and a great comment. I think we could present a program on how we're narrowing the gap in health disparities, Dr. Reid. I've been at two institutions that really focused on this now, and I've got to say, here at the Ohio State Wexner Medical Center, I have not only incredible confidence, but pride in the efforts. We could bring this back, Elizabeth Seely is here, Steve Gabbe, and other programs where we've gone underway. It would be great to innumerate those.

Dr. Reid:

Yes. I would like to dive deeper there.

Ms. Link:

We have a motion, may I have a second?

Upon motion of Dr. Wadsworth, 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. Retchin, Dr. Drake, Mrs. Wexner, Ms. Krueger, Mr. Jurgensen, Dr. Reid, and Dr. Wadsworth.

***

Dr. Retchin:

Next item, Mr. Chair, are Bylaws for the medical staff for both the University Hospitals and Arthur G. James Cancer Hospital and Richard J. Solove Research Institute. You have a resolution there, if you want any details on this, I'll be glad and provide. These were bylaws recommended to the board for consideration. Can I have a motion to approve?

AMENDMENTS TO THE *BYLAWS OF THE MEDICAL STAFF* OF THE OHIO STATE UNIVERSITY HOSPITALS

Resolution No. 2016-48

Synopsis: Approval of the following amendments to the *Bylaws of the Medical Staff* of The Ohio State University Hospitals, is proposed.

WHEREAS the proposed amendments to the *Bylaws of the Medical Staff* of The Ohio State University Hospitals were approved by a joint University Hospitals and James Bylaws Committee on August 4, 2015; and

WHEREAS the proposed amendments to the *Bylaws of the Medical Staff* of The Ohio State University Hospitals were approved by the UH Medical Staff Administrative Committee on August 12, 2015; and

WHEREAS the proposed amendments to the *Bylaws of the Medical Staff* of The Ohio State University Hospitals were approved by the UH Medical Staff on August 21, 2015; and

WHEREAS the proposed amendments to the *Bylaws of the Medical Staff* of The Ohio State University Hospitals were approved by the Quality and Professional Affairs Committee on August, 25, 2015:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves and recommends the attached *Bylaws of the Medical Staff* of The Ohio State University Hospitals to the Board of Trustees for approval.

(See Attachment XI for background information, page 128)

***

AMENDMENTS TO THE *BYLAWS OF THE MEDICAL STAFF* OF THE ARTHUR G. JAMES CANCER HOSPITAL AND RICHARD J. SOLOVE RESEARCH INSTITUTE

Resolution No. 2016-49

Synopsis: Approval of the following amendments to the *Bylaws of the Medical Staff* of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, is proposed.

WHEREAS the proposed amendments to the *Bylaws of the Medical Staff* of The James Cancer Hospital were approved by a joint University Hospitals and James Bylaws Committee on August 4, 2015; and

WHEREAS the proposed amendments to the *Bylaws of the Medical Staff* of The James Cancer Hospital were approved by the James Medical Staff Administrative Committee on August 14, 2015; and

WHEREAS the proposed amendments to the *Bylaws of the Medical Staff* of The James Cancer Hospital were approved by the James Medical Staff on August 21, 2015; and

WHEREAS the proposed amendments to the *Bylaws of the Medical Staff* of The James Cancer Hospital were approved by the Quality and Professional Affairs Committee on August, 25, 2015:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves and recommends the attached *Bylaws of the Medical Staff* of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute to the Board of Trustees for approval.

(See Attachment XII for background information, page 134)

Upon motion of Dr. Retchin, seconded by Mrs. Wexner, the Wexner Medical Center Board members adopted the foregoing motion by unanimous voice vote.

***

Dr. Retchin:

Next are the *Bylaws of the Wexner Medical Center Board* for the Quality and Professional Affairs Committee (QPAC). These are amendments that were recommended from QPAC to the full board. I would be glad to provide any details, but otherwise would ask for a motion.

AMENDMENTS TO THE *BYLAWS OF*
THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER BOARD
Resolution No. 2016-50

Synopsis: Approval of the following amendments to the *Bylaws of the Ohio State University Wexner Medical Center Board*, is proposed.

WHEREAS the University Board of Trustees approved the creation of The Ohio State University Wexner Medical Center Board at its August 2013 meeting; and

WHEREAS pursuant 3335-1-09C of the Administrative Code the rules and regulations for the university may be adopted, amended, or repealed by a majority vote of the Board of Trustees at any regular meeting of the Board; and

WHEREAS the proposed amendments to the Chapter 3335-97 of the *Bylaws of the Ohio State University Wexner Medical Center Board* were approved by the Quality and Professional Affairs Committee on October 20, 2015:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves and recommends the attached Amendments to the *Bylaws of the Ohio State University Wexner Medical Center Board* to the Board of Trustees for approval.

(See Attachment XIII for background information, page 140)

Upon motion of Dr. Retchin, seconded by Mrs. Wexner, the Wexner Medical Center Board members adopted the foregoing motion by unanimous voice vote.

***

Dr. Retchin:

Next on the agenda is to talk about the professional services and construction contracts. Jay Kasey?

Mr. Kasey:

Thank you. I will try to go as quickly as I can after making sure that you understand that I'm here representing Marti Taylor and the University Hospital and medical center as all of these projects have been reviewed by them and asked to be moved forward. Also the facilities committee of this board has had a discussion and review of these projects and is recommending them forward.

In your folder you will see that there are three projects. Two of these are in the capital plan. One is a change to an existing project, an increase in scope for the brain and spine hospital which is located at 300 West 10th; the old James building.

There are two elements to that. We are asking for design and construction approval for that entire piece which totals $3.3 million of increase. I'll explain that the first $2.4 million of that is to add a canopy to the front entrance of the old James building. Those of you who know that building know that it is not a good patient or visitor centric welcome. While this building is being refurbished and moved to new services, the medical center decided this was the time to add a canopy to the front of it. It also includes an enhancement to the park, which is right next to it and the canopy should allow four to five cars to queue out of the weather, and will protect our patients and visitors going in and out of there.

You may know that as the building where we currently have a $14.3 million project going on to put three new neuro spine floors into that building for Dr. Rezai. In addition to that, it also handles the expansion of the executive health program, it handles two floors of outpatient clinics, a pharmacy floor, and soon I'll be requesting a patient care floor. We simply felt it was time to commit to the increased business that's going to go in and out of that door.

In addition, there's another $900,000 that is funded from the campus utility fund to increase the chilled water loop that currently stops right under that entrance of the medical center expansion project, which was completed several years ago. We anticipated that we would bring chilled water for the first time to that building. Now, as we redo that entrance, we're anticipating that as Postle Hall, or other buildings around the east side of the campus are increased, we'll want to join it to that line and move chilled water to those new buildings. While we have that torn up, we felt we would run the piping. These are two 30 inch lines that have to run up to the new site. We have put utility funds in here from the campus to do that element of the project.

For the next project, we are asking for design funds for an estimated $5.1 million project. It is for the build out of 29 new beds in the old James building, the 300 building as we're calling it. These are currently vacant beds on the 7th floor of the 300 building. These beds are anticipated to serve as swing beds as other units are renovated across the medical center or we can simply add to our bed component because we are, as you've heard, almost out of beds. It will primarily operate though as swing space and give the medical center a way to renovate floors and not lose that capacity at the same time. This project is funded out of routine 2016 capital in the medical center and at this point we're only asking you for planning dollars of about a half million dollars. We'll come back to you when we have a firm estimate following the schematic plan that building.

Mr. Wexner:

I am curious about two things about the rehab of the James. As we've gotten into it, which I think was good decision, how long do we think that facility will be the neuro center? Based on growth or resource, is this a three year or five year facility?

Dr. Retchin:

The facility itself or its service line?

Mr. Wexner:

Dr. Rezai's center. What do we think the life of that is? The anticipated life, will he outgrow it in a year or 10 years?

Mr. Kasey:

I can tell you the conversation that has been had. To get a replacement building for Dr. Rezai for the approximate 90 beds there, is going to be five to seven years. That is what we're considering the smallest, shortest window.

Mr. Wexner:

Is there a need?

Dr. Retchin:

I think your point's well made. If there's another facility you don't want to continue to restrict it. In terms of service line that would allow us the flexibility to grow, I would say building a separate facility that he might outgrow, I think we're years away.

Mr. Wexner:

Let's say nominally, in terms of filling beds and the growth of that, we'll say it's five to seven years probably, or three to seven years. I don't know what the bandwidth is. It isn't 20?

Dr. Retchin:

No, it is not 20. The flexibility that I was trying to answer your question with Les, is that there are many service lines that we would want to grow. He might outgrow that, but I would say there would be other services I would want to as well. That's why I was going to more of a generic.

Mr. Wexner:

The other question was in building a canopy, do you have to build a canopy? A hotel might have a canvas canopy, but does it have to be structured? Is there something about hospitals that require it to be a real structure, that's architected and built?

Mr. Kasey:

Our goal at this point is to cover one and a half lanes wide of traffic so that the patient, visitor, and driver can get out together. There are a variety of ways to do that.

Mr. Wexner:

For a few million bucks, I'd take a look at it, see if you have to build the structure, or could you, you know, build a frame that's covered with canvas and just make the whole

thing look softer and more inviting and probably save a few million dollars. I'd be happier spending the money on rooms or equipment. I don't want to scale back to handing people umbrellas, but when you say canopy then it's an architect design and something built. Circus tents can handle a thousand people and it's cheaper than building an arena.

Mr. Kasey:

We will put that in the design phase. We're going in the design for this thing, we'll consider that, all these options.

Mr. Wexner:

The question is, what's the intent? If I want to build something that is efficient and inexpensive I might go one way, if had to build a permanent structure because safety or the nature of hospitals, then I'd have to build it. We can talk about it offline.

Mr. Kasey:

One more and that is the expansion of the surgical pathology area. Surgical pathology is currently located in a cramped space on the fourth floor of Rhodes Hall and services the ORs (operating rooms), some which we've just talked about earlier today that reside on Rhodes and Doan on the fourth floor.

We have been sighted by the College of American Pathology (CAP) during their most recent visit telling us that the space isn't adequate for the ORs that they serve with the addition of the James ORs, the 14 which are now further away toward the west of our campus. There is a plan to expand on 1,800 square feet on the fifth floor just above those 14 ORs in the James and annex of surgical pathology, and then go back into the existing surgical pathology area and do some renovation to make that prepared for the future. This a request to do the planning to see if we could make that work on the fifth floor of the James tower.

We are asking for half a million dollars and will come back to you with a final estimate.

Mr. Wexner:

I'm confused, sorry. You're talking about how to finish the shelled floors in the James?

Mr. Kasey:

No. The fifth floor is built out. It's soft space to support the ORs on the fourth floor of the James. We are going back into that soft space and taking 1,800 square feet of it to make it surgical pathology.

Mr. Wexner:

If we decided to finish the shelled space and put them in the rooms, would that impact this decision?

Mr. Kasey:

It wouldn't have the adjacencies so the pathologist could move directly into surgery to do frozen sections and support our surgeons.

Mr. Wexner:

I think the big issue is adding more beds. I think that's the tail and the other stuff is the dog, but you got to think about both. We have three floors, those beds produce a lot of revenue for the hospital.

Mr. Kasey:

This space could never be used for patients, for inpatient beds. It is surgical only.

Mr. Wexner:

In terms of what you're finishing out, again, does that impact the finishing of those other floors on how they might be used or impacted?

Mr. Kasey:

No.

Mr. Wexner:

Okay, I'll go quietly.

Dr. Reid:

I have a real quick question on the brain and spine center. There is shell space that is there for that, for expansion in the short term, is that true or not?

Mr. Kasey:

The three floors that are committed now for brain and spine allow for some growth in our current patient population that they have now in house. Ninety beds gives them some growth. Beyond that, we don't have more growth anticipated for the inpatients there. They may get some ambulatory space there when some of the other clinics move. I think their main concern right now is ambulatory space.

Ms. Taylor:

The current average daily census of those neuro patients that are in University Hospital is about 60 on any given day. We have got incremental growth already built into those 90 beds that they'll move into.

Dr. Reid:

I hope we don't run out of space in the short term is where I'm going.

Mr. Kasey:

That concludes my report Mr. Chair.

Dr. Retchin:

We need a motion.

APPROVAL TO ENTER INTO/INCREASE PROFESSIONAL SERVICES AND INCREASE CONSTRUCTION CONTRACTS

Resolution No. 2016-51

APPROVAL TO ENTER INTO/INCREASE PROFESSIONAL SERVICES CONTRACTS

300 W 10th Avenue - Brain and Spine
300 W 10th Avenue - 7th Floor - design only
University Hospital - Relocate Surgical Pathology - design only

APPROVAL TO INCREASE CONSTRUCTION CONTRACTS

300 W 10th Avenue - Brain and Spine

Synopsis: Authorization to enter into/increase professional services and increase construction contracts, as detailed in the attached materials, is proposed.

WHEREAS in accordance with the attached materials, the university desires to enter into/increase professional services contracts for the following projects:

	Prof. Serv. Increase/ Approval Requested	Total Project Cost	
300 W. 10th Ave - Brain and Spine - for project increase to include exterior improvements, roadway system, and extended chilled water infrastructure for additional project cost of $3.3M	$0.4M	$1.1M Previously Approved $0.4M Requested	auxiliary funds and university debt
300 W. 10th Avenue - 7th Floor - design only	$0.5M	$5.1M	auxiliary funds
University Hospital - Relocate Surgical Pathology - design only	$0.5M	$4.9M	auxiliary funds

WHEREAS in accordance with the attached materials, the university desires to increase construction contracts for the following projects:

	Construction Increase/ Approval Requested	Total Project Cost	
300 W 10th Avenue - Brain and Spine - for project increase to include exterior improvements, roadway system, and extended chilled water infrastructure for additional project cost of $3.3M	$2.9M	$13.2M Previously Approved $2.9M Requested	auxiliary funds and university debt

NOW THEREFORE

BE IT RESOLVED, that the Wexner Medical Center Board hereby approves and proposes that the professional services and construction contracts for the projects listed above be recommended to the university Board of Trustees for approval.

(See Attachment XIV for background information, page 143)

Upon motion of Mr. Jurgensen, seconded by Dr. Reid, the Wexner Medical Center Board members adopted the foregoing motion by unanimous voice vote.

***

Dr. Retchin:

Mr. Chair, I'm going to go on to the next item and tell you that The Ohio State University has not only the smartest medical student class in the nation, they're also the fastest.

Dan Clinchot is going to take us through a simulation. I'm sure the press will be all over this but when I was a third year medical student I had to do a spinal tap on a patient for the first time. I have to tell you, the movement in these hands and the patient, we were both scared out of our minds. Thankfully over the last few years, we have moved into simulation. This is a state of the art effort. Do you want to introduce it Dan?

Dr. Clinchot:

Yes. Thank you for allowing us to give you a glimpse into the education of the next generation of health care providers. We have adapted our wonderful students to shorten this in respect of your time, in a matter of just talking back here.

This is a hybrid scenario that the faculty have developed that combines high fidelity, mannequin imposed simulation, with an actual post-patient encounter. The students will work here and then have to talk to the family members, and you'll be able to witness that.

I would like to introduce our team here: this is Meghan Thompson, a fourth year medical student; Juan Santiago-Torres, another fourth year medical student; behind him is Shuvro Roy, a third year medical student; and next to him is Phillip Hamilton, a fourth year medical student; across the table is Jessica Rutsky, a third year medical student; and at the head of the table is Michael Ratti, a third year medical student.

Typically the students are not aware of what the simulation contains. The junior students know they're going to a simulation. For the more senior students, it is typically spontaneous, they don't even know that a simulation will be occurring in order for them to be prepared to go. Dr. Sheryl Pfeil, who directs our clinical skills education and assessment center, will work as the faculty member. James Beck, our systems analyst in the back, controls all of the physiology of the mannequin, such that the faculty member can direct the learning points for the students. So with that, we will begin.

Team, this is a 65 year old gentleman who'd been transported through Medic for evaluation. He was found down in an alley with a gunshot wound outside of a bar in central Columbus. He was stable in route except towards the end of the route his blood pressure has been dropping. Go.

Simulation

Dr. Clinchot:

This was to demonstrate a hybrid simulation where the students enter a high anxiety situation and have to manage the resuscitation of a patient that they don't necessarily know what's going on. Then, unfortunately, have to switch very quickly into a compassionate mode to speak with the family in complete distress, not aware of what has happened to their loved one, and being told relatively quickly and then being ask to make very significant decisions in a very short period of time.

What we wanted to show and what we tried to do is combine types of learning so that students are really able to integrate the knowledge they have into practical experience before they have to work with real patients and patients on the unit. Students have simulation from the first week in medical school and it continues in an advanced settings. I'm sure any of the students would be more than happy to answer any questions, and we thank our standardized family. This is Ian McAllister and Linda Thompson Kohli who have worked the case for you.

Dr. Retchin:

Mr. Chair, maybe there will be some questions for the medical students, who, in the throes of this, I have to say, were extraordinary. I always think though, just like the tour

earlier this morning, that a picture is worth a thousand words, but seeing a demo is worth 10,000. Any questions?

Dr. Reid:

I have a question about the poor patient who didn't make it. When you are working on the mannequin and doing chest compressions and other things, does it feel like a real chest?

Mr. Hamilton:

Yes, it definitely does. There is a little bit of noise to let you know you are getting depth with the chest compressions. It also simulates the experience in compressions where in order to get the accurate depth you might need to break a rib.

Dr. Reid:

If there is a circumstance where you think the treatment ought to be something different, then how comfortable would any of you be to say, I think we ought to do something other than what we're doing?

Ms. Thompson:

Yes. There always has to be role assignment during the code and there's a team leader. I think simulation gives us an opportunity to have increased comfort even at the medical student level of training during real patient situations to point things out. We try to incorporate that into simulation and communication, asking anyone if they have anything else that they're thinking of. We ask people to speak up. I think that aspect of simulation training translates into increased patient safety, which is one of the core values we try to learn and improve upon, especially during simulation. I think safety is one of the main benefits of having simulation.

Mr. Wexner:

I'm curious, kind of the reverse. You were sitting through the board meeting. Do you have any questions for us about the stuff we did. I'm serious.

Mr. Roy:

I don't necessarily have a question, but I think it is interesting to reflect upon parallels between what we see trying to get accomplished during a board meeting and the core tenants of our curriculum. A lot of it ties back to the clinical skills center. The whole point of it is to push our performance. To not just make us students who are learning the basic skills during our clinical years but to already be comfortable in those areas, and then build upon them once we're working with patients. I think one of the themes that came up during the board meeting over and over again is "how do we push our performance, how do we move into that next percent, and how do we move up a quartile?"

I think that is what's at stake with our learning here. It is one thing to go into these new situations, but it's another thing to feel comfortable and competent while working with patient interaction for the first time.

Mr. Wexner:

I am pleased with that observation. Please tell all your friends and colleagues, because the board aren't cheerleaders, and we're not passive. We are pushing for the best possible patient care, best possible performance, and best possible outcomes for students, patients, and the hospital. If we appear engaged, that's really good, because I truly believe we are. Thank you.

Dr. Thomas:

What they're doing as medical students, we are also translating into what our residents and fellows learn, as well as our faculty. In a real world setting, medical students typically don't run codes on their own, they're obviously senior house staff, or residents, as well faculty that are involved, whether it's a trauma bay, a critical care room, or floor. The training that's done in the skills lab is not just for medical students, but we're using that in a multidisciplinary way with nurses, pharmacists, and physicians, and then multiple levels of folks. It is beyond just the education part of it. There are real world activities that go on there as well for training for a variety things.

Ms. Krueger:

How has their training differed now versus 10 years ago, if they were a medical student 10 or 15 years ago versus today?

Dr. Clinchot:

I certainly can answer that. Very different. It used to be that you were in the classroom for two years, not really seeing a patient at all. Where not only are these students seeing patients earlier, but they're having to apply the things like the basic science concepts they learn to actual patient care simulation, and then there are patients in the clinic or in the hospital. It is really applying their knowledge very quickly so that they can build on better skills when they graduate. To say that two years in the classroom is going to, solely in the classroom, is going to make you a good physician, is just not reasonable.

Dr. Retchin:

I believe there was a requirement for board members to be participating.

Dr. Drake:

We had no simulation 10 years ago. Everything that I would have done would have been with a patient. When I would have been in a code, it would have been a real code, or if I was doing a lumbar puncture, that was a real lumbar puncture. That was a real difference between having something to practice on. When I did chest compressions it was on someone's chest. You would be in a situation where'd you have relatively low responsibility but then move into a level where you have real responsibility, it was gradual but it was not done for practice. The risk reward was much, much higher. I was watching the chest compressions, you get to practice chest compressions and see what's happening on a monitor and that's just different then having to do it on, in the field. This is very powerful.

Dr. Clinchot:

Our standardized patients and families is a unique aspect now for students. It is a live person in front of them. Yes they're portraying a case, but it's very different then when we went to school.

Dr. Drake:

When I was watching this I was thinking about when I also did this as an intern. I was by myself with real people, the person's family members, and the patient died. That was difficult. This is much better to get a chance to practice.

Mrs. Wexner:

In what year do you start to introduce the simulations?

Dr. Clinchot:

First week of medical school.

Mrs. Wexner:

In the first week of medical school?

Dr. Clinchot:

Yes. They learn office based procedures using tests and training.

Dr. Wadsworth:

What is the most sophisticated simulation that's available if you go into eye surgery or brain surgery, and where is this going? What would it look like in five to 10 years?

Dr. Pfeil:

There is increasingly sophisticated technical simulations. We have a laparoscopic surgery simulator that our surgical residents practice on. There's robotic surgery simulation. There is eye surgery simulation. Our most sophisticated mannequins can literally do everything but get off the table. They can even vomit.

It really is sophisticated. When we rolled in our standardized patients, you get the actual patient aspect as well. It is advancing at lightning speed.

Dr. Retchin:

How much is one of the most sophisticated?

Dr. Clinchot:

This one is $100,000 but the more sophisticated ones run around $250,000 because it has lungs and a liver application. Yes, it is very expensive.

Dr. Reid:

How do you get the training to be able to address the family in the proper fashion? Is there a psychologist who teaches it?

Ms. Rutski:

We work with standardized patients at the beginning of medical school. We have been working with the standardized patients since the first year. The first time you do it you have all these nerves but you get used to it. You don't start out by telling someone that their loved one has died, you take baby steps, and build up the strength within you and the poise within you to be able to talk to real people. I am sure, as you could see, they're very good.

Dr. Clinchot:

It is a PhD psychologist who knows the communication program so that the students learn. It is a team of individuals, that when we started included patients from the James patient population, and gave us advice about developing the curriculum for the students.

Ms. Rutski:

We get together weekly in groups of about 10 to 12 during the first two years to practice to bounce off of each other the best ways to talk to patients.

Mr. Roy:

I would like to add one more real world example. I think Dr. Clinchot was one of the ones who pushed the idea of longitudinal groups where we are put in different situations every week, interacting with a different type of patient. You learn to handle very difficult situations in those first two years. For example, last week I was seeing a patient who had come in because he fainted. It didn't seem like a big deal, but because of the training I received in my first two years, I was able to pick up on enough clues and eventually got to the point where I found out that this patient had had a gun to his head a week ago and wanted to kill himself. There is no way I would have been prepared to address that situation if I hadn't had the extensive training on addressing those very difficult to handle situations in my first two years.

Dr. Retchin:

Great, thank you. I hope that that gave you a flavor for not only the quality of the training and the education but also the caliber of the medical student at your medical school.

Mr. Chair, if it's okay I'm going to read a statement for us to go into executive session. The board will now recess into executive session to discuss personnel matters regarding the appointment, employment, and compensation of public officials, to consider business sensitive trade secret matters required to be kept confidential by Federal and State statutes, and to discuss the purchase and sale of real property.

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

Attest:

Leslie H. Wexner
Chairman

Heather Link
Associate Secretary

ATTACHMENT VIII

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

FY16 YTD | Through September 2015

MEDICAL CENTER PERFORMANCE	FY15 Actual	FY16 YTD Actual	FY16 Target	Current Status	2020 Target
A. Quality and Service					
1. Quality and Patient Safety					
1a. Inpatient Mortality[1]	0.64	0.64	0.63	◆	Top 3 of UHC Hospitals
1b. PSI 90 (Patient Safety Index)[2]	0.64	0.66	0.62	◆	TBD
1c. Overall Readmissions[2]	13.2%	13.2%	11.9%	◆	TBD
1d. CAUTI (Standardized Infection Ratio)[3]	1.16	0.48	0.85	◆	TBD
2. Overall Patient Satisfaction[4]					
2a. Inpatient: HCAHPS	75.2%	77.3%	79.4%	▲	Top Decile
2b. Outpatient: CG-CAHPS/Physician Offices Satisfaction	90.8%	90.6%	96.0%	▼	Top Decile
2c. HCAHPS Doctor Communication	81.1%	82.3%	82.8%	◆	Top Decile
2d. HCAHPS Nurse Communication	80.3%	81.6%	81.0%	◆	Top Decile
B. Financial Viability					
1. Net Medical Center Operating Margin (and %)[5]	$201M (7.0%)	$62M (6.7%)	$222M (7.0%)	◆	TBD
2. Days Cash on Hand: Health System	87.3	99.3	92.5	▲	110.0
3. Days Cash on Hand: OSUP + College of Medicine	84.5	89.8	88.4	◆	80.5
C. Revenue Enhancement and Scale					
1. Health System Total Operating Revenue per Adjusted Admission	$21,839	$22,772	$23,289	▲	$24,419
2. Development Dollars (including OSP)	$124.7M	$23.2M	$137.0M	◆	$260.0M
D. Cost Management					
1. Health System Total Operating Expenses per Adjusted Admission	$18,850	$19,719	$20,211	▲	$21,951
2. Spending per Medicare Beneficiary[6]	0.998	0.998	0.980	◆	TBD
E. Research Excellence					
1. Total NIH Awards[7]	$95.9M	$23.9M	$97.0M	◆	TBD
F. Education Excellence					
1. USNWR Best Medical Schools Ranking	#31	Reported April 2016	#30	DATA PENDING	Top10 Public
G. Clinical Excellence					
1. USNWR Best Hospitals: Number of Specialties Ranked	7	Reported July 2016	10	DATA PENDING	11
2. USNWR Best Hospitals: Number of Specialties in Top 20	1	Reported July 2016	2	DATA PENDING	7
H. Talent Management					
1. Workforce Engagement: Staff[8]	NA	Reported January 2016	TBD	DATA PENDING	90th percentile

1 Inpatient Mortality data through August 2015
2 PSI 90 and Overall Readmissions data through June 2015 - New Metric
3 CAUTI=Catheter Associated Urinary Tract Infections- data through March 2015 - New Metric
4 Overall Patient Satisfaction data through August 2015. Doctor and Nurse Comm. new metrics
5 Net Operating Margin = combined margin of Health System, COM and OSUP - New Metric
6 Spending per Medicare Beneficiary data through December 2014 - New Metric
7 Total NIH Awards exclude Nationwide Children's awards
8 Workforce Engagement to be reported in Jan 2016

Meets or Exceeds Goal
Caution
Below Goal - Action Needed
Data Pending

▲ Performance Up from last Board report
◆ No Performance Change from last Board report
▼ Performance Down from last Board report

Data Definitions for Quality and Patient Safety Measures:

Inpatient Mortality: This measure is expressed as the observed (actual) mortality in the hospital (deaths per 100 patients), compared to the "expected" mortality rate for similar patients at academic medical centers in the United States who participate in the University HealthSystem Consortium's Clinical Data Base.

PSI 90 (Patient Safety Index): It is a composite measure that includes PSI 03 Pressure Ulcer Rate; PSI 06 Iatrogenic Pneumothorax Rate; PSI 07 Central Venous Catheter-Related Blood Stream Infection Rate; PSI 08 Postoperative Hip Fracture Rate; PSI 09 Perioperative Hemorrhage or Hematoma Rate; PSI 10

Overall Readmissions: Estimates of unplanned readmission for any cause to an acute care hospital within 30 days of discharge from a hospitalization.

CAUTI (Standardized Infection Ratio): Measures all patients anywhere in the hospital that develops a catheter-related urinary tract infection.

Inpatient HCAHPS: Percent of patients who gave the hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).

Outpatient: CG-CAHPS/Physician Offices Satisfaction: Shows the percentage of patients who asked "Would you recommend this provider's office to your family and friends?" answered 'Yes, definitely'.

HCAHPS Doctor Communication: How well did the doctors treat with courtesy and respect, listen carefully, explain things

HCAHPS Nurse Communication: How well did nurses treat with courtesy and respect, listen carefully, explain things, answer the call button

ATTACHMENT IX

The Ohio State University Wexner Health System
Consolidated Operating and Financial Highlights
FIRST QUARTER ENDING: SEPTEMBER 30, 2015

	ACTUAL	BUDGET	BUDGET % VAR	PRIOR YEAR	PY % VAR	ANNUAL BUDGET
Inpatient Admissions	15,050	15,295	-1.6%	14,729	2.2%	60,521
Patients in Beds including Obs Area	19,872	19,743	0.7%	19,048	4.3%	77,928
Patient Discharges	14,967	15,225	-1.7%	14,674	2.0%	60,325
Total Surgeries	10,424	10,152	2.7%	9,875	5.6%	41,873
Outpatient Visits	427,831	434,802	-1.6%	415,084	3.1%	1,736,297
ED Visits	33,740	32,494	3.8%	31,476	7.2%	127,433
Adjusted Admissions	27,943	28,465	-1.8%	27,166	2.9%	112,508
Oper. Rev. / Adjust. Admit	$ 22,772	$ 23,005	-1.0%	$ 20,337	12.0%	$ 23,289
Expense / Adj. Admit	$ 19,719	$ 19,844	0.6%	$ 17,432	-13.1%	$ 20,212
(in millions)						
Operating Revenues	$ 636.3	$ 654.8	-2.8%	$ 552.5	15.2%	$ 2,620.2
Total Expenses	$ 551.0	$ 564.9	2.5%	$ 473.6	16.4%	$ 2,274.0
Gain from Operations	$ 85.3	$ 89.9	-5.2%	$ 78.9	8.1%	$ 346.2
Excess Rev.Over Exp.	$ 87.2	$ 90.4	-3.5%	$ 78.9	10.5%	$ 347.7
Worked Hours per Adjust. Admit	197	194	-1.6%	181	-8.8%	194
Total Paid FTEs with Contract	11,914	12,059	1.2%	10,830	-10.0%	12,048
Case Mix Index - All Payor	1.801	1.780	1.2%	1.743	3.3%	2.026
			Y/E Target			
Operating EBIDA Margin	20.6%	20.7%	20.1%	18.1%		
Days Cash on Hand	99.3	97.2	92.5	77.0		
Debt Service Coverage	5.9	6.0	5.8	7.5		

Key for arrows:
Green - positive variance
Yellow - variance 0 to -5.0%
Red - variance worse than -5.1%

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

2

ATTACHMENT 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 2015 -2016

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 includes 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.

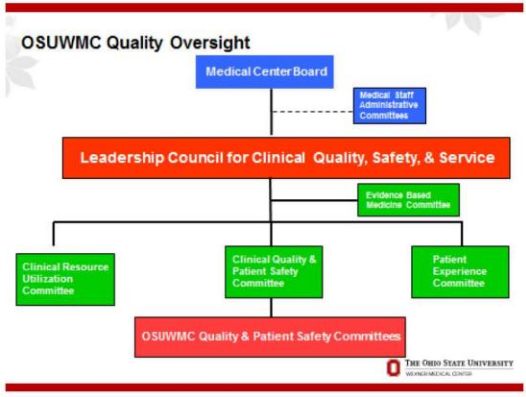
8) Provide appropriate levels of data transparency to both internal and external customers.

9) Assure processes involve an interdisciplinary teamwork approach.

10) Improve processes to prevent patient harm.

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 through the President and Executive Vice President (EVP) for Health Sciences and is responsible for overseeing the quality and safety 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.

Chief Quality and Patient Safety Officer (CQPSO)
The CQPSO 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. Associate Chief Quality and Patient Safety Officer supports the CQPSO in the development, implementation and measurement of OSUWMC's approach to quality, safety and service.

Associate Chief Quality and Patient Safety Officer
The Associate Chief Quality and Patient Safety Officer supports the CQPSO in the development, implementation and measurement of OSUWMC's approach to quality, safety and service.

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

Medical Director/Director of Medical Affairs
Each business unit Medical Director is responsible to the appropriate Board for the implementation and oversight of the Clinical Quality Management and Patient Safety Plan. 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 CQPSO 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.

Housestaff Quality Forum (HQF)

The Housestaff Quality Forum (HQF) was created in 2012 with support from the Medical Staff Administration Committee and the Graduate Medical Education Committee. The group is Executive Sponsored by Dr. Susan Moffatt-Bruce and Faculty Championed by Dr. Iahn Gonsenhauser.

The overarching theme of the group is: To provide post-graduate trainees an opportunity to participate in institutional QI/PS initiatives while incorporating the perspective of the frontline provider in the generation of institutional policy.

The HQF includes housestaff with an interest in leadership, process improvement and patient-safety and representation is required from all ACGME accredited residency training programs active at WMC by GME. HQF meets at regular intervals to discuss QI/PS activities, identify improvement needs and engage in professional review activities. The HQF has proven to be a viable and highly effective way to bridge the gap between residents and leadership and has created an open and active forum through which ideas can be passed bi-directionally between residents and leadership.

In addition the group creates resident leadership opportunities within the quality and administrative structure of the Wexner Medical Center, fosters peer to peer education, provides essential process improvement training, engages housestaff in improvement initiatives leading to publication and presentation at local and national meetings, and provides mentoring of medical students by current residents.

Leaders and frontline hospital staff, midlevel providers and managers from areas such as nursing, pharmacy, administration, quality and operations and information technology are frequently invited participants and presenters engaging with this group. The HQF reports directly to WMC medical administration through Clinical Quality and Patient Safety as well as through the office of medical administration, specifically Dr. Susan Moffatt-Bruce. HQF also reports directly to the Office of Graduate Medical Education through the DIO/Dean of GME and the GME board of program directors.

Past Projects:

Past HQF projects have focused on many issues presented in the LCCQSS goals: Reducing readmission rates, improving patient satisfaction, targeting hospital acquired infections including: C. difficile, CLABSI and SSI. Additional project focus will include projects specific to improving the Value Based Purchasing outcomes measures: timely post-op antibiotic discontinuation, VTE prophylaxis ordering consistently and improving discharge instruction inclusion rate. The group has also engaged in projects on the topics of interdisciplinary communication, patient transitions, fire-safety and more

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 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, pastoral care, team facilitation, and use of performance improvement tools, data collection, statistical analysis, and reporting. The Department also oversees the Patient and Family Experience 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 as advisory members on committees and workgroups, complete public speaking engagements and review materials.

COMMITTEES:

Medical Staff Administrative Committees (MSACs)

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 Director and the MSAC(s) for each institution, implements the Clinical Quality Management and Patient Safety Plan throughout the clinical departments.

The MSAC(s) reviews reports and recommendations related to clinical quality management, efficiency, patient safety and service quality activities. This committee has responsibility for evaluating the quality and appropriateness of clinical performance and service quality of all individuals with clinical privileges. The MSAC(s) reviews corrective actions and provides authority within their realm of responsibility related to clinical quality management, patient safety, efficiency, and service quality activities.

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 data, comments, letters and related measures.
3. Monitor publicly reported and other metrics used by various payers to ensure optimal reimbursement.
4. Recommend system goals and expectations for a consistent patient experience.
5. Collaborate with other departments to reward and recognize faculty and staff for service excellence performance.

6. Provide guidance and oversight on patient experience improvement efforts ensuring effective deployment and accountability throughout the system.
7. Serve as a communication hub reporting out objectives and performance to the system.
8. Serve as a coordinating body for subcommittees working on specific aspects of the patient experience.

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
- Availability of necessary services
- Timeliness of necessary services
- Appropriate use of necessary services

- Medical necessity and appropriateness of level of care and related denial management.

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 chaired by the Chief Quality and Patient Safety Officer. It is composed of the Chair of the Clinical Quality and Patient Safety Committee, physicians, and advanced practice licensed health care providers from various business units & clinical areas as appointed by the CMO & Physician in Chief s at the James. The Medical Center CMO & Physician-in-Chief at the James serves 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 State 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 and Patient Safety Officer, the Associate Executive Director for Quality & Patient Safety, a member of the Physician Executive Council, a member of the Nurse 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

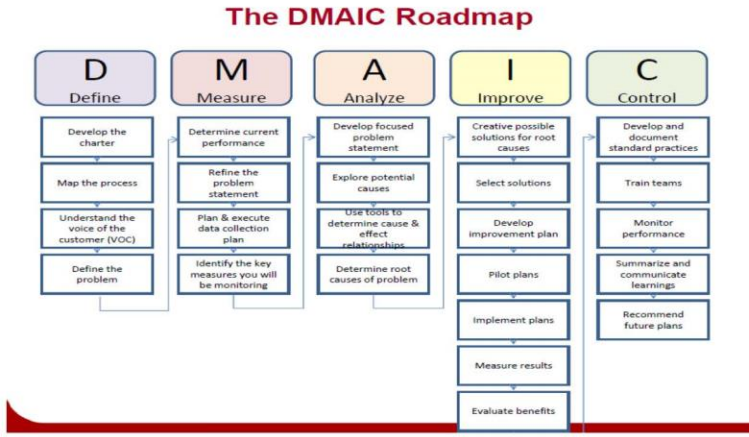
Systematic Approach/Model to Process Improvement

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 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.

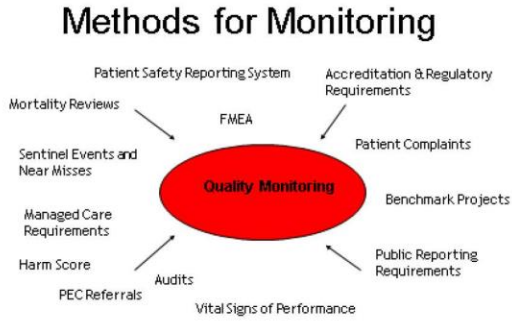
Conflict of Interest

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).

Vital Signs of Performance
The Vital Signs of Performance is an online dashboard available to everyone in the Medical Center with a valid user account. It shows Mortality, Length of Stay, and Readmission data over time and compared to goals and external benchmarks. The data can be displayed at the health system, business unit, clinical service, and nurse station level.

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 hospital or outpatient area. The dashboard covers performance in areas such as physician communication, nurse communication, 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 contained on the dashboard is shared in various forums with staff, clinicians, administration, including the Boards. Performance on many of these indicators serves 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)
- Patient Safety Lessons Learned
- Patient Safety Alerts

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, National Database of Nursing Quality Indicators, 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
- Department chairs have online access to physician profiles for their ongoing review
    - Individual physician access to their profiles will be rolled out in FY 2016
- 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 monitor and evaluate medical staff performance ensuring a competent medical staff
- To integrate medical staff performance data into the reappointment process and create the foundation for high quality care, safe, and efficacious care
- To provide periodic feedback and inform clinical department chairs of the comparative performance of individual medical staff
- To identify opportunities for improving the 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 2015-2016

Key Result Area: Quality

- Achieve all Infection Control Targets (top quartile)
  - Reduce SSIs 24%
  - Reduce CLABSIs 12%
  - Reduce CAUTIs 15%
  - Reduce C Diff 5%
- Improve UHC risk adjusted mortality index to 0.63
- Improve UHC risk adjusted sepsis mortality index to 0.80
- Reduce Total PSIs (all payers) 10%
- Reduce US News & World PSIs 10%
- Reduce PE/DVT PSI 15%
- Reduce medication safety (Opiod related events) 25%
- Utilize medication safety trigger tools to increase harm detection by 50%
- Hand Hygiene Compliance $\geq$ 95%

Key Result Area: Productivity and Efficiency

- Achieve the UHC Top decile for 30 day readmission rates in Knee/Hip Replacements
- Achieve the UHC top quartile for 30 day readmission rates in Heart Failure and AMI
- Achieve the UHC median for 30 day readmission rates in Pneumonia, and COPD
- 10% reduction in overall readmission rate
- Achieve VBP Medicare Beneficiary points

Key Result Area: Service and Reputation

- Achieve Top Decile HCAPS overall satisfaction of 79.4%
- Achieve Top Decile HCAPS doctor communication of 85.2%
- Achieve Top Decile CGCAHPS of 96%
- Achieve Top Decile CGCAHPS test results of 94%

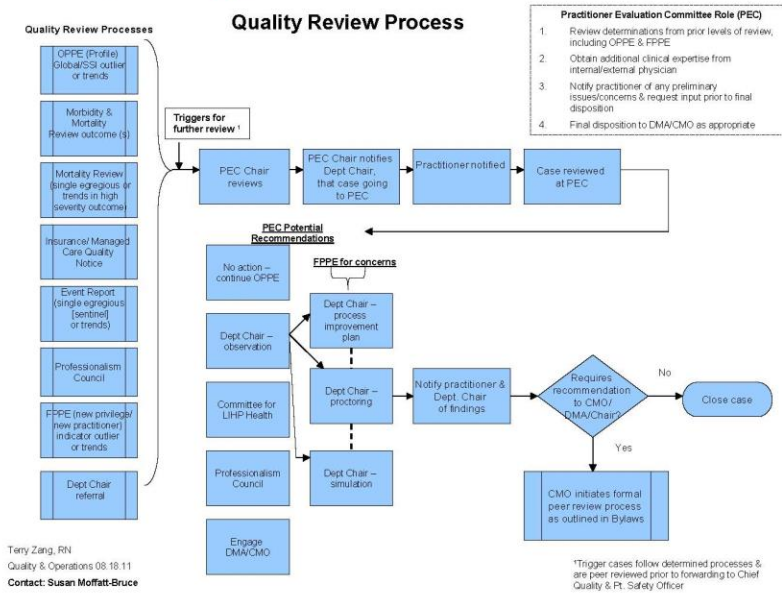
James Priorities for 2016 to be inserted here – currently under review

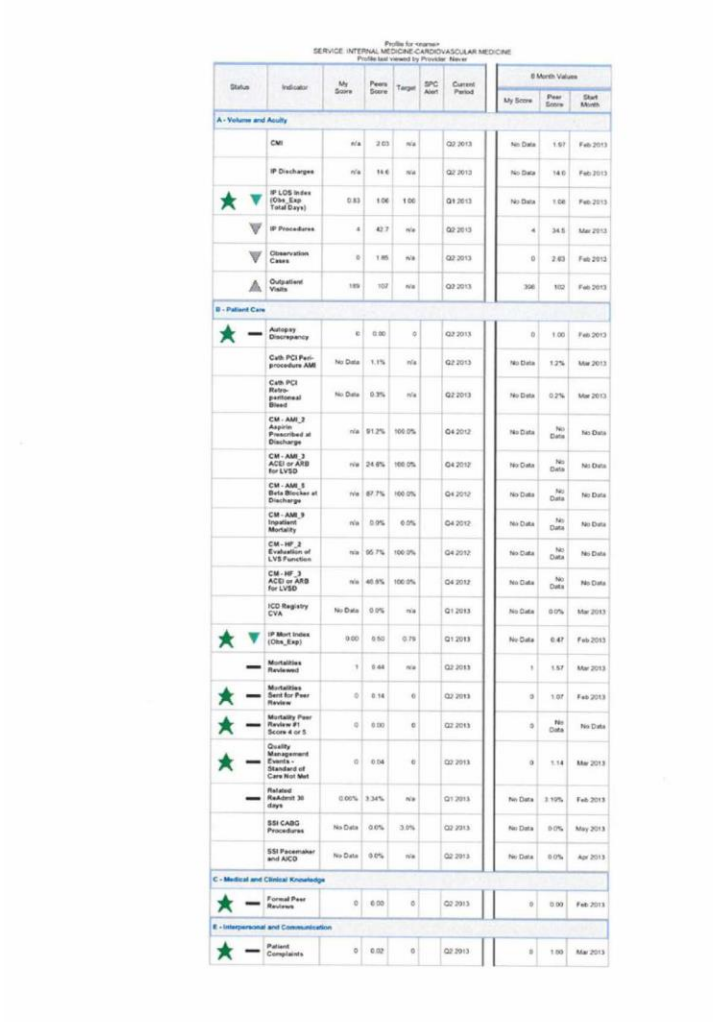
Attachment II: Priority Criteria

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)

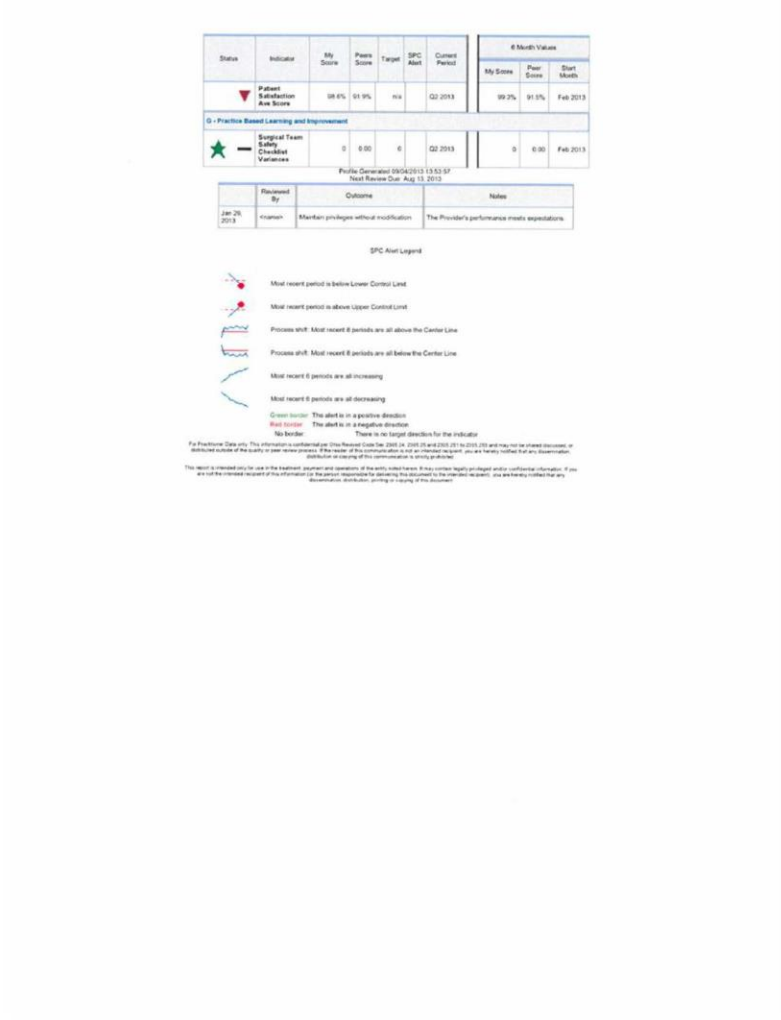
Attachment III: Physician Performance Based Profile





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	14.6	Feb 2013
★ ▼	IP LOS Index (Obs_Exp Total Days)	0.83	1.06	1.06		Q1 2013	No Data	1.06	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	2.83	Feb 2012
▲	Outpatient Visits	189	107	n/a		Q2 2013	396	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-peritoneal Bleed	No Data	0.3%	n/a		Q2 2013	No Data	0.2%	Mar 2013
	CM - AMI_3 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	0.9%	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	46.9%	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	3.10%	Feb 2013
	SSI CABG Procedures	No Data	0.6%	3.0%		Q2 2013	No Data	0.0%	May 2013
	SSI Pacemaker and AICD	No Data	0.6%	n/a		Q2 2013	No Data	0.0%	Apr 2013
C - Medical and Clinical Knowledge									
★ —	Formal Peer Reviews	0	6.00	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 13:52:57
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:

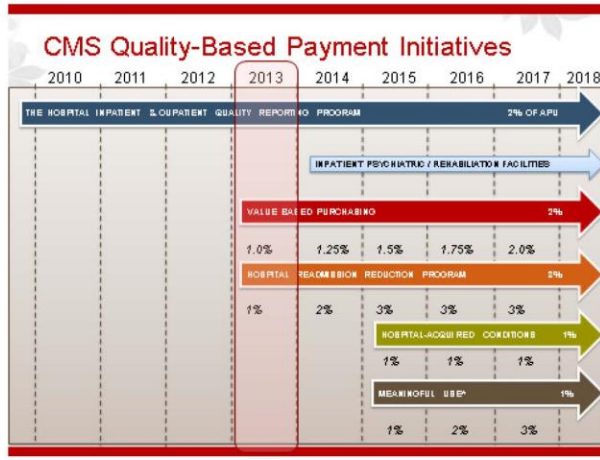
- Culture of safety
- Performance monitoring and improvement
- Regulatory and accreditation
- Event reporting
- Sentinel events
- Education
- Innovation
- Recognition

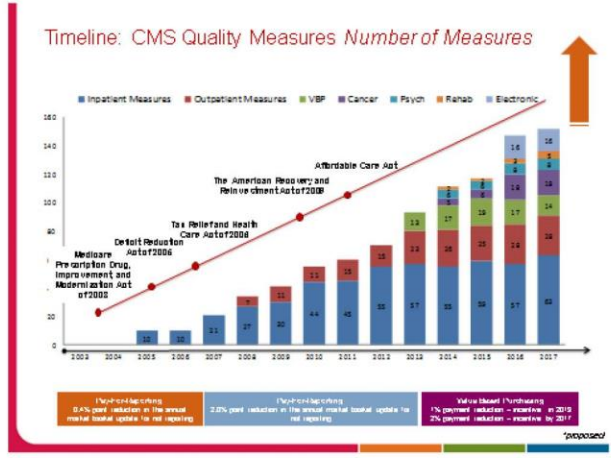
Attachment V: External Reporting

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


CMS Quality-Based Payment Initiatives
2010
2011
2012
2013
2014
2015
2016
2017
2018
THE HOSPITAL INPATIENT & OUTPATIENT QUALITY REPORTING PROGRAM
2% OF APU
INPATIENT PSYCHIATRIC / REHABILITATION FACILITIES
VALUE BASED PURCHASING
2%
1.0%
1.25%
1.5%
1.75%
2.0%
HOSPITAL READMISSION REDUCTION PROGRAM
1%
2%
3%
3%
3%
HOSPITAL-ACQUIRED CONDITIONS
1%
1%
1%
1%
MEANINGFUL USE*
1%
1%
2%
3%


Timeline: CMS Quality Measures Number of Measures
Inpatient Measures
Outpatient Measures
VBP
Cancer
Psych
Rehab
Electronic
Medicare Prescription Drug, Improvement and Modernization Act of2003
Deficit Reduction Act of2006
Tax Relief and Health Care Act of2006
The American Recovery and Reinvestment Act of2009
Affordable Care Act
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
*proposed

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 (≥ Stage II)
Central Line Blood Stream Infections
Ventilator Associated Events (Probable)
Hospital Acquired Surgical Site Infections
Hospital Acquired Clostridium Difficile Infection
Catheter Associated Urinary Tract Infections (UH/UHE ICUs)
Total Potentially Avoidable Events

ATTACHMENT XI

Bylaws Committee: August 4, 2015
MSAC: August 12, 2015
UH Medical Staff Vote: August 21, 2015
Quality & Professional Affairs Committee: August 25, 2015
Wexner MC Board:
University Board of Trustees:

Chapter 3335-43 *Bylaws of the Medical Staff* of The Ohio State University Hospitals

3335-43-04 Membership.

(G) Resumption of clinical activities following leave of absence.

(2) The member must submit a written request for the reinstatement of clinical privileges to the chief of the clinical service. The chief of the clinical service shall forward his recommendation to the credentialing committee which, after review and consideration of all relevant information, shall forward its recommendation to the medical staff administrative committee and quality and professional affairs committee of the Wexner medical center board. The credentials committee, the chief medical officer, the chief of the clinical service or the medical staff administrative committee shall have the authority to require any documentation, including advice and consultation from the member's treating physician or the committee for ~~licensed independent~~ practitioner health that might have a bearing on the medical staff member's ability to carry out the clinical and educational responsibilities for which the medical staff is seeking privileges. Upon return from a leave of absence for medical reasons the medical staff member must demonstrate his or her ability to exercise his or her clinical privileges upon return to clinical activity.

3335-43-05 Peer Review and corrective action.

(B) Formal Peer Review

(4) The ~~senior~~ executive vice president for health sciences or designee shall exercise any or all duties or responsibilities assigned to the chief medical officer under these rules for implementing corrective action and appellate procedure if:

3335-43-06 Hearing and appeal process.

(E) Appeal process

(7) Any final decision by the Wexner medical center board shall be communicated by the chief medical officer and by certified return receipt mail to the affected medical staff member at that member's last known address as determined by university records. The chief medical officer shall also notify in writing the ~~senior~~ executive vice president for health sciences, the dean of the college of medicine, the chief executive officer of the Ohio state university hospitals and the vice president for health services, chief of staff, the chief of the clinical department, and the person(s) who initiated the request for formal peer review. The chief medical officer shall take immediate steps to implement the final

decision.

(B/T 6/7/2002, B/T 5/6/2005, 2/1/2008, 9/19/2008, 9/18/2009, 5/14/2010, 4/8/2011)

3335-43-07 Categories of the medical staff

(I) Clinical privileges.

(8) Other licensed health care professionals.

(k) Appeal process

(vii) Any final decision by the Wexner medical center board shall be communicated by the chief quality officer and by certified return receipt mail to the last known address of the licensed health care professional as determined by university records. The chief quality officer shall also notify in writing the ~~senior~~ executive vice president for health sciences, the dean of the college of medicine, the chief executive officer of the Ohio state university hospitals and the vice president for health services and the chief of the applicable clinical department or departments. The chief medical officer shall take immediate steps to implement the final decision.

3335-43-10 Administration of the medical staff of the Ohio state university hospitals.

(B) Chief Quality Officer

The chief quality and patient safety officer of the Ohio state university medical center is referred to herein these bylaws as the chief quality officer. The chief quality officer reports to the chief medical officer for administrative and operational issues and has an independent reporting relationship to the ~~senior~~ executive vice president for health sciences regarding quality data and patient safety events. The chief quality officer works collaboratively with clinical leadership of the medical center, including the director of medical affairs for the James cancer hospital, nursing leadership and hospital administration. The chief quality officer provides leadership in the development and measurement of the medical center's approach to quality, patient safety and reduction of adverse events. The chief quality officer communicates and implements strategic, operational and programmatic plans and policies to promote a culture where patient safety is an important priority for medical and hospital staff.

(E) Medical staff administrative committee.

(1) Composition.

(a) This committee shall consist of the following voting members: chief of staff, chief of staff-elect, chiefs of the clinical departments, three medical staff representatives elected at large, the chief medical officer, and the chief executive officer of the Ohio state university hospitals. Additional members may be appointed to the medical staff administrative committee at the recommendation of the dean or the chief medical officer of the medical center subject to the approval of the medical staff administrative committee and subject to review/renewal on a yearly basis. Any members may be removed from the medical

staff administrative committee at the recommendation of the dean, the ~~senior~~ executive vice president for health sciences or the chief medical officer of the medical center and subject to the review and approval of the medical staff administrative committee. A replacement will be appointed as outlined above to maintain the medical staff administrative committee's constituency. The chief medical officer shall be the chairperson and the chief of staff shall be vice-chairperson.

(G) Committee for ~~licensed independent~~ practitioner health.

(L) Leadership council for clinical quality, safety and service.

(1) Composition:

The leadership council shall consist of members appointed in accordance with paragraph (A)(6) of rule 3335-43-09 of the Administrative Code, and shall include the ~~senior~~executive vice president for health sciences, the dean of the college of medicine and the chairperson of the quality and professional affairs committee of the Wexner medical center board as ex-officio members without a vote. The chief quality officer shall be the chairperson of the leadership council.

3335-43-11 History and physical.

(A) History and physical examination.

(1) A history and physical appropriate to the patient and/or the procedure to be completed shall be documented in the medical record of all patients either:

(a) Admitted to the hospital

(b) Undergoing outpatient/ambulatory procedures

(c) Undergoing outpatient/ambulatory surgery

(d) In a hospital-based ambulatory clinic

(2) For patients admitted to the hospital, the history and physical examination shall include at a minimum:

(a) Date of admission

(b) History of present illness, including chief complaint

(c) Past medical and surgical history

(d) Relevant past social and family history

(e) Medications and allergies

(f) Review of systems

(g) Physical examination

(h) Test results

(i) Assessment or impression

(j) Plan of care

(2) For patients undergoing outpatient/ambulatory procedures or outpatient/ambulatory surgery, the history and physical examination shall include at a minimum:

(a) Indications for procedure or surgery

(b) Relevant medical and surgical history

(c) Medications and allergies or reference to current listing in the medical record

(e) Focused review of systems, as appropriate for the procedure or surgery

(e) Pre-procedure assessment and physical examination

(f) Assessment/impression and treatment plan

(4) For patients seen in a hospital-based ambulatory clinic, the history and physical shall include at a minimum:

(a) Chief complaint

(b) History of present illness

(c) Medications and allergies

(d) Problem-focused physical examination

(e) Assessment or impression

(f) Plan of care

(5) Deadlines and sanctions.

(a) ~~A history and physical examination is performed on all patients, both inpatient and outpatient, regardless of whether the medical treatment or procedure is high or low risk. The~~A history and physical examination must be performed by a member of the medical staff~~,~~ ~~or~~ his/her designee or other licensed health care professional, who is appropriately credentialed by the hospital, and be signed, timed and dated. ~~In the event the history and physical is performed by the medical staff member's designee, it shall be countersigned, timed and dated by the responsible medical staff member.~~

(b) Patients admitted to the hospital: If the history and physical is performed by the medical staff member's designee or other licensed health care professional who is appropriately credentialed by the hospital, the history and physical must be countersigned by the responsible medical staff member.

~~(b)~~(c) The complete history and physical examination shall be dictated, written or updated no later than twenty-four hours after admission for all inpatients.

(~~c~~d) ~~For a~~Admitted patients or patients undergoing ~~a an outpatient/ambulatory~~ procedure or ~~outpatient/ambulatory~~ surgery, the history and physical examination may be performed or updated up to thirty days prior to admission or the procedure/surgery. If completed before admission or the procedure/surgery, there must be a notation documenting an examination for any changes in the patient's condition since the history and physical was completed. The updated examination must be completed and documented in the patient's medical record within twenty-four hours after admission or before the procedure/surgery, whichever occurs first. It must be performed by a member of the medical staff, ~~or~~ his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital, and be signed, timed and dated. In the event the history and physical update is performed by the medical staff member's designee or other licensed health care professional who is appropriately credentialed by the hospital, it shall be countersigned, timed and dated by the responsible medical staff member.

(i) For patients undergoing an outpatient procedure or surgery, regardless of whether the treatment, procedure or surgery is high or low risk, a history and physical examination must be performed by a member of the medical staff, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital and must be signed or countersigned when required, timed and dated.

(ii) If a licensed health care professional is appropriately credentialed by the hospital to perform a procedure or surgery independently, a history and physical performed by the licensed health care professional prior to the procedure or surgery is not required to be countersigned.

(e) ~~H~~Hospital-based ambulatory clinic: If a history and physical examination is performed by a licensed health care professional who is appropriately credentialed by the hospital to see patients independently, the history and physical is not required to be countersigned.

(~~d~~f) When the history and physical examination, ~~signed by the responsible medical staff member,~~ including the results of indicated laboratory studies and x-rays, is not recorded in the medical record before the time stated for a procedure or surgery, the procedure or surgery cannot proceed until the history, and physical is signed or countersigned when required, by the responsible medical staff member, and indicated test results are entered into the medical record. In cases where such a delay would likely cause harm to the patient, this condition shall be entered into the medical record by the ~~attending~~ responsible medical staff member, ~~or~~his/her designee or other licensed health care professional, who is appropriately credentialed by the hospital, and the procedure or surgery may begin. When there is a disagreement concerning the urgency of the procedure, it shall be adjudicated by the medical director or the medical director's designee. (B/T 10, 29/2009, 8/31/12)

(~~e~~g) Ambulatory patients must have a history and physical at the initial visit as outlined in A(4).

(h) For psychology, psychiatric and substance abuse ambulatory sites, if no other acute or medical condition is present on the initial visit, a history and physical examination may be performed either:

i. within the past six months prior to the initial visit,

ii. at the initial visit, or

iii. within 30 days following the initial visit.

ATTACHMENT XII

Bylaws Committee: August 4, 2015
MSAC: August 14, 2015
CHRI Medical Staff Vote: August 21, 2015
Quality & Professional Affairs Committee: August 25, 2015
Wexner MC Board:
University Board of Trustees:

***Chapter 3335-111 Bylaws of the Medical Staff* of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute**

3335-111-04 Membership

(G) Resumption of clinical activities following a leave of absence:

(2) The member must submit a written request for the reinstatement of clinical privileges to the chief of the clinical service. The chief of the clinical service shall forward his recommendation to the credentialing committee which, after review and consideration of all relevant information, shall forward its recommendation to the medical staff administrative committee and quality and professional affairs committee of the Wexner medical center board. The credentials committee, the chief medical officer, the chief of the clinical service or the medical staff administrative committee shall have the authority to require any documentation, including advice and consultation from the member's treating physician or the committee for ~~licensed independent~~ practitioner health that might have a bearing on the medical staff member's ability to carry out the clinical and educational responsibilities for which the medical staff is seeking privileges. Upon return from a leave of absence for medical reasons the medical staff member must demonstrate his or her ability to exercise his or her clinical privileges upon return to clinical activity.

3335-111-05 Peer review and corrective action.

(B) Formal peer review.

(4) Whenever the director of medical affairs determines that formal peer review is warranted and that a reduction, suspension or revocation of clinical privileges could result, the director of medical affairs shall refer the request for formal peer review to the formal peer review committee. The affected member of the medical staff shall be notified of the referral to the formal peer review committee, and be informed that these medical staff bylaws shall govern all further proceedings. The ~~senior~~executive vice president for health sciences or designee shall exercise any or all duties or responsibilities assigned to the director of medical affairs under these rules for implementing corrective action and appellate procedure only if:

(a) The director of medical affairs is the medical staff member charged;

(b) The director of medical affairs is responsible for having the charges brought against another medical staff member; or

(c) There is an obvious conflict of interest.

(6) Upon receipt of the written report from the formal peer review committee, the appropriate clinical department chief shall, within seven days, make his or her own written determination and forward that determination along with the findings and recommendations of the formal peer review committee to the director of medical affairs, or if required by paragraph (B)(3) of this rule, to the ~~senior~~executive vice president for health sciences or designee.

(7) Following receipt of the recommendation from the clinical department chief and the report from the formal peer review committee, the director of medical affairs, or the ~~senior~~ executive vice president for health sciences or designee, shall have ten days to approve or to modify the determination of the clinical department chief. Following receipt of the report of the clinical department chief, the director of medical affairs or ~~senior~~ executive vice president for health sciences or designee shall decide whether the grounds for the requested corrective action are such as should result in a reduction, suspension or revocation of clinical privileges. If the director of medical affairs, or ~~senior~~ executive vice president for health sciences or designee, decides the grounds are not substantiated, the director of medical affairs will notify the formal peer review committee; clinical department chief and if applicable, the academic department chairperson; section chief; person(s) who filed the complaint and the affected medical staff member, in writing, that no further action will be taken.

In the event the director of medical affairs or ~~senior~~ executive vice president for health sciences or designee finds the grounds for the requested corrective action are substantiated, the director of medical affairs shall promptly notify the affected medical staff member of that decision and of the affected medical staff member's right to request a hearing before the medical staff administrative committee pursuant to rule 3335-111-06 of the Administrative Code. The written notice shall also include a statement that the medical staff member's failure to request a hearing in the timeframe prescribed in rule 3335-111-06 of the Administrative Code shall constitute a waiver of rights to a hearing and to an appeal on the matter; a statement that the affected medical staff member shall have the procedural rights found in rule 3335-111-06 of the Administrative Code; and a copy of the rule 3335-111-06 of the Administrative Code. This notification and an opportunity to exhaust the administrative hearing and appeal process shall occur prior to the imposition of the proposed corrective action unless the emergency provisions outlined in paragraph (D) of this rule apply. This written notice by the director of medical affairs shall be sent certified return receipt mail to the affected medical staff member's last known address as determined by university records.

3335-111-06 Hearing and appellate review procedure.

(E) Appeal process.

(7) Any final decision by the Wexner medical center board shall be communicated by the chief executive officer by certified return receipt mail to the affected medical staff member at the member's last known address as determined by university records. The chief executive officer shall also notify in writing the ~~senior~~ executive vice president for health sciences, the dean of the college of medicine, the chief medical officer of OSU medical center, the vice president for health services, the director of medical affairs, chief of staff, the section chief, clinical department chief and the academic department chairperson and the person(s) who initiated the request for formal peer review. The chief executive officer shall take immediate steps to implement the final decision.

3335-111-07 Categories of the medical staff.

(A) Honorary staff.

The honorary staff will be composed of those individuals who are recognized for outstanding reputation, notable scientific and professional contributions, and high professional stature in an oncology field of interest. The honorary staff designation is awarded by the Wexner medical center board on the recommendation of the chief executive officer of the CHRI, ~~senior~~ executive vice president for health sciences, section chief, or the credentials committee after approval by the medical staff administrative committee. This is a lifetime appointment. Honorary staff are not entitled to patient care privileges.

3335-111-08 Organization of the CHRI medical staff.

(A) The chief executive officer.

(1) Method of appointment:

The chief executive officer shall be appointed by the board of trustees of the Ohio state university upon recommendation of the president, ~~senior~~ executive vice president for health sciences, and the vice president for health services following consultation with the medical center board in accordance with university bylaws, rules and regulations. The chief executive officer shall be a member of the attending medical staff of the CHRI.

(B) The director of medical affairs (physician-in-chief/chief medical officer of the James cancer hospital).

(1) Method of appointment:

The director of medical affairs shall be appointed by the ~~senior~~ executive vice president for health sciences upon recommendation by the chief executive officer. The director of medical affairs is the physician-in-chief and shall be the chief medical officer of the CHRI and must be a member of the attending medical staff of the CHRI.

(2) Responsibilities:

The director of medical affairs shall be responsible to the chief executive officer, the ~~senior~~ executive vice president for health sciences, the CHRI hospital board, and the medical center board for the quality of patient care provided in the CHRI. The director of medical affairs shall assist the chief executive officer in the administration of medical affairs including quality assurance and credentialing.

(D) The chief quality officer of the Ohio state university medical center.

The chief quality and patient safety officer of the Ohio state university medical center is referred to herein these bylaws as the chief quality officer. The chief quality officer reports to the chief medical officer for administrative and operational issues and has an independent reporting relationship to the ~~senior~~ executive vice president for health sciences regarding quality data and patient safety events. The chief quality officer works collaboratively with clinical leadership of the medical center, including director of medical affairs for the CHRI, nursing leadership and hospital administration. The chief quality officer provides leadership in the development and measurement of the medical center's approach to quality, patient

safety and reduction of adverse events. The chief quality officer communicates and implements strategic, operational and programmatic plans and policies to promote a culture w here patient safety is an important priority for medical and hospital staff.

3335-111-10 Administration of the medical staff of the CHRI.

(C) Medical staff administrative committee:

(1) Composition:

(b) Ex-officio non-voting membership includes: the CHRI executive director, the CHRI associate director for professional education, the CHRI chief nursing officer, the medical director of university hospital and/or the chief medical officer of the medical center, the dean of the Ohio state university college of medicine, the ~~senior~~ executive vice president for health sciences and the associate director for medical staff affairs.

(e) Any members may be removed from the medical staff administrative committee at the recommendation of the dean of the college of medicine, the director of medical affairs or the ~~senior~~ executive vice president for health sciences and subject to the review and approval of the medical staff administrative committee. A replacement w ill be appointed as outlined above to maintain the medical staff administrative committee's composition as stated in this paragraph.

(G) Committee for ~~licensed independent~~ practitioner health.

3335-111-11 History and physical.

(B) Deadlines and sanctions

1) ~~A history and physical examination is performed on all patients, both inpatient and outpatient, regardless of w hether the medical treatment or procedure is high or low risk. The~~A history and physical examination must be performed by a member of the medical staff, ~~or~~ his/her designee or other licensed healthcare professional, ~~,~~ w ho is appropriately credentialed by the hospital, and be signed, dated and timed. ~~In the event the history and physical is performed by the medical staff member's designee w ho is appropriately credentialed by the hospital, it shall be countersigned, dated and timed by the responsible medical staff member.~~

(2) Patients admitted to the hospital: If the history and physical is performed by the medical staff member's designee or other licensed healthcare professional w ho is appropriately credentialed by the hospital, the history and physical must be countersigned by the responsible medical staff member.

~~(~~3~~)~~ The complete history and physical examination shall be dictated, w ritten or updated no later than 24 hours after admission for all inpatients. ~~A summary of pertinent findings must be recorded in the patient's medical record at the time of dictation. In the event the history and physical examination is performed by an appropriately credentialed physician~~

~~designee, it shall be countersigned by the responsible medical staff member.~~

(~~3~~4) ~~For a~~Admitted patients or patients undergoing ~~an outpatient/ambulatory~~ a procedure or ~~outpatient/ambulatory~~ surgery, the history and physical examination may be performed or updated up to thirty days prior to admission, or the procedure/surgery ~~or the visit~~. If completed before admission or the procedure~~/surgery or patient's initial visit~~, there must be a notation ~~indication~~ documenting ~~the presence or absence~~ an examination for ~~of~~ any changes in the patient's condition since the history and physical was completed. ~~This notation~~The updated examination must be completed and documented in the patient's medical record within 24 hours after admission, or before the procedure/surgery, whichever occurs first. ~~The update~~It must be performed by a member of the medical staff, his/her designee, or other licensed health care professional ~~with~~who is appropriately credential~~s~~ed by the hospital, and be signed, dated and timed. In the event the history and physical update is performed by the medical staff member's designee or other licensed health care professional who is appropriately credentialed by the hospital, it shall be countersigned, dated and timed by the responsible medical staff member.

(a) For patients undergoing an outpatient procedure or surgery, regardless of whether the treatment, procedure or surgery is high or low risk, a history and physical examination must be performed by a member of the medical staff, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital and must be signed or countersigned when required, timed and dated.

(b) If a licensed health care professional is appropriately credentialed by the hospital to perform a procedure or surgery independently, a history and physical performed by the licensed health care professional prior to the procedure or surgery is not required to be countersigned.

(5) Hospital-based ambulatory clinic: If a history and physical examination is performed by a licensed health care professional who is appropriately credentialed by the hospital to see patients independently, the history and physical is not required to be countersigned.

(46) When the history and physical examination including the results of indicated laboratory studies and x-rays is not recorded in the medical record before the times stated for a procedure or surgery, the procedure or surgery cannot proceed until the history and physical is signed or countersigned, when required, by the responsible medical staff member, and indicated test results are entered into the medical record. In cases where such a delay would likely cause harm to the patient, this condition shall be entered into the medical record by the responsible medical staff member, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital, and the procedure or surgery may begin. When there is disagreement concerning the urgency of the procedure, it shall be adjudicated by the medical director or the medical director's designee.

(6) Ambulatory patients must have a history and physical at the initial visit.

(75) For psychology, psychiatric and substance abuse ambulatory sites, if no other acute or medical condition is present on the initial visit, a history and physical examination may be performed either:

(a) within the past six months prior to the initial visit,

(b) at the initial visit, or

(c) within 30 days following the initial visit.

(Board approval dates: 5/14/2010, 6/6/2014, 11/7/2014)

ATTACHMENT XIII

OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER BOARD BYLAWS

Chapter 3335-93 Establishment of the Ohio state university medical center board

3335-93-05 Meetings and notice.

(A) Board year. The board year~~, including board member appointments and board officer terms,~~ shall be from May fourteenth to May thirteenth of each year to coincide with the terms of membership of the university board of trustees as articulated in section 3335.02 of the Revised Code.

(B) through (E) No change

Chapter 3335-97 Committees

3335-97-03 Quality and Professional Affairs Committee.

(A) Responsibilities. The quality and professional affairs committee shall be responsible for the following specific duties:

(1) Reviewing and evaluating the patient safety and quality improvement programs of the university Wexner medical center;

(2) Overseeing all patient care activity in all facilities that are a part of the university Wexner medical center, including, but not limited to, the hospitals, clinics, ambulatory care facilities, and physicians' office facilities;

(3) Monitoring quality assurance performance in accordance with the standards set by the university Wexner medical center;

(4) Monitoring the achievement of accreditation and licensure requirements;

(5) Reviewing and recommending to the university Wexner medical center board changes to the medical staff bylaws and medical staff rules and regulations;

(6) Reviewing and approving clinical privilege forms~~;~~

~~(6)~~(7) Reviewing and approving membership and granting appropriate clinical privileges for the credentialing of practitioners recommended for membership and clinical privileges by the university hospitals medical staff administrative committee and the James medical staff administrative committee;

~~(7)~~(8) Reviewing and approving membership and granting appropriate clinical privileges for the expedited credentialing of such practitioners that are eligible by satisfying minimum approved criteria as determined by the university Wexner medical center board and are recommended for membership and clinical privileges by the university hospitals medical staff administrative committee and the James medical staff administrative committee;

~~(8)~~(9) Reviewing and approving reinstatement of clinical privileges for a practitioner after a leave of absence from clinical practice;

~~(9)~~(10) Conducting peer review activities and recommending professional review actions to the university Wexner medical center board;

~~(10)~~(11) Reviewing and resolving any petitions by the medical staffs for amendments to any rule, regulation or policy presented by the chief of staff on behalf of the medical staff pursuant to the medical staff bylaws and communicating such resolutions to the university hospitals medical staff administrative committee and the James medical staff administrative committee for further dissemination to the medical staffs; and

~~(11)~~(12) Such other responsibilities as assigned by the chair of the university Wexner medical center board.

(B) Composition. The committee shall consist of: no fewer than four voting members of the university Wexner medical center board, appointed annually by the chair of the university Wexner medical center board, one of whom shall be appointed as chair of the committee. The chief medical officer of the medical center; the director of medical affairs of the James; the medical director of credentialing for the James; the chief of the medical staff of the university hospitals; the chief of the medical staff of the James; ~~and~~ the associate dean of graduate medical education; the chief quality and patient safety officer; the chief nurse executive for the OSU health system; and the chief nursing officer for the James shall serve as ex-officio, voting members. Such other members may be appointed by the chair of the university Wexner medical center board, in consultation with the chair of the quality and professional affairs committee.

(C) Review and Recommendation. The chief medical officer of the medical center and the chief of the medical staff of university hospitals shall present and make recommendations to the quality and professional affairs committee only with respect to those actions involving the university hospitals. The director of medical affairs of the James, the medical director of credentialing for The James and chief of the medical staff of The James shall present and make recommendations to the quality and professional affairs committee only with respect to those actions involving The James.

(D) Voting. With respect to items coming before the quality and professional affairs committee as detailed in paragraph (A) of this rule, at least two voting, non-public members of the University Wexner Medical Center Board must be present. Any action taken by this Committee pursuant to the responsibilities as defined in Section 3335-97-03(A)(1) to (A)(11) of the Administrative Code shall be taken only by the voting, non-public, committee members and approved by a majority vote thereof. The chief quality and patient safety officer shall recuse themselves from voting on matters defined in Section 3335-97-03(A)(7) and (A)(10).

(E) Meetings. The committee shall meet at least bimonthly (six times per calendar year, typically in the even numbered months) or at the call of the chair of the committee and shall advise the university Wexner medical center board of its activities regularly. The committee shall act on behalf of the university Wexner medical center board in order to maintain the continuity of operations of the hospitals of the Ohio state university and the university hospitals and the James medical staffs; to review and to approve medical staff membership and to grant appropriate clinical privileges for practitioners in accordance with applicable laws, accreditation requirements, bylaws and rules established by the university board of trustees, university Wexner medical center board and university hospitals and the James

medical staffs. Meetings shall be conducted in accordance with the state laws of Ohio and open meetings laws.

(Board approval dates: 8/30/2013, 11/08/2013)

ATTACHMENT XIV

Project Data Sheet for Board of Trustees Approval

300 W 10th Avenue - Brain and Spine

OSU-130683 (CNI# 14000439)

Project Location: 300 W 10th Avenue (former James Cancer Hospital) *265,423 GSF*

- approval requested and amount
  prof s ervices/construction increase $3.3M

- project budget

	Orig.	Incr.	Rev
professional s ervices	$1.1M	$0.4M	$1.5M
construction w/contingency	$13.2M	$2.9M	$16.1M
total project budget	$14.3M	$3.3M	$17.6M

- project funding
  - ☒ university debt
  - ☐ development funds
  - ☐ university funds
  - ☒ auxiliary funds
  - ☐ state funds

- project schedule

BoT professional s ervices approval	01/15
BoT construction approval	08/15
design/bidding	02/15 – 11/15
construction	12/15 – 11/16

- project delivery method
  - ☐ general contracting
  - ☐ design/build
  - ☒ construction manager at risk

- planning framework
  - this is a signature project backfilling spaces vacated as a result of the expansion of the Ohio State University Wexner Medical Center
  - this project is included in the FY 2015 Capital Improvement Plan

- project scope
  - the project will renovate 59,000 GSF on three floors to house the inpatient component of a Brain and Spine Hospital, approximately 90 private inpatient beds. This capacity includes epilepsy monitoring beds, progressive care beds, a neuro "safe" unit, and the acute rehabilitation clinically necessary to support the Brain and Spine Hospital.
  - upgrades include an exterior building sign and lobby modification required for the program's image and branding
  - additional scope includes the development of exterior improvements including the main entry canopy for patient pick-up and drop-off, improved roadway system, courtyard and supporting utilities; and extending chilled water infrastructure for future connectivity

- approval requested
  - approval is requested to increase construction contracts in the amount of $2.9M and professional services contracts in the amount of $0.4M for a total increase of $3.3M

- project team

University project manager:	Paul Lenz
AE/design architect:	Design Group
CM at Risk:	Whiting-Turner Contracting Co.

Office of Administration and Planning — November 2015

Project Data Sheet for Board of Trustees Approval

300 W 10th Avenue - 7th Floor - design only

OSU-160277 (CNI#13000186)

Project Location: 300 W 10th Avenue (former James Cancer Hospital) *265,423 GSF*

- approval requested and amount
  prof services $0.5M
- project budget

professional services	$0.5M
construction w/contingency	$4.6M
total project budget	$5.1M

- project funding
  - ☐ university debt
  - ☐ development funds
  - ☐ university funds
  - ☒ auxiliary funds
  - ☐ state funds
- project schedule
  BoT professional services approval 11/15
- project delivery method
  - ☐ general contracting
  - ☐ design/build
  - ☐ construction manager at risk
- planning framework
  - this is a signature project backfilling spaces vacated as a result of the expansion of the Ohio State University Wexner Medical Center
  - this project is included in the FY 2016 Capital Improvement Plan
- project scope
  - the project will renovate the seventh floor to create private beds
  - adds 29 in-patient beds, nursing cores and support areas
- approval requested
  - approval is requested to enter into professional services contracts

- project team
  University project manager: Paul Lenz
  AE/design architect

Office of Administration and Planning November 2015

Project Data Sheet for Board of Trustees Approval

University Hospital - Relocate Surgical Pathology - design only

OSU-150403 (CNI# 13000186)

Project Location: Doan Hall, Charles Austin *GSF*

- **approval requested and amount**
  professional services $0.5M
- **project budget**

professional services	$0.5M
construction w/contingency	$4.4M
total project budget	$4.9M

- **project funding**
  - ☐ university debt
  - ☐ development funds
  - ☐ university funds
  - ☒ auxiliary funds
  - ☐ state funds
- **project schedule**
  BoT professional services approval 11/15
- **project delivery method**
  - ☐ general contracting
  - ☐ design/build
  - ☐ construction manager at risk
- **planning framework**
  - project is included in the FY 2016 Capital Improvement Plan
  - project developed in response from recommendations in most recent College of American Pathologists accreditation survey
- **project scope**
  - relocates a portion of Surgical Pathology to the new James Tower, aligning with cancer services
  - renovates and expands the Pathology lab in University Hospital
- **approval requested**
  - approval is requested to enter into professional services contracts

- **project team**
  University project manager: Brendan Flaherty
  AE/design architect:

Office of Administration and Planning November 2015