TUESDAY, AUGUST 19, 2025
WEXNER MEDICAL CENTER BOARD MEETING

Leslie H. Wexner, chair
Gary R. Heminger
Tomislav B. Mitevski
Juan Jose Perez
George A. Skestos
Kara J. Trott
Robert H. Schottenstein
Stephen D. Steinour
Cindy Hilsheimer
Amy Chronis
Hiroyuki Fujita
John W. Zeiger (ex officio, voting)
Walter E. Carter Jr. (ex officio, voting)
Ravi V. Bellamkonda (ex officio, voting)
Michael Papadakis (ex officio, voting)
John J. Warner (ex officio, voting)

Location: Sanders Grand Lounge, Longaberger Alumni House
2200 Olentangy River Road, Columbus, Ohio 43210

Time: 1:00-4:00 p.m.

Public Session **1:00-1:45 p.m.**

1. Approval of May 2025 Wexner Medical Center Board Meeting Minutes
2. *CEO Report – Dr. John Warner* 1:00-1:10 p.m.
3. *James Cancer Hospital Report – Dr. Kimryn Rathmell* 1:10-1:20 p.m.
4. *Wexner Medical Center Financial Report – Mr. Richard Silveria* 1:20-1:25 p.m.
5. Recommend Approval to Enter Into Professional Services and Enter Into Construction Contracts – Ms. P'Elizabeth Koelker 1:25-1:35 p.m.
6. Quality and Professional Affairs Committee: Items for Approval – Mr. John Perez, Dr. Andrew Thomas, Dr. David Cohn 1:35-1:45 p.m.
    a. Ratification of Committee Appointments FY2026
    b. The Ohio State University Wexner Medical Center Clinical Quality Management, Patient Safety and Patient Experience Plan
    c. The James Cancer Hospital Quality, Safety and Experience Council Plan
    d. Plan for Patient Care Services
        i. OSU Wexner Medical Center
        ii. James Cancer Hospital
    e. Scope of Care
        i. New Albany Ambulatory Surgery Center
        ii. Dublin Ambulatory Surgery Center
    f. Patient Complaint and Grievance Management
        i. OSU Wexner Medical Center
        ii. James Cancer Hospital
    g. Direct Patient Care Services Contracts and Patient Impact Service Contracts Evaluation
        i. OSU Wexner Medical Center
        ii. James Cancer Hospital
        iii. New Albany Ambulatory Surgery Center
        iv. Dublin Ambulatory Surgery Center

Executive Session **1:45-4:00 p.m.**

THE OHIO STATE UNIVERSITY

Board of Trustees

University Square South
15 East 15th Avenue, 5th Floor
Columbus, OH 43201

Phone (614) 292-6359
Fax (614) 292-5903
trustees.osu.edu

SUMMARY OF ACTIONS TAKEN

May 20, 2025 – Wexner Medical Center Board Meeting

Members Present:

Leslie H. Wexner
Alan A. Stockmeister
Gary R. Heminger
Tomislav B. Mitevski
Juan Jose Perez
George A. Skestos (arr. 1:18 p.m.)
Joshua H.B. Kerner
Robert H. Schottenstein
Stephen D. Steinour (arr. 1:15 p.m.)
Cindy Hilsheimer
Amy Chronis
John W. Zeiger (ex officio)
Walter E. Carter Jr. (ex officio)
Ravi V. Bellamkonda (ex officio) (arr. 1:21 p.m.)
Michael Papadakis (ex officio)
John J. Warner (ex officio)

Members Present via Zoom:

Hiroyuki Fujita

Members Absent: N/A

PUBLIC SESSION

The Wexner Medical Center Board convened for its 54th meeting on Tuesday, May 20, 2025, in person at Longaberger Alumni House on Ohio State's Columbus campus. Board Secretary Jessica A. Eveland called the meeting to order at 12:59 p.m.

Item for Action:

1. Approval of Minutes: No changes were requested to the February 18, 2024, meeting minutes; therefore, a formal vote was not required, and the minutes were considered approved.

Items for Discussion:

2. Chief Executive Officer's Report: Dr. John Warner, chief executive officer, Wexner Medical Center, celebrated the hire of former National Cancer Institute director Kimryn Rathmell to lead The Ohio State University Comprehensive Cancer Center Arthur G. James Cancer Hospital and Richard J. Solove Research Institute. Additionally, the medical center exceeded its $1.6 billion fundraising goal during the recently concluded *Time and Change* campaign. Among other highlights, Dr. Warner provided an update on the new inpatient hospital building and recounted events surrounding the Sarah Ross Soter Women's Health Day, the opening of the Bob Crane Community Center, Nurses Week and Hospital Week.

   (See Attachment X for background information, page XX)

3. Wexner Medical Center Financial Report: Mr. Richard Silveria, the medical center's chief financial officer, updated the Board on the organization's financial performance through the first three quarters of Fiscal Year 2025. Across the health system, Ohio State University Physicians, Inc., and the College of Medicine, revenues and expenses are both over budget, resulting in a positive margin of 3.7% for the fiscal year to date, compared to a budgeted margin of 2.8%.

   (See Attachment X for background information, page XX)

Items for Action:

4. Recommend for Approval Wexner Medical Center FY26 Budget: Mr. Silveria is seeking the Board's endorsement of the medical center's FY26 budget. It has been reviewed by the Finance and Investment Committee of the Board of Trustees and will go before the full Board for final approval. He shared the proposed FY26 budget for the combined Wexner Medical Center, which forecasts an 8.1% increase in total operating revenue and a 9.5% increase in expenses.

   (See Attachment X for background information, page XX)

5. Resolution No. 2025-70, Recommend Approval To Enter Into Professional Services And Enter Into Construction Contracts:

APPROVAL TO ENTER INTO PROFESSIONAL SERVICES CONTRACTS
UH-DOAN HALL SPRINKLER INSTALLATION

APPROVAL TO ENTER INTO PROFESSIONAL SERVICES AND CONSTRUCTION CONTRACTS
DOAN – REPLACE SPECT CTS
OUTPATIENT EAST – EXISTING LOT RENOVATION
OUTPATIENT EAST –NEW WEST PARKING LOT

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

WHEREAS in accordance with the attached materials, the University desires to enter into professional services contracts for the following project; and

	Prof. Serv. Approval Requested	Total Requested	
UH-Doan Hall Sprinkler Installation	$1.2M	$1.2M	Auxiliary Funds

WHEREAS in accordance with the attached materials, the University desires to enter into professional services contracts and enter into construction contracts for the following projects; and

	Prof. Serv. Approval Requested	Construction Approval Requested	Total Requested	
Doan – Replace SPECT CTs	$0.3M	$4.3M	$4.6M	Auxiliary funds
Outpatient East – Existing Lot Renovation	$0.8M	$4.7M	$5.5M	Auxiliary funds
Outpatient East – New West Parking Lot	$1.1M	$6.1M	$7.2M	Auxiliary funds

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.

BE IT FURTHER RESOLVED, That the President and/or Senior Vice President for Business and Finance be authorized to enter into professional services and construction contracts for the projects listed above in accordance with established University and State of Ohio procedures, with all actions to be reported to the Board at the appropriate time.

(See Attachment X for background information, page XX)

6. Resolution No. 2025-71, Recommend for Approval the Purchase of Real Property:

5.070+/- ACRES AT 1800 ZOLLINGER ROAD,
UPPER ARLINGTON, FRANKLIN COUNTY, OHIO

Synopsis: Authorization to purchase property described as Outpatient Care Upper Arlington from Medstone Realty Company, LLC located at 1800 Zollinger Road, Upper Arlington, Ohio is proposed.

WHEREAS The Ohio State University seeks to acquire 5.070 acres of improved real property located at 1800 Zollinger, Upper Arlington, Ohio, identified as Franklin County parcel number 070-003229; and

WHEREAS the purchase of this property supports the university's plan for strategic investment in outpatient services for neighboring communities:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves and proposes that the purchase of said property be recommended to the University Board of Trustees for approval; and

BE IT RESOLVED, That the Board of Trustees hereby approves that the President and/or Senior Vice President for Business and Finance shall be authorized to take any action required to effect the purchase of the aforementioned property upon the terms and conditions deemed to be in the best interest of the university.

(See Attachment X for background information, page XX)

7. Approval of the Community Health Needs Assessment and Implementation Strategy: Dr. Andrew Thomas, Wolfe Foundation Chief Clinical Officer and senior associate vice president, presented the community health needs assessment and implementation strategy for University Hospital and The James. This assessment is conducted every three years in collaboration with the Central Ohio Hospital Council and is a requirement under federal law.

(See Attachment X for background information, page XX)

Action: Upon the motion of Mr. Stockmeister, seconded by Mr. Heminger, the Wexner Medical Center Board recommended these items for approval by roll-call vote with the following members present and voting: Mr. Wexner, Mr. Stockmeister, Mr. Heminger, Mr. Mitevski, Mr. Perez, Mr. Skestos, Mr. Kerner, Mr. Schottenstein, Mr. Steinour, Ms. Hilsheimer, Ms. Chronis, Dr. Fujita, Mr. Zeiger, President Carter, Dr. Bellamkonda, Mr. Papadakis and Dr. Warner.

THE OHIO STATE UNIVERSITY

EXECUTIVE SESSION

It was moved by Mr. Zeiger and seconded by Mr. Perez that the Wexner Medical Center Board recess into executive session to consider business-sensitive trade secrets and quality matters required to be kept confidential by federal and state statutes and to discuss personnel matters involving the appointment, employment and compensation of public officials, which are required to be kept confidential under Ohio law.

A roll-call vote was taken, and the Board voted to go into executive session with the following members present and voting: Mr. Wexner, Mr. Stockmeister, Mr. Heminger, Mr. Mitevski, Mr. Perez, Mr. Skestos, Mr. Kerner, Mr. Schottenstein, Mr. Steinour, Ms. Hilsheimer, Ms. Chronis, Dr. Fujita, Mr. Zeiger, President Carter, Dr. Bellamkonda, Mr. Papadakis and Dr. Warner.

The Wexner Medical Center Board entered executive session at 1:33 p.m. and adjourned at 3:46 p.m.

OSUCCC – James Wexner Medical Center Board Presentation

August 19, 2025

W. Kimryn Rathmell, MD, PhD

Chief Executive Officer

James Cancer Hospital and Solove Research Institute

The James

THE OHIO STATE UNIVERSITY
COMPREHENSIVE CANCER CENTER

Introduction

The Leadership Team
Creating a Cancer-Free World






Pelotonia 2025

- 7500 Riders - largest number ever
- 24-mile route **Sold Out**
- First time ever a route **Sold Out**
- Incredible community support
- First Pelotonia Hike happens October 4 in Nelsonville

The James

The Ohio State University
Comprehensive Cancer Center

Successful NCI Support Grant Site Visit

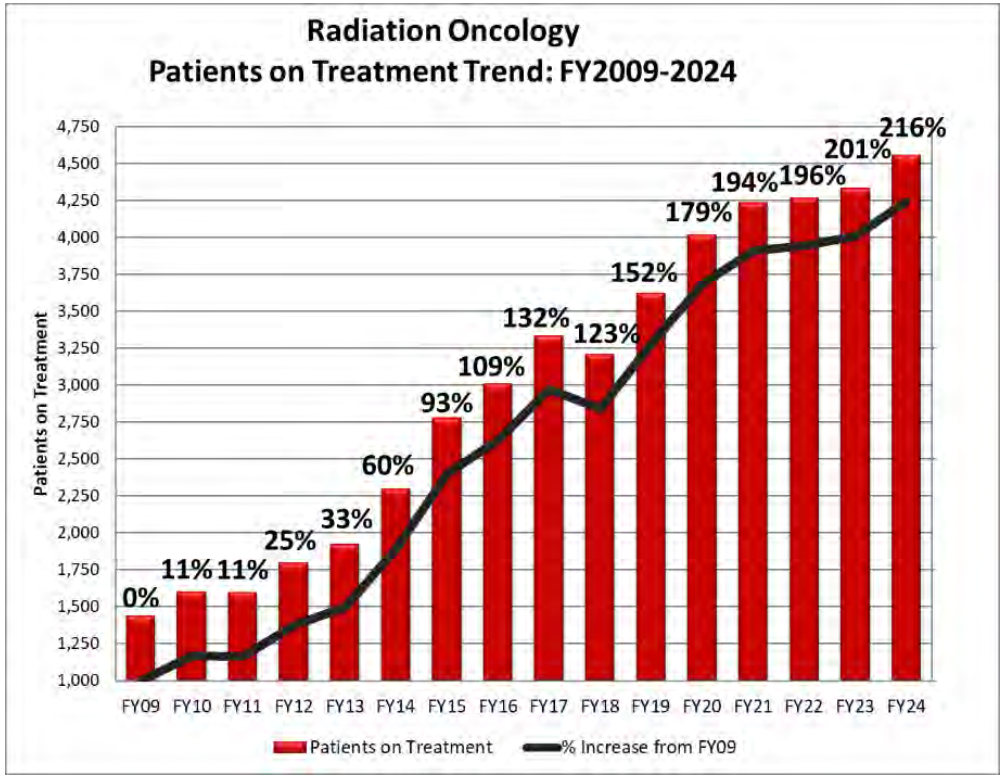
Scored in the **Exceptional range** for the 4th time in a row

The James

The Ohio State University
Comprehensive Cancer Center

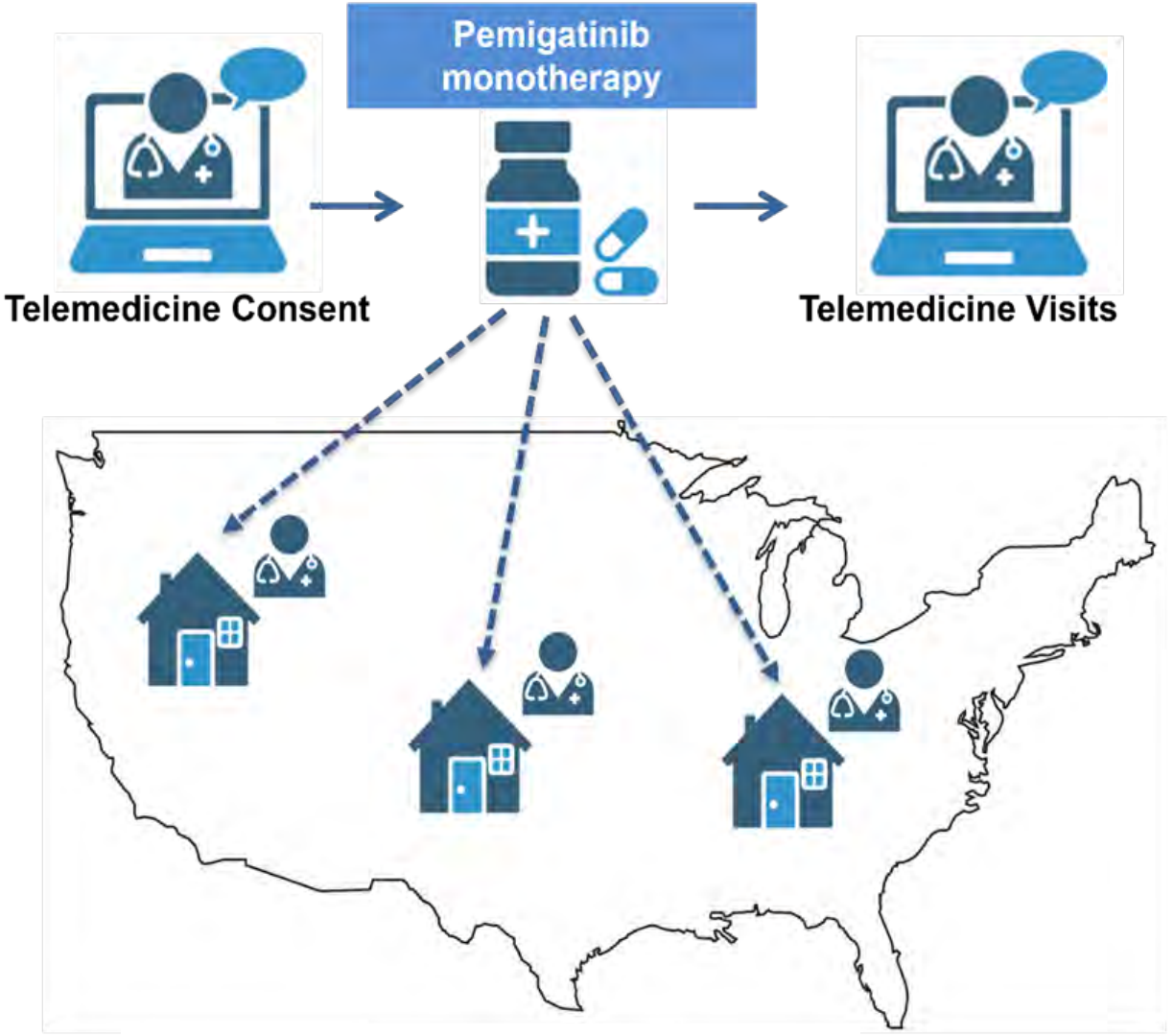
Radiation Oncology Success

Explosive growth since FY09, with double-digit growth in the last year

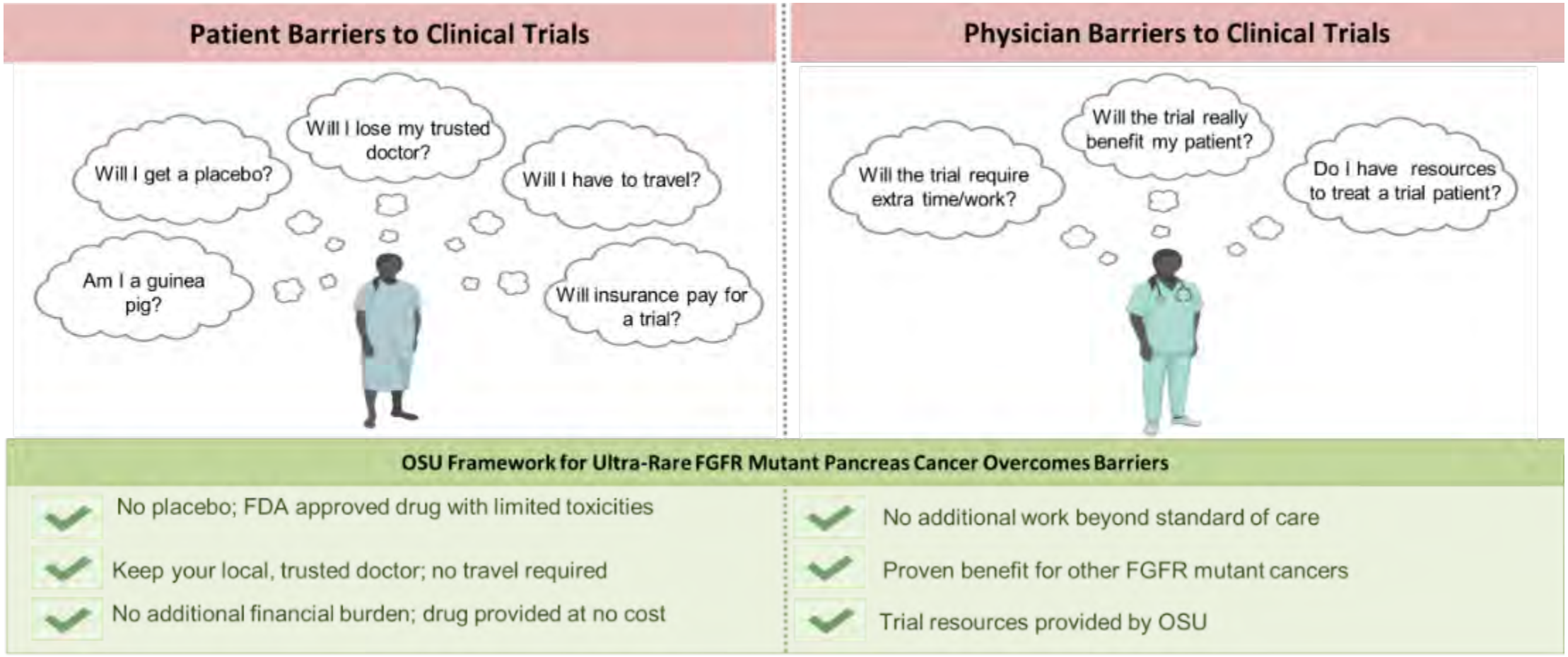


First-of-its-kind Nationwide telemedicine-enabled trial to treat patients with FGFR-positive pancreatic cancer

- Up to **40 adults** will be enrolled
- Telehealth allows **patients nationwide** to participate **without the burden and cost** of travelling to The James
- Team hopes to develop a **network** of national telemedicine trials



OSU Framework for Ultra-Rare FGFR Mutant Pancreas Cancer Overcomes Barriers



The James

The Ohio State University
Comprehensive Cancer Center

Lung Screening Mobile Unit

The James hopes to **help increase the detection of lung cancer early** before it advances, **significantly improving survival rates** — up to 90% for stage 1A cases.

"It's absolutely fantastic, because there are a lot of people that live down in this area that are **maybe a little shy on medical attention and wouldn't necessarily have the option** of even doing something like that because **it's just not here, until Ohio State started coming down**," he says. "They're doing that. And it's a godsend."

The James

The Ohio State University
Comprehensive Cancer Center

Thank You

Connect with us on social media:

The James

The Ohio State University
Comprehensive Cancer Center

cancer.osu.edu

Wexner Medical Center Board
Financial Report
Public Session

August 19, 2025

Preliminary FY25 Year-End Financials

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

The Ohio State University Health System

Consolidated Statement of Operations
For the YTD ended: June 30, 2025
(in thousands)

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	5,035,323	4,712,845	322,478	6.8%	4,444,042	13.3%
Operating Expenses						
Salaries and Benefits	2,003,957	1,948,966	(54,991)	-2.8%	1,867,090	-7.3%
Resident/Purchased Physician Services	259,697	256,454	(3,243)	-1.3%	224,229	-15.8%
Supplies/Pharmaceuticals/Other	2,045,536	1,838,083	(207,453)	-11.3%	1,722,512	-18.8%
Depreciation	259,959	252,881	(7,078)	-2.8%	231,473	-12.3%
Interest	50,719	50,027	(692)	-1.4%	41,362	-22.6%
Total Expense	4,619,868	4,346,411	(273,457)	-6.3%	4,086,666	-13.0%
Gain (Loss) from Operations (pre MCI)	415,455	366,434	49,021	13.4%	357,376	16.3%
Medical Center Investments	(270,547)	(237,560)	(32,987)	-13.9%	(235,433)	-14.9%
Income from Investments	108,314	54,946	53,368	97.1%	92,051	17.7%
Other Gains (Losses)	56,523	37,656	18,867	50.1%	71,299	-20.7%
Excess of Revenue over Expense	$ 309,745	$ 221,476	$ 88,269	39.9%	$ 285,293	8.6%
Margin Percentage	6.2%	4.7%	1.5%	30.9%	6.4%	-0.2%
EBIDA	$ 620,423	$ 524,384	$ 96,039	18.3%	$ 558,128	11.2%
EBIDA Margin Percentage	12.3%	11.1%	1.2%	10.6%	12.6%	-0.3%

Pre-Audit

The Ohio State University Wexner Medical Center

Combined Statement of Operations
For the YTD ended: June 30, 2025
(in thousands)

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	6,757,638	6,351,643	405,994	6.4%	6,007,922	12.5%
Operating Expenses						
Salaries and Benefits	3,550,181	3,476,460	(73,721)	-2.1%	3,282,948	-8.1%
Resident/Purchased Physician Services	259,697	256,454	(3,243)	-1.3%	224,229	-15.8%
Supplies/Pharmaceuticals/Other	2,502,502	2,196,009	(306,494)	-14.0%	2,087,548	-19.9%
Depreciation	264,895	257,542	(7,353)	-2.9%	251,662	-5.3%
Interest	50,925	50,027	(898)	-1.8%	49,312	-3.3%
Total Expense	6,628,200	6,236,492	(391,708)	-6.3%	5,895,700	-12.4%
Gain (Loss) from Operations	129,438	115,151	14,286	12.4%	112,222	15.3%
Income from Investments	118,215	65,643	52,572	80.1%	102,206	15.7%
Other Gains (Losses)	51,748	33,259	18,489	55.6%	62,841	-17.7%
Excess of Revenue over Expense	$ 299,401	$ 214,053	$ 85,348	39.9%	$ 277,269	8.0%
Margin Percentage	4.4%	3.4%	1.0%	31.5%	4.6%	-0.2%
EBIDA	$ 615,221	$ 521,622	$ 93,598	17.9%	$ 578,243	6.4%
EBIDA Margin Percentage	9.1%	8.2%	0.9%	10.9%	9.6%	-0.5%

*** Combined Medical Center includes Health System, OSUP, and College of Medicine.**

**** This statement does not conform to Generally Accepted Accounting Principles. Different accounting methods are used in each of these entities and no eliminating entries are included.**

Pre-Audit

The Ohio State University Wexner Medical Center

Combined Balance Sheet
As of: June 30, 2025
(in thousands)

	June 2025	June 2024	Change
Assets			
Cash	$ 1,592,376	$ 1,476,652	$ 115,724
Net Patient Receivables	839,052	756,178	82,874
Other Current Assets	239,877	218,438	21,440
Assets Limited as to Use	842,180	958,622	(116,442)
Property, Plant & Equipment - Net	4,040,368	3,706,478	333,891
Other Assets	632,215	610,379	21,836
Total Assets	$ 8,186,069	$ 7,726,747	$ 459,322
Liabilities & Net Position			
Current Liabilities	$ 696,691	$ 477,234	$ 219,457
Other Liabilities	425,145	426,301	(1,156)
Total Debt	1,348,084	1,438,011	(89,927)
Net Position	5,716,149	5,385,201	330,948
Liabilities and Net Position	$ 8,186,069	$ 7,726,747	$ 459,322
Days Cash on Hand	133.8	151.7	(17.9)
Net Days in Accounts Receivable	52.7	54.3	1.6
Debt to Capital	19.1%	21.1%	2.0%

* Combined Medical Center includes Health System, OSUP, and College of Medicine.

** This Balance sheet is not intended to conform to Generally Accepted Accounting Principles. Different accounting methods are used in each of these entities and no eliminating entries are included.

Pre-Audit

Thank You

Wexnermedical.osu.edu

RECOMMEND APPROVAL TO ENTER INTO PROFESSIONAL SERVICES AND ENTER INTO CONSTRUCTION CONTRACTS

APPROVAL TO ENTER INTO PROFESSIONAL SERVICES CONTRACTS
BRAIN AND SPINE HOSPITAL – LOWER-LEVEL RENOVATION
DOAN HALL – PET/CT REPLACEMENT
OUTPATIENT CARE EAST – CLINIC RENOVATIONS & RELOCATIONS

APPROVAL TO ENTER INTO PROFESSIONAL SERVICES AND CONSTRUCTION CONTRACTS
EAST HOSPITAL – CHILLER & COOLING TOWER REPLACEMENT
POLARIS MEP UPDATES
600 ACKERMAN – SPECIALTY PHARMACY EXPANSION

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

WHEREAS in accordance with the attached materials, the University desires to enter into professional services contracts for the following projects; and

	Prof. Serv. Approval Requested	Total Requested	
Brain and Spine Hospital – Lower-Level Renovation	$0.3M	$0.3M	Auxiliary funds
Doan Hall – PET/CT Replacement	$0.4M	$0.4M	Auxiliary funds
Outpatient Care East – Clinic Renovations & Relocations	$1.1M	$1.1M	Auxiliary funds

WHEREAS in accordance with the attached materials, the University desires to enter into professional services contracts and enter into construction contracts for the following projects; and

	Prof. Serv. Approval Requested	Construction Approval Requested	Total Requested	
East Hospital – Chiller & Cooling Tower Replacement	$1.2M	$5.8M	$7.0M	Auxiliary funds
Polaris MEP Updates	$0.8M	$6.6M	$7.4M	Auxiliary funds
600 Ackerman – Specialty Pharmacy Expansion	$1.2M	$14.0M	$15.2M	Auxiliary funds

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.

BE IT FURTHER RESOLVED, That the President and/or Senior Vice President for Business and Finance be authorized to enter into professional services and construction contracts for the projects listed above in accordance with established University and State of Ohio procedures, with all actions to be reported to the Board at the appropriate time.

Project Data Sheet for Board of Trustees Approval

Brain and Spine Hospital – Lower-Level Renovation

OSU-230598 (REQ ID# Jam230040)

Project Location: Brain and Spine Hospital (0372)

- **Approval Requested and Amount**

Professional services	$0.3M
Total requested	$0.3M

- **Project Budget**

Professional services	TBD
Construction w/contingency	TBD
Total project budget	TBD

- **Project Funding**
  Auxiliary funds

- **Project Schedule**

BoT professional services approval	08/25
Design	TBD
BoT construction approval	TBD
Construction	TBD
Facility opening	TBD

- **Project Delivery Method**
  Construction Manager at Risk

- **Planning Framework**
  - This project is included in the FY26 Capital Investment Plan.

- **Project Scope**
  - The project will assess ways to optimize the ground floor of the Brain and Spine Hospital to support nuclear pharmacy, James diagnostic/treatment spaces and imaging services.
  - This project includes infrastructure and support space improvements for new LINAC and SPECT-CT equipment installations.
  - Total project cost will be validated during design.

- **Approval Requested**
  - Approval is requested to enter into professional services contracts.

- **project team**
  University project manager: Brown, Vanessa
  AE/design architect: BHDP
  CM at Risk or Design Builder: Messer Construction

Project Data Sheet for Board of Trustees Approval

Doan Hall - PET/CT Replacement

OSU-250112 (REQ ID# JAM250012)

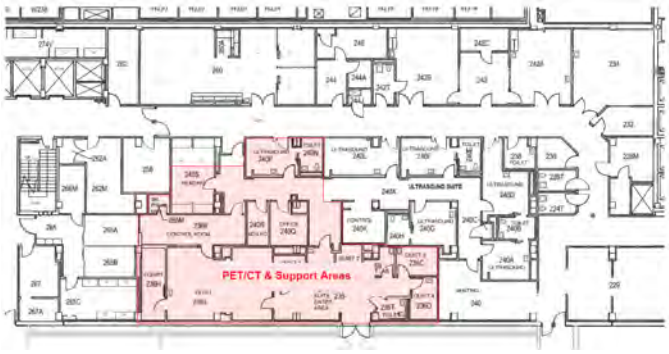
Project Location: Doan Hall (0089)

- **Approval Requested and Amount**

Professional services	$0.4M
Total requested	$0.4M

- **Project Budget**

Professional services	$0.4M
Construction w/contingency	TBD
Total project budget	TBD



- **Project Funding**
  Auxiliary funds

- **Project Schedule**

BoT professional services approval	08/25
Design	09/25 – 05/26
BoT construction approval	02/26
Construction	06/26 – 03/27
Facility opening	05/27

- **Project Delivery Method**
  Construction Manager at Risk

- **Planning Framework**
  - This project is included in the FY26 Capital Plan.

- **Project Scope**
  - This project will support the installation of a new PET/CT machine in the Nuclear Medicine Department in Doan Hall.
  - Renovations to existing space will provide expanded support areas to accommodate the higher capacity and operational needs of the new equipment.
  - Total project budget and construction schedule to be validated during design.

- **Approval Requested**
  - Approval is requested to enter into professional services contracts.

- **project team**
  University project manager: Dollery, Mitchell
  AE/design architect: TBD
  CM at Risk or Design Builder: TBD

Project Data Sheet for Board of Trustees Approval

Outpatient Care East – Clinic Renovations & Relocations

OSU-255228 (REQ ID# WMC240003)

Project Location: Outpatient Care East (0837)

- **Approval Requested and Amount**

Professional services	$1.1M
Total requested	$1.1M

- **Project Budget**

Professional services	$1.1M
Construction w/contingency	TBD
Total project budget	TBD

- **Project Funding**
  Auxiliary funds

- **Project Schedule**

BoT professional services approval	08/25
Design	09/25 – 08/26
BoT construction approval	TBD
Construction	TBD
Facility opening	TBD

- **Project Delivery Method**
  Construction Manager at Risk

- **Planning Framework**
  - This project is included in the FY26 Capital Investment Plan.

- **Project Scope**
  - The project expands, renovates, and relocates healthcare services at Outpatient Care East, encompassing primary care, new optometry services, advanced urgent care, and non-oncology infusion spaces.
  - Total project cost will be validated during design.

- **Approval Requested**
  - Approval is requested to enter into professional services contracts.

- **project team**
  University project manager: Radabaugh, Alexandra
  AE/design architect: TBD
  CM at Risk or Design Builder: TBD

Project Data Sheet for Board of Trustees Approval

East Hospital - Chiller and Cooling Tower Replacement

OSU-255136 (REQ ID# WMC240003)

Project Location: East Hospital - Tower (0397)

- **Approval Requested and Amount**

Professional services	$1.2M
Construction w/contingency	$5.8M
Total requested	$7.0M

- **Project Budget**

Professional services	$1.2M
Construction w/contingency	$5.8M
Total project budget	$7.0M

- **Project Funding**
  Auxiliary funds

- **Project Schedule**

BoT professional services approval	08/25
BoT construction approval	08/25
Design	08/25 – 03/26
Construction	03/26 – 05/27
Facility opening	05/27

- **Project Delivery Method**
  Construction Manager at Risk

- **Planning Framework**
  - This project is included in the FY26 Capital Investment Plan.

- **Project Scope**
  - To address aging infrastructure, this project will replace the two main chillers, pumps and associated infrastructure, along with the cooling tower located on the west side of the facility.
  - The units that are being replaced are part of the redundant infrastructure serving the hospital, replacements will be staged with cooling unit replacement to occur during off-peak season.

- **Approval Requested**
  - Approval is requested to enter into professional services and construction contracts.

- **project team**
  University project manager: Hyde, Carrie
  AE/design architect: TBD
  CM at Risk or Design Builder: TBD

Polaris MEP updates

OSU-255690 (REQ ID# WMC240003)

Project Location: Polaris Pkwy, 2001 (0836)

- **Approval Requested and Amount**

Professional services	$0.8M
Construction w/contingency	$6.6M
Total requested	$7.4M

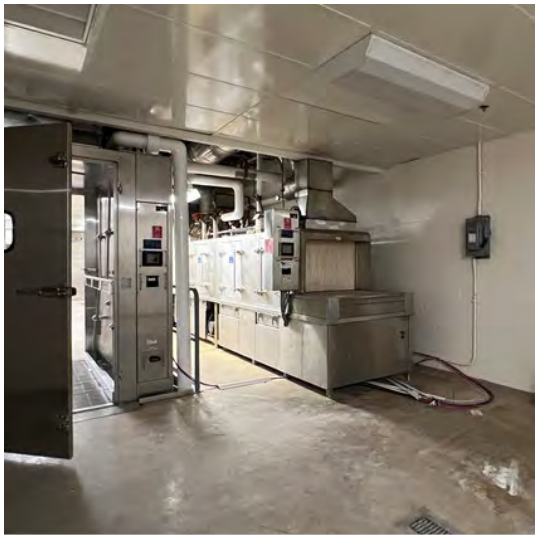
- **Project Budget**

Professional services	$0.8M
Construction w/contingency	$6.6M
Total project budget	$7.4M

- **Project Funding**
  Auxiliary funds

- **Project Schedule**

BoT professional services approval	08/25
BoT construction approval	08/25
Design	09/25 – 05/26
Construction	06/26 – 02/27
Facility opening	02/27



- **Project Delivery Method**
  General Contracting

- **Planning Framework**
  - This project is included in the FY26 Capital Investment Plan.

- **Project Scope**
  - The project will update MEP infrastructure, including emergency electrical power in support of the overall building and cell therapy modular units. Updates will provide increased capacity for future expansion of the building.

- **Approval Requested**
  - Approval is requested to enter into professional services and construction contracts.

- **project team**
  University project manager: Whitmore, Steven
  AE/design architect: TBD
  CM at Risk or Design Builder: TBD

Project Data Sheet for Board of Trustees Approval

600 Ackerman - Specialty Pharmacy Expansion

OSU-240182 (REQ ID# WMC240001)

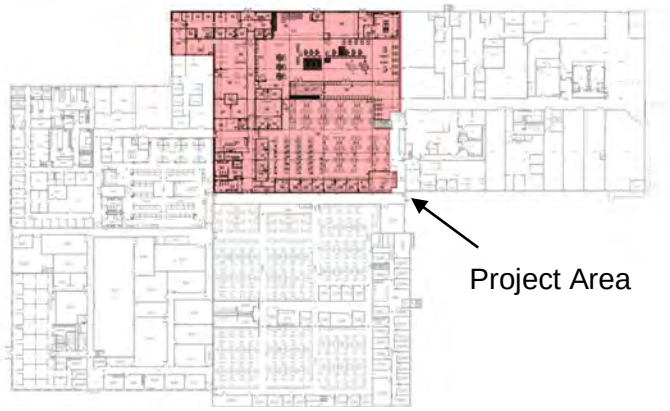
Project Location: Ackerman Rd, 600 (2435)

- **Approval Requested and Amount**

Professional services	$1.2M
Construction w/contingency	$14.0M
Total requested	$15.2M

- **Project Budget**

Professional services	$1.2M
Construction w/contingency	$14.0M
Total project budget	$15.2M



- **Project Funding**
  Auxiliary funds

- **Project Schedule**

Design	04/24 – 10/25
BoT professional services approval	08/25
BoT construction approval	08/25
Construction	11/25 – 05/27
Facility opening	06/27

- **Project Delivery Method**
  Construction Manager at Risk

- **Planning Framework**
  - This project is included in the FY24 and FY26 Capital Investment Plans.

- **Project Scope**
  - This project will renovate approximately 30,000 SF in the 600 Ackerman building to accommodate the growth of the Specialty Pharmacy space and services to meet the demand of the patient population.
  - The scope includes increasing the dispensing pharmacy from 1,800 SF to 10,000 SF, adding automation equipment, and additional storage capabilities in the form of freezers and coolers.
  - Equipment costs, which are included in the total project budget, are estimated to be $2.8M.

- **Approval Requested**
  - Approval is requested to enter into professional services and construction contracts.

- **project team**
  University project manager: Lively, Sarah
  AE/design architect: BDTAID
  CM at Risk or Design Builder: The Ruhlin Company

The Ohio State University
Wexner Medical Center Board

August 19, 2025

RATIFICATION OF COMMITTEE APPOINTMENTS FY2026

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves that the ratification of appointments to the Quality and Professional Affairs Committee for FY2026 are as follows:

Quality and Professional Affairs Committee

Juan Jose Perez, Chair
George A. Skestos
Ravi Bellamkonda
Michael Papadakis
John J. Warner
Jay M. Anderson
Eric Bourekas
Carol Bradford
Stacy Brethauer
David E. Cohn
Scott A. Holliday
Kami J. Maddocks
Elizabeth Seely
Deana Sievert
Corrin Steinhauer
Andrew M. Thomas

August 19, 2025

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER
CLINICAL QUALITY MANAGEMENT, PATIENT SAFETY AND PATIENT EXPERIENCE PLAN

OHIO STATE UNIVERSITY HOSPITALS d/b/a OSU WEXNER MEDICAL CENTER

Synopsis: Approval of the annual review of the Clinical Quality Management, Patient Safety and Patient Experience Plan for FY26 for the hospitals at the Ohio State University Hospitals d/b/a OSU Wexner Medical Center, including: Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital, is proposed.

WHEREAS the mission of the Ohio State University Hospitals is to improve people's lives through the provision of high-quality patient care; and

WHEREAS the Clinical Quality Management, Patient Safety and Patient Experience Plan for FY26 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 University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital and Ohio State East Hospital; and

WHEREAS the annual review of the Clinical Quality Management, Patient Safety and Patient Experience Plan for FY26 was approved by the Quality Leadership Council on May 28, 2025; and

WHEREAS the annual review of the Clinical Quality Management, Patient Safety and Patient Experience Plan for FY26 was approved by the University Hospitals Medical Staff Administrative Committee on July 9, 2025; and

WHEREAS on July 22, 2025, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the annual review of the Clinical Quality Management, Patient Safety and Patient Experience Plan for FY26:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the Clinical Quality Management, Patient Safety and Patient Experience Plan for FY26 for University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital and Ohio State East Hospital as outlined in the attached document.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

QUALITY LEADERSHIP COUNCIL

The Ohio State University Wexner Medical Center Clinical Quality Management, Patient Safety, & Patient Experience Plan

FY 2026

July 1, 2025 - June 30, 2026

The Ohio State University Wexner Medical Center

Clinical Quality Management, Patient Safety, & Patient Experience Plan

Table of Contents

Ambition, Mission, Vision and Values

Ambition: To be a top (Honor Roll) academic health center driving breakthrough healthcare solutions to improve people's lives and the communities in which we live.

Mission: To improve health in Ohio and across the world through innovations in research and transformation in research, education, patient care and community engagement.

Vision: By pushing the boundaries of discovery and knowledge, we will solve significant health problems and deliver unparalleled care

Values: Inclusiveness, Determination, Empathy, Sincerity, Ownership and Innovation

Definition

The Clinical Quality Management, Patient Safety and Patient Experience Plan is the health system approach to the systematic assessment and improvement of process design and performance aimed at improving quality of care, patient safety, and patient experience.

The approach to clinical quality management, patient safety, and patient experience is leadership-driven and involves significant staff and provider engagement. The activities within the health system are multi-disciplinary and rooted in the system's ambition, mission, vision, and values. The plan embodies a culture of continuously measuring, assessing, and initiating changes to improve outcomes. The health system employs the following principles which support the Institute of Medicine's six aims of care (Safe, Timely, Effective, Efficient, Equitable and 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 all staff, employees, clinicians, patients, and learners.
- **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.
- Process Improvement: Analysis of processes for redesign and variance reduction using a scientific approach.
- **Continuous:** Measurement and improvement are ongoing.
- **Safety 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.

The Plan was developed in accordance with The Joint Commission (TJC) accreditation standards and the Center for Medicare & Medicaid Services (CMS) Conditions of Participation outlining a

Quality Assurance and Performance Improvement (QAPI) program. In addition to the principles outlined above, the following will also serve as fundamental components of the plan.

Consistent Level of Care

Certain elements of the OSUWMC Clinical Quality Management, Patient Safety, & Patient Experience Plan assure that patient care standards for the same or similar services are comparable in all areas throughout the health system. For example,

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

Performance Transparency

The OSUWMC Medical and Administrative leadership, in conjunction with the Board of Trustees, has a strong commitment to transparency of performance as it relates to clinical quality, patient safety, and patient experience performance. As supported by the long-range quality plan, the organization is committed to providing transparency to our patients and communities regarding our performance.

Performance data are 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.

Online performance scorecards have been developed to cover a variety of clinical quality, safety and patient experience 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.

Scope/Purpose

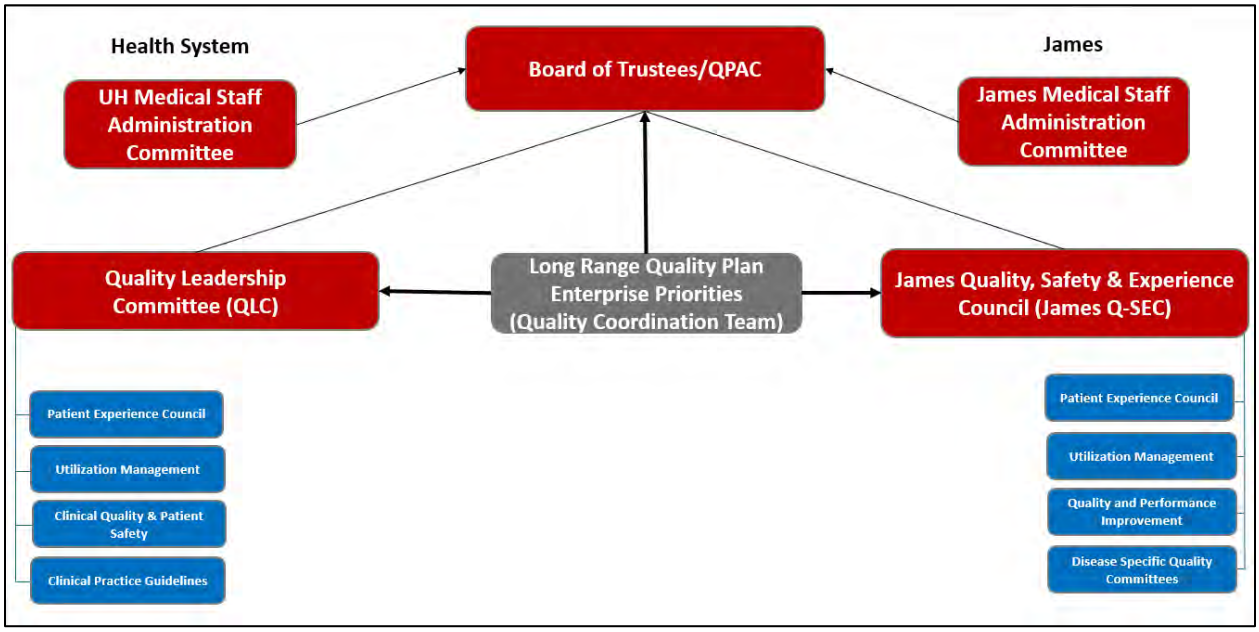
The Clinical Quality Management, Patient Safety & Patient Experience Plan includes all inpatient and outpatient facilities in The OSU Wexner Medical Center (OSUWMC) and appropriate entities across the continuum of care and in any clinical setting. The execution of the Clinical Quality Management, Patient Safety & Patient Experience Plan will demonstrate measurable improvements in health outcomes and the value of patient care provided within the OSUWMC.

As part of the Quality Assurance and Performance Improvement (QAPI program), the organization provides oversight for contracted services. The contracts are reviewed annually by the Medical Staff Administrative Committee (MSAC) and then forwarded to the Quality and Professional Affairs Committee of the governing body for review and approval.

Objectives

- Continuously monitor, evaluate, and improve outcomes and sustain improved performance.
- Implement 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.
- Assure optimal compliance with accreditation standards, state, federal and licensure regulations.
- 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.
- Improve patient experience and perception of treatment, care and services by identifying, evaluating, and improving performance based on patient needs, expectations, and satisfaction.
- Improve value by providing the best quality of care at the minimum cost possible. Incorporate value metrics, specifically the cost of care, into quality data and discussions where appropriate.
- Provide a mechanism by which the governance, medical staff and health system staff members are educated in quality management principles and processes.
- Provide appropriate levels of data transparency to both internal and external customers.
- Create a level of accountability for all system-wide quality improvement initiatives at the dyad/triad leadership level and assure processes involve an interdisciplinary teamwork approach.
- Improve processes to prevent patient harm.
- Improve clinical documentation to accurately reflect the severity of illness for the patients in which we provide care.

Structure for Quality Oversight



The Quality Leadership Council serves as the single, multidisciplinary quality and safety oversight committee for the OSUWMC. In accordance with the Long-Range Quality Plan (Appendix A), The Quality Leadership Council utilizes criteria (Appendix B) to determine priorities for the health system that are reported in the Quality & Safety Priorities (Appendix C). Given the James Cancer Hospital has a separate provider number with a requirement for a distinct QAPI program, they have a specific substructure that ultimately reports to QPAC (Appendix D).

Committees

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 patient experience reports, and provides resources and support systems for clinical quality management, patient safety and patient experience 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 Patient Experience Plan. The Medical Center Board ensures all caregivers are competent to provide services.

Quality Professional Affairs Committee (QPAC)

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 executive officer of the Ohio state university health system; 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; 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. Other members as appointed by the chair of the university Wexner medical center board, in consultation with the chair of the quality and professional affairs committee.

Function:

The QPAC shall be responsible for the following specific duties:

- Reviewing and evaluating the patient safety and quality improvement programs of the university Wexner medical center;
- Overseeing all patient care activities 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;
- Monitoring quality assurance performance in accordance with the standards set by the university Wexner medical center;
- Monitoring the achievement of accreditation and licensure requirements;
- Reviewing and recommending to the university Wexner medical center board changes to the medical staff bylaws and medical staff rules and regulations;
- Reviewing and approving clinical privilege forms;
- 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;
- 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;
- Reviewing and approving reinstatement of clinical privileges for a practitioner after a leave of absence from clinical practice;
- Conducting peer review activities and recommending professional review actions to the university Wexner medical center board;
- Reviewing and resolving any petitions by the medical staff 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
- Such other responsibilities as assigned by the chair of the university Wexner medical center board.

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, Patient Safety and Patient Experience 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.

Quality Leadership Council (QLC)

Composition: Refer to Medical Staff Bylaws and Rules and Regulations

Function: Refer to Medical Staff Bylaws and Rules and Regulations

The QLC is responsible for designing and implementing systems and initiatives to enhance clinical care, outcomes and patient experience throughout the integrated health care delivery system. The QLC serves as the oversight council for the Clinical Quality Management, Patient Safety and Patient Experience plan. Quality improvement activities within the Quality Accountability Team will be reported up to the QLC to ensure alignment of priorities for system- wide quality improvement projects and to provide consistent interventions (toolkits) to all stakeholders in the system.

Clinical Practice Guideline Committee (CPGC)

Composition: The CPGC consists of multidisciplinary representatives from Hospital Administration, Medical Staff, Information Technology, Pharmacy, Nursing, and other allied health professionals. An active member of the medical staff chairs the committee. The CPGC reports to QLC and shares pertinent information with the Medical Staff Administrative Committees.

Function:

- Develop and update evidence-based clinical practice guidelines and best practices to support the delivery of patient care that promotes high quality, safe, efficient, effective, and patient centered care.
- 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.
- Develop measures to evaluate guideline use, processes, 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 QLC and additional committees as deemed applicable.

The primary role of the CQPSC is to ensure that OSUWMC is compliant with the Joint Commission and CMS Requirements for Participation.

Function:

- Creates, a culture of safety which promotes organizational learning and minimizes individual blame or retribution for reporting or involvement in a medical/health care error
- Assure optimal compliance with patient safety-related accreditation standards
- Proactively identifies risks to patient safety and initiates actions to reduce risk with a focus on process and system improvement
- Oversees completion of proactive risk assessment as required by TJC
- Oversees education & risk reduction strategies as they relate to Sentinel Event Alerts from TJC
- Provides oversight for clinical quality management committees
- Evaluates and, when indicated, provides recommendations to improve clinical care and outcomes
- Ensures actions are taken to improve performance whenever an undesirable pattern or trend is identified
- Receive reports from committees that have a potential impact on the quality & safety in delivering patient care

Patient Experience Council(s)

Composition: The Patient Experience Councils consists of executive, physician, and nursing leadership spanning the inpatient and outpatient care settings. The University Hospitals Council is co-chaired by the Chief Nurse Executive for the Health System, The Chief Administrative Officer for the Hospitals Division, and Chief Quality and Patient Safety Officer. The committee reports to the QLC and reports out to additional committees as applicable. The James Patient Experience Council reports to the James Quality, Patient Safety and Experience Council which then reports to QPAC. The Council's key strategic initiatives center on empathy, trust, and personal connections as well as leveraging technology to enhance communication with patients and families.

Function:

- Create a culture and environment that delivers an unparalleled patient experience consistent with the OSU Medical Center's mission, vision and values focusing largely on service quality.
- Set strategic goals and priorities for improving the patient experience to be implemented by area specific patient experience councils and teams.
- Serve as a communication hub reporting out objectives and performance to the system.
- Serve as a coordinating body for subcommittees working on specific aspects of the patient experience.
- 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.
- Monitor publicly reported and other metrics used by various payers to ensure optimal reimbursement.
- Collaborate with other departments to reward and recognize faculty and staff for service excellence performance.

Practitioner Evaluation Committee (PEC)

Composition: The Practitioner Evaluation Committee (PEC) (Appendix E) is the Peer Review committee that provides medical leadership in overseeing the Peer Review process. The PEC is co-chaired by the CQPSO and a CMO appointee. The committee 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 at the James. The Medical Center CMO & Physician-in-Chief at the James serves Ex- Officio. In FY24, a subcommittee of PEC will be established to review OPPE outliers and to report these concerns to PEC.

Function:

- Provide leadership for OSUWMC clinical quality improvement processes.
- Provide clinical expertise to the practitioner peer review process thorough and timely review of clinical care and/or patient safety issues referred to the PEC.
- Advises the CMO & Director of Medical Affairs at the James regarding action plans to improve the quality and safety of clinical care at the OSUWMC.
- Develop follow up plans to ensure action is successful in improving quality and safety.
- Monitor OPPE reports (via subcommittee) to identify outliers in the faculty prior to their recredentialling review every three years.
- Establish Peer Review Process Policy to clearly define the scope, methods, and timing of peer review events.

Sentinel Event Team

Composition: The OSUWMC Sentinel Event Team (SET) includes an Administrator, the Chief Quality and Patient Safety Officer, the Administrative 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.

Function:

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

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, a significant event or a non-event. SEDG has the authority to assign the Root Cause Analysis (RCA) Executive Sponsor, RCA Workgroup Leader, RCA Workgroup Facilitator, and recommends the Workgroup membership to the Executive Sponsor. When the RCA is presented to the Sentinel Event Team, the RCA Workgroup Facilitator will attend to support the members.

Composition: The SEDG voting membership includes the CQPSO or designee, Director of Risk Management, and Quality Director of respective business unit for where the event occurred (or their designee). Additional guests attend as necessary.

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(s) 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.

Quality Improvement (QI) Teams/Work Groups

The QI Teams serve as the functional arm of Quality and Patient Safety to implement specific quality improvement initiatives within the Health System. The teams leverage the triad/dyad leaders across the system to establish a clear level of accountability for quality improvement activities. The councils use data provided by ACE to identify and prioritize processes and tactics to improve a specific outcome or priority. The teams may develop implementation toolkits consistent with best practice. These toolkits decrease variation in how quality improvement efforts are undertaken across the system for common issues such as falls, hospital acquired infections, and patient safety indicators. QI Team members are responsible for the successful implementation and maintenance of these QI efforts within their areas of responsibility.

Composition: Co-chaired by the Chief Quality and Patient Safety Officer and the Senior Director of Quality and Patient Safety. The teams consist of multidisciplinary leaders across the system and selected business units, nursing, pavilion, as well as educational and administrative leaders.

Function:

- System-wide implementation of quality improvement efforts for specific quality opportunities impacting a broad patient population.
- QI Teams are not intended to replace any service line or business unit level quality committee or activity but are intended to align QI efforts across the system for specific opportunities.
- Priorities are established based on current performance and identified gaps in performance when compared to industry leaders; data is provided from the ACE and quality teams.
- QI Teams are tasked with creating a system-wide QI plan to improve performance to include a standardized toolkit for implementation.
- The team coordinates with ACE to develop process measures, adherence reports, and outcome reporting for the project.
- After implementation, council leaders are responsible for ongoing surveillance of process adherence and outcomes for their respective units.
- QI teams report priorities, progress, and results to the QLC as appropriate.

Roles and Responsibilities

Executive Vice President/CEO

The EVP leads all seven health science colleges and the Wexner Medical Center Enterprise which includes seven hospitals, a nationally ranked college of medicine, 20-plus research institutes, multiple ambulatory sites, an accountable care organization and a health plan. Additionally, the EVP serves as the Chief Executive Officer for Wexner Medical Center and serves in an ex-officio role for the Wexner Board of Trustees, as well as being the Chairman for the Quality and Professional Affairs committee which is a Board committee.

Chief Operating Officer (COO)

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

Chief Clinical Officer (CCO)

The CCO for the Medical Center is responsible for facilitating the implementation of the overall Clinical Quality Management, Patient Safety & Patient Experience Plan at OSUWMC. The CCO is responsible for facilitating the implementation of the recommendations approved by the various committees under the Quality Leadership Committee (QLC).

Chief Quality and Patient Safety Officer (CQPSO)

The CQPSO reports to the Chief Operating Officer and provides oversight and leadership for the OSUWMC in the conceptualization, development, implementation and measurement of the OSUWMC approach to quality, patient safety and patient experience.

Senior Director, Quality and Safety

The Senior Director of Quality and Safety works in dyad partnership with the CQPSO to provide oversight and leadership for the OSUWMC in the conceptualization, development, implementation, and measurement of the OSUWMC approach to quality, patient safety, and patient experience.

Associate Chief Quality and Patient Safety Officers

The Associate Chief Quality and Patient Safety Officers support the CQPSO in the development, implementation, and measurement of OSUWMC's approach to quality, safety, and patient experience.

Medical Director/Director of Medical Affairs

Each business unit Medical Director is responsible for the review, implementation and oversight of the Clinical Quality Management, Patient Safety & Patient Experience Plan.

Associate Medical Directors

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

Chief Administrative Officers – Acute Care Division/Post-Acute and Home-Based Care Division/Outpatient and Ambulatory Division/Clinical and Physician Network

The OSUWMC Chief Administrative Officers are responsible to the Board for implementation of the Clinical Quality Management, Patient Safety & Patient Experience Plan for their respective divisions.

Business Unit Executive Directors

The OSUWMC staff, under the direction of the Health System Chief Administrative Officer and Hospital Administration, implements the program throughout the organization. Hospital Administration provides authority and supports corrective actions within its realm for clinical quality management, patient safety, and patient experience activities.

Clinical Department Chief and Division Directors:

Each department chairperson and division director are responsible for ensuring the standards of care and service are maintained within their department/division. In addition, department chairpersons/division directors may be asked to implement recommendations from the Clinical Quality Management, Patient Safety and Patient Experience 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, & Patient Experience Plan. In addition, members may be asked to serve on quality management committees and/or quality improvement teams.

House Staff Quality Forum (HQF)

The House Staff Quality Forum (HQF) is comprised of representatives from each Accreditation Council for Graduate Medical Education (ACGME) program. HQF has Executive Sponsorship from the CQPSO and the Associate CQPSO.

The purpose of the HQF is to provide post-graduate trainees with an opportunity to participate in clinical quality, patient safety and patient experience-related initiatives while incorporating the perspective of the frontline provider. HQF will work on quality, safety and patient experience related projects and initiatives that are aligned with the health system goals and will report to the Clinical Quality and Patient Safety committee. The Chair HQF will serve as a member of the Leadership Council.

Nursing Quality

The primary responsibility of the Nursing Quality and Evidence-Based Practice (EBP) Department is to monitor and evaluate performance of the nursing staff in support of organizational quality, safety and patient experience goals, submit required data to the National Database for Nursing Quality Indicators (NDNQI), review benchmark data and identify opportunities for improvement, use the literature to guide recommended changes to nursing practice and policy, coordinate and facilitate nursing quality improvement initiatives, facilitate participation/collaboration with system-wide patient safety activities, and use EBP and research to improve both the delivery and outcomes of personalized nursing care.

Nursing Quality team members serve as internal consultants for the development and evaluation of quality improvement, patient safety, and EBP activities. The department maintains human and technical resources for team facilitation, use of performance improvement tools, data collection, statistical analysis, and reporting.

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, Patient Safety and Patient Experience 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 patient experience efforts, including but not limited to:

- Reporting events, including near misses or “good catches” via the internal Patient Safety Reporting System (PSRS)
- Suggesting processes to improve quality, safety and service
- 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 including Root Cause Analysis and Proactive Risk Assessments

Quality and Operations Improvement

The primary responsibility of the Quality and Operations Improvement team 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 quality and operations improvement staff also serve as an internal consultant for the development and evaluation of quality management and patient safety activities. The team maintains human and technical resources for team facilitation, use of performance improvement tools, data collection, statistical analysis, and reporting.

The department is comprised of five main functions (Appendix F):

1. Patient Safety
2. Quality Outcomes Management
3. Quality Program Reporting
4. Provider Engagement / Peer Review

Patient Experience

The primary responsibility of the Patient Experience team 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 as well as a representative of the "voice of the patient" throughout the organization by reflecting or providing patient feedback to shape decision making.

The Patient Experience Department maintains human and technical resources for interpreter services, information desks, patient relations, pastoral care, team facilitation, survey management, and performance improvement. 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 facility. These individuals are volunteers who serve as advisory members on committees and workgroups, complete public speaking engagements and review materials.

Approach to Clinical Quality, Patient Safety & Patient Experience Management Systematic Approach/Model to Process Improvement

The OSUWMC embraces change and innovation as one of its core values. Organizational focus on process improvement and innovation is embedded within the culture using a general Process Improvement Model that includes:

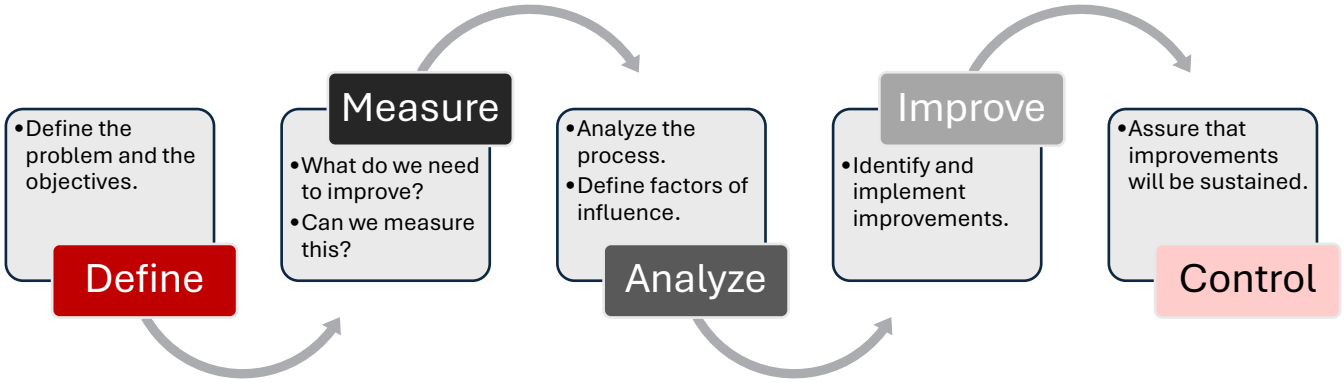
1. An organizational expectation that the entire workforce is responsible for enhancing organizational performance and;
2. Active involvement of multidisciplinary teams and committees focused on improving processes.

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.

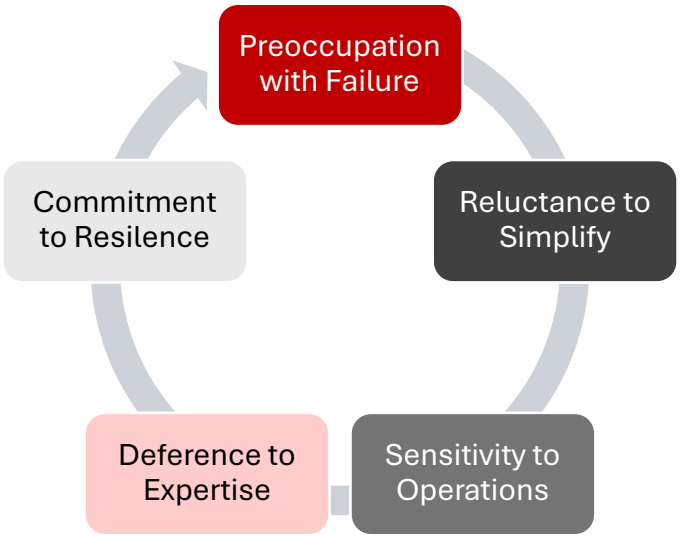
Determining Priorities

The OSUWMC has a process in place to identify and direct resources toward quality management, patient safety, and patient experience activities. The OSUWMC criteria are approved and reviewed by QLC and the Medical Center Board. The prioritization criteria are reevaluated annually according to the mission and strategic plan of the OSUWMC. The leaders may also set performance improvement priorities and reevaluate on an ad hoc basis in response to unusual or urgent events.

DMAIC Roadmap



High Reliability Organization Principles



Data Measurement and Assessment

Determination of Data Needs

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

Collection/Measurement

Data, including patient demographic and clinical information, are systematically collected throughout the OSUWMC through various mechanisms including:

- Administrative and clinical registries and databases
- Retrospective and concurrent medical record review (e.g., infection surveillance)
- Reporting systems (e.g., patient safety reporting system)
- Surveys (i.e. patients, families, and staff)

Assessment

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 previous performance, and external benchmarks. Accepted standards of care and aspirational performance targets are used to establish metrics and goals. Annual goals are established to evaluate performance. Where appropriate, OSUWMC has adopted the philosophy of setting multi-year aspirational targets. Annual targets are set as steps to achieve the aspirational goal.

Surveillance

The OSUWMC 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. Other mechanisms by which data may be obtained are outlined in the graphic below.

Benchmark data

Both internal and external benchmarking provides value to evaluating performance.

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: OSUWMC participates in various database systems, clinical registries and focused benchmarking projects to compare performance with that of peer institutions. Vizient, The US News & World Report, National Database of Nursing Quality Indicators, and The Society of Thoracic Surgery are examples of several external organizations that provide benchmarking opportunities.

External Reporting Requirements

There are several external reporting requirements related to quality, safety, and service. These include regulatory, governmental, payer, and specialty certification organizations. An annual report is given to the Compliance Committee to ensure all regulatory requirements are met.

Methods for Monitoring

Communication of Data/Performance

Metric Headquarters (Metric HQ)

Quality and patient safety related data are collected to monitor key processes and outcomes related to care delivery and according to improvement priorities and surveillance needs. For example, Metric HQ is an internal set of dashboards for visualizing quality and safety data. This serves as a single source of truth across the organization. Additional data sets are available from IHIS reports and/or the Analytics Center of Excellence for specific initiatives as needed and at the requested frequency.

Specific data within Metric HQ is available at the system, business unit, and unit level. Additional process measure data as leading indicators for established outcomes or priorities are also included to help target improvement efforts.

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 that shows Mortality, Length of Stay, Patient Safety Indicators, and Readmission data over time. The data can be displayed at the health system, business unit, clinical service, and nurse station level.

Patient Satisfaction Dashboard

The Patient Satisfaction dashboard consists of patient experience indicators and comments gathered from surveys after discharge or visit to a hospital or outpatient area. The dashboard covers performance in areas such as overall experience, physician communication, nurse communication, responsiveness, and environment. It also measures process indicators, such as joint physician-nurse rounding 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.

Frequency of Data Collection

Dashboards are automatically refreshed daily without the need for manual refresh processes. Data collection frequency through other reports and/or data sets occurs at the timeframes designated for each specific initiative. Project and departmental teams set the data collection plan and frequency that meets their project's goals and objectives.

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 (division directors as well) have online access 24/7 to physician profiles for their ongoing review
    - Individual physician access to their profiles 24/7
- 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 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

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.

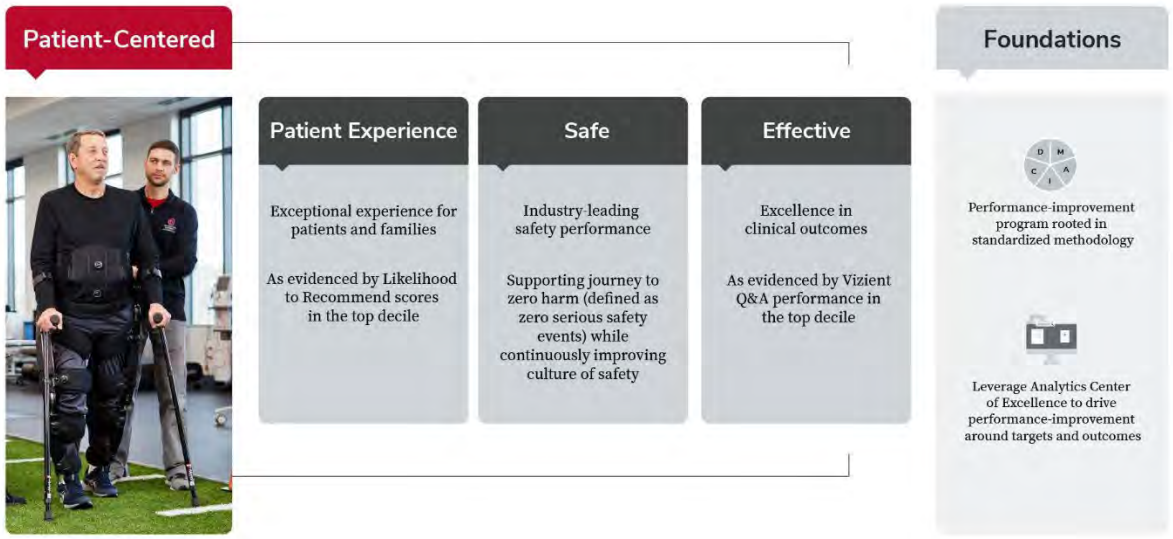
Persons who are professionally involved in the care under review are to refrain from participation except as requested by the appropriate administrative or medical leader. During peer review evaluations, deliberations, or voting, the chairperson will take steps to avoid the presence of any person, including 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.

Annual Approval and Continuous Evaluation

The Clinical Quality Management, Patient Safety & Patient Experience Plan is approved by the QLC, 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.

Appendix A: Long Range Quality Plan



Appendix B: Prioritization Criteria

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

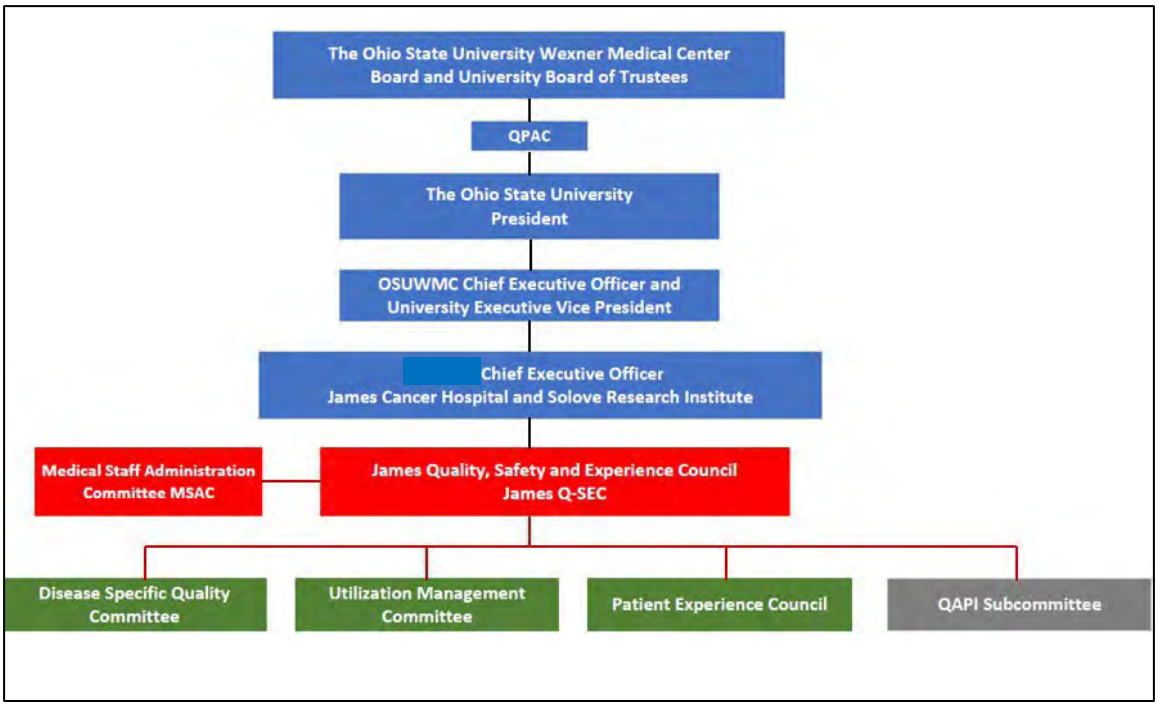
1. Ties to strategic initiatives and is consistent with hospital's mission, vision, and values
2. Reflects areas for improvement in patient safety, appropriateness, quality, and/or medical necessity of patient care (e.g., high risk, serious events, problem-prone)
3. Has considerable impact on our community's 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)

Appendix C: FY26 Priorities/Metrics

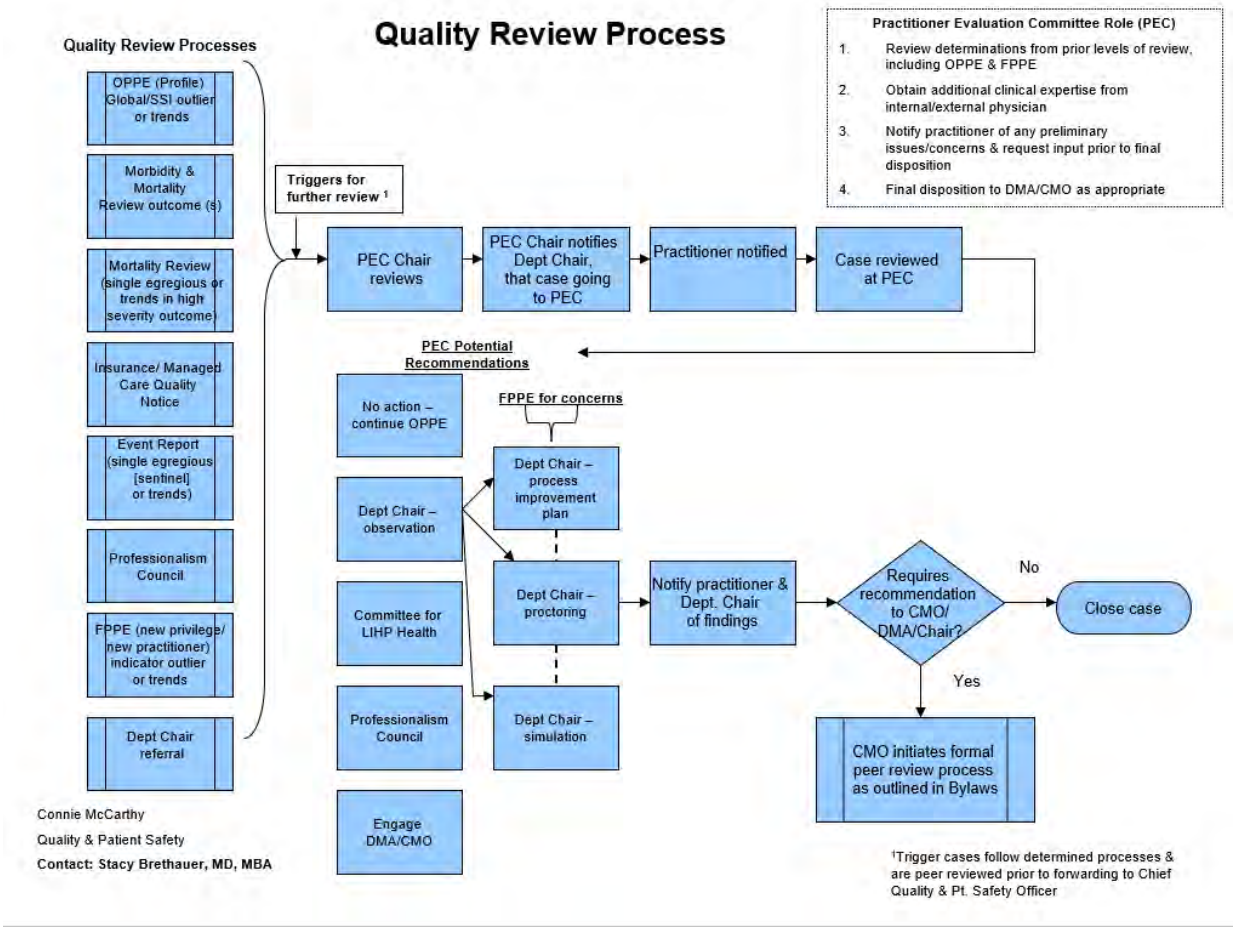
Board Endorsed FY26 Quality & Safety Priorities

- Mortality
- Patient Experience (Likelihood to Recommend)
- Central Line Associated Blood Stream Infection (CLABSI)
- Falls with Injury
- Serious Safety Event Rate
- Execute on HRO

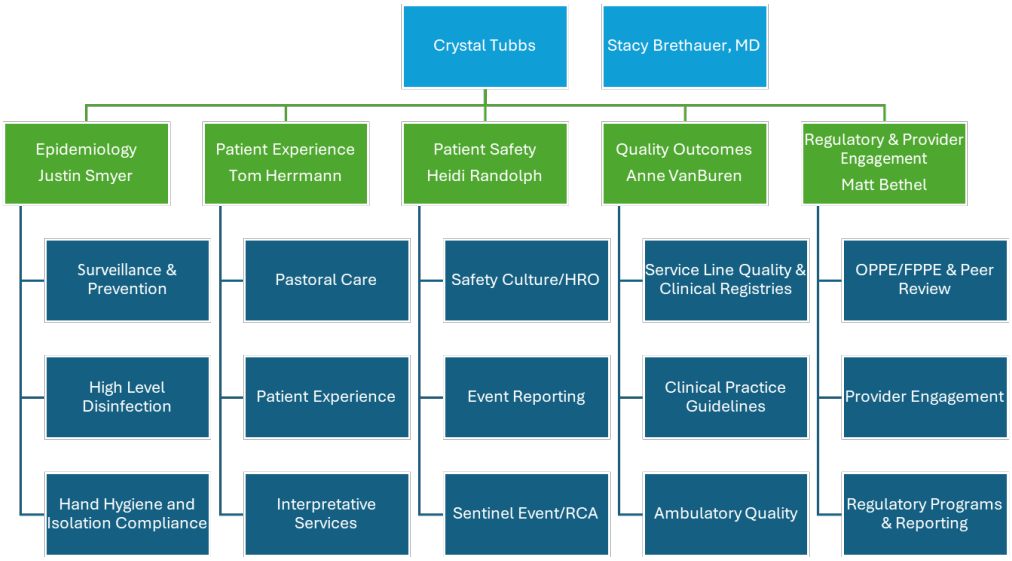
Appendix D: Quality Structure for The James Cancer Hospital & Solove Research Institute



Appendix E: Quality Review Process & Physician Performance Based Profile



Appendix F: Quality & Operations Improvement Organizational Chart



August 19, 2025

THE JAMES CANCER HOSPITAL QUALITY, SAFETY AND EXPERIENCE COUNCIL PLAN

THE OHIO STATE UNIVERSITY COMPREHENSIVE CANCER CENTER
ARTHUR G. JAMES CANCER HOSPITAL AND
RICHARD J. SOLOVE RESEARCH INSTITUTE

Synopsis: Approval of the annual review of The James Quality, Safety and Experience Council Plan for FY26 for the Ohio State Comprehensive Cancer Center — James Cancer Hospital and Solove Research Institute, is proposed.

WHEREAS the mission of The James is to eradicate cancer from individuals' lives by generating knowledge and integrating groundbreaking research with excellence in education and patient-centered care*;* and

WHEREAS The James Quality, Safety, and Experience Council Plan for FY26 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 James; and

WHEREAS the annual review of The James Quality, Safety and Experience Council Plan for FY26 was approved by The James Quality, Patient Safety, and Reliability Committee on April 23, 2025; and

WHEREAS the annual review of The James Quality, Safety and Experience Council Plan for FY26 was approved by The James Medical Staff Administration Committee on May 16, 2025; and

WHEREAS on July 22, 2025, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the annual review of The James Quality, Safety and Experience Council Plan for FY26:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves The James Quality, Safety and Experience Council Plan for FY26 as outlined in the attached document.

Approvals
MSAC: 5/16/2025
QPAC:
Wexner Medical Center Board:

The James Cancer Hospital Quality, Safety and Experience Council Plan

The Ohio State University
James Cancer Hospital and
Solove Research Institute
The Comprehensive Cancer Center
(The James and CCC)

Fiscal Year 2026
July 1, 2025, through June 30, 2026

The James
THE OHIO STATE UNIVERSITY
COMPREHENSIVE CANCER CENTER

The James Cancer Hospital Quality, Safety and Experience Council Plan

Table of Contents

The James Cancer Hospital & Solove Research Institute

The James Quality, Safety and Experience Council Plan

Mission, Vision, and Values:

Mission: To eradicate cancer from individuals' lives by creating knowledge and integrating groundbreaking research with excellence in education and patient-centered care.

Vision: Creating a cancer-free world. One person, one discovery at a time.

Values: Excellence, Collaborating as One University, Integrity and Personal Accountability, Openness and Trust, Diversity in People, and Ideas, Change and Innovation, Simplicity in Our Work, Empathy, Compassion, and Leadership.

The James' model of patient-centered care is enhanced by the teaching and research programs. Patient service, both directly and indirectly, provides the foundation for teaching and research programs. This three-part mission and a staff dedicated to its fulfillment, distinguish The Arthur G. James Cancer Hospital and Richard J. Solove Research Institute as a Comprehensive Cancer Center and as one of the nation's premier cancer treatment centers.

Definition:

The James Quality, Safety, and Experience Council Plan (hereinafter The Plan) of The James Cancer Hospital and Solove Research Institute is our organization-wide approach to systematic assessment of process design and performance improvement targeting quality of care, patient safety, and patient experience. The Plan serves to provide direction for how clinical care and activities are to be designed to enrich patient outcomes, reduce harm, and improve value-added care and service to the cancer patient population.

Scope:

As a Prospective-Payment-System-exempt (PPS-exempt) hospital, which serves as the clinical care delivery-arm of an NCI-designated Comprehensive Cancer Center, The James has a unique opportunity to ensure value-added services and research expertise are provided to our patients, families, and the community – both nationally and internationally. The Plan encompasses all clinical services. Through close partnership with the Comprehensive Cancer Center, The Plan includes quality and patient safety goals for process improvements related to functions and processes involving both the Cancer Center and the hospital and ambulatory clinics/treatment areas.

With a close partnership within OSUWMC, The Plan provides oversight of the clinical contracted services and serves as a component of The Quality Assessment and Performance Improvement (QAPI) requirements from the Center for Medicaid and Medicare Services. These services are evaluated on an annual basis by The James Quality, Safety and Experience Council (Q-SEC), The James Quality Assessment and Performance Improvement (QAPI) Subcommittee, The James Medical Staff Administrative Committee (MSAC), and then forwarded each year to the Quality and Professional Affairs Committee (QPAC) as a part of the governing body, to ensure quality and safety of care is provided to all James' patients.

Purpose:

The purpose of the Plan is to provide guidance for the resources and processes available to ensure measurable improvements to patient care are occurring. The James recognizes the vital importance of creating and maintaining a safe environment for all patients, visitors, employees, and others within the organization to bring about personalized care through evidence-based medicine.

Objectives:

The central objectives of The James Quality, Safety and Experience Council Plan are to:

1. Provide guidance for monitoring and evaluation of effort(s) in clinical care to sustain high performance and improved outcomes for all patients.
2. Evaluate and recommend evidence-based system changes to improve patient care and safety by assessing, identifying, and reducing risk within the organization when undesirable patterns or trends in performance are identified, or when events requiring intensive analysis occur.
3. Assure overall program meets or exceeds accreditation standards, state, federal and licensure regulations.
4. Provide information for adherence to evidence-based practice guidelines to standardize clinical care and reduce practice variation.
5. Improve patient satisfaction and perception of treatment, care, and services by continuously identifying, evaluating, and improving performance based on needs, expectations, and satisfaction results.
6. Enhance the patient experience by providing safe and high-quality care at the best value.
7. Provide education to the governance, faculty and staff regarding quality management principles and processes for improving systems.
8. Provide appropriate levels of data transparency.
9. Assure quality and patient safety processes developed involve trans-disciplinary teamwork.
10. Provide process improvement initiatives to clinical systems to prevent or eliminate patient harm.

Structure for Quality Oversight:

The James Quality, Safety and Experience Council (Q-SEC) serves as the primary entity within The James to develop annual goals which are consistent with goals from the Health System. However, these goals are designed specifically for The James to target and focus on the cancer patient population and cancer research agendas.

Governance and Committees:

Governing Body

The Wexner Medical Center Board is the governing body, responsible to The Ohio State University Board of Trustees, for operation, oversight, and coordination of the Wexner Medical Center and The James Cancer Hospital. The Wexner Medical Center Board is composed of sixteen voting members, plus an additional group of university and medical center senior leaders who serve in ex-officio roles. The Quality & Professional Affairs Committee (QPAC) reports to the Wexner Medical Center Board and is responsible for, among other things, annually reviewing and evaluating The James Quality Safety, and Experience Council Plan, along with goals and process improvements made for improved patient safety and quality programs, QPAC is also responsible for granting clinical privileges for the credentialing of practitioners. The Board of Trustees and its committees meet throughout the year with focused agendas and presentations.

The Quality and Professional Affairs Committee (QPAC):

Composition:

This committee consists of no fewer than four voting members of the University Wexner Medical Center Board of Trustees. Members are appointed each year by the Chair of the OSUWMC Board, and one of these shall be assigned as the Chair of the committee. The CEO of the OSU Health System; CMO of the University Medical Center; CMO of The James; the Medical Director of Credentialing for The James; the Chief of Medical Staff of the University hospitals; the Chief of Medical Staff for The James; 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 serve in ex-officio, voting positions. Other members as may be appointed by The Chair of the OSUWMC board, in consultation with the Chair of Quality and Professional Affairs committee.

Function:

The Quality and Professional Affairs Committee (QPAC) shall be responsible for the following specific duties:

1. Reviewing and evaluating the Quality and Patient Safety programs of OSUWMC.
2. Overseeing all patient care activity in all facilities as a part of OSUWMC, including but not limited to, hospitals, clinics, ambulatory care, and physician office facilities.
3. Monitoring quality assurance performance in accordance with the standards set by OSUWMC.
4. Monitoring the achievement of accreditation and licensure requirements.
5. Reviewing and then recommending to the OSUWMC board changes to the medical staff bylaws and medical staff rules and regulations.
6. Reviewing and approving clinical privilege forms.
7. Reviewing and approving membership, as well as granting appropriate clinical privileges for the credentialing of practitioners, recommended for membership and clinical privileges by the hospital's Medical Staff Administrative Committees (MSAC).
8. Reviewing and approving membership and granting appropriate clinical privileges for the expedited credentialing of such practitioners that are eligible by satisfying the minimum approved criteria which is determined by the OSUWMC board and recommended for membership and clinical privileges to the MSACs of OSUWMC and The James.
9. Reviewing and approving the reinstatement of clinical privileges for a practitioner after a leave of absence from clinical practice.
10. Conducting Peer Review activities and recommending professional review actions to the OSUWMC board.
11. Reviewing and resolving any petitions by the medical staff 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 hospital's MSACs.
12. Such other responsibilities as assigned by the Chair of the OSUWMC Board.

The James Medical Staff Administrative Committee (MSAC)

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 Director of Medical Affairs/Chief Medical Officer, implements The Plan throughout the clinical departments. The James MSAC reviews reports, and makes recommendations related to clinical quality management, 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 James MSAC reviews corrective actions and provides authority within their realm of responsibility related to clinical quality management, patient safety, and service quality activities.

The James Quality, Safety and Experience Council (Q-SEC)

Composition:

The James Quality, Safety and Experience Council (Q-SEC) consists of representatives from Medical Staff, Administration, Advanced Practice Providers, Quality and Patient Safety, Clinical Outcomes, Analytics Center of Excellence, Nursing, Operations Improvement, and Patient Experience (Attachment A). Membership varies due to due the fluency of ongoing quality initiatives and is subject to change. This Council reports to Executive Leadership and The James Medical Staff Administrative Committee (MSAC).

Function:

- Create a culture which promotes organizational learning and recognition of clinical quality (improving outcomes) and patient safety (reducing harm).
- Develop and sustain a culture of safety which strives to embed Just Culture principles in the follow-up of healthcare errors.
- Assure compliance with patient safety-related accreditation standards.
- Proactively identify risks to patient safety and creates a call-to-action to reduce risk with a focus on process and system improvement.
- Oversee education and risk reduction strategies as they relate to Sentinel Event Alerts from The Joint Commission.
- Evaluate standards of care and evidence-based practices and provide recommendations to improve clinical care and outcomes.
- Ensure actions are taken to improve performance whenever an undesirable pattern or trend is identified.
- Receive reports from disease specific committees that have a potential impact on the quality & safety in delivering patient care such as, but not limited to, Apheresis, BMT and Acute Leukemia, Cell Therapy, Lymphoma, Sickle Cell, Radiation Oncology, Translational Research, Patient Experience, Grievance Committee, Utilization Management Committee, and Infection Prevention Committees.
- Receive reports from Shared Services as they represent the metrics for quality and safety of care for the cancer patient population.
- Maintain follow-up on Shared Services action plans as necessary for improving metrics for quality and safety of care for the cancer patient population.

The James Quality, Safety and Experience Council QAPI Sub-Committee

Composition:

The James Quality, Safety and Experience QAPI Sub-Committee refers to the sub-committee functioning under the quality oversight structure of The James Quality, Safety and Experience Council (Q-SEC). The term QAPI refers to Quality Assessment and Performance Improvement. Membership on this sub-committee represents the major clinical and support services throughout the hospitals and/or clinical departments, as well as members from The James Quality, Safety and Experience Council. The QAPI Sub-committee will identify department barriers requiring escalation to The James Quality, Safety and Experience Council (Q-SEC), or as defined by The Plan.

Function:
Serves 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.

- Conducts department reviews for services provided by The James and services received from Wexner Medical Center, including process/patient safety metrics and PSRS events reviews.
- Receive and review reports from Shared Services as they present quality and safety of care metrics for the cancer patient population.
- Maintain continuous follow-up on Shared Services action plans for improving metrics for quality and safety of care for the cancer patient population.

The James Human Experience Strategic Steering Council

Composition:
The James Human Experience Strategic Steering Council consists of multidisciplinary representatives from Hospital Administration, Medical Staff, Nursing, Nutrition Services, Environmental Services, Communications, and the Patient Experience Department. The James Human Experience Strategic Steering Council has a liaison member connected to The James Quality, Safety and Experience Council (Q-SEC).
Function:

- Create a culture and environment to deliver exceptional patient experience consistent with the mission, vision and values focused on service quality.
- Measure and review voice of the customer information in the form of patient satisfaction, comments, letters, and related measures.
- Recommend system goals and expectations for consistent patient experience.
- Provides guidance and oversight into patient experience improvement efforts ensuring effective deployment and accountability throughout the system.
- Communicates the work of the Council throughout the organization.

The James Utilization Management Committee (JUMC)

Composition:
The James Utilization Management Committee (JUMC) is co-chaired by the Associate Chief Medical Officer of the Care Continuum and the Director of Patient Care Resource Management. Committee membership will include James Physician Advisors and Emergency Department Physician Advisors, physician members of the medical staff, representatives from the Patient Care Resource Management (PCRM) Department, Administration, Finance, Advance Practice Professionals, Providers, Quality and Safety, Revenue Cycle and Compliance, Nursing and Service Line Administration. Other departments in The James will be invited to join meetings as necessary when opportunities have been identified for improvement and input. JUMC members will not include any individual who has a financial interest in any hospital in the health system. No JUMC member will be included in the review process for a case when that member has direct responsibility for patient care in the case being reviewed.
Function:
The JUMC has a responsibility to establish and implement The James Utilization Management Plan. The JUMC implements procedures for reviewing the efficient utilization of care and services, including, but not limited to admissions, continued stays, readmissions, over and under-utilization of services, the efficient scheduling of services, appropriate stewardship of hospital resources, access and throughput and timeliness of discharge planning. Any quality or utilization opportunities identified by the JUMC through utilization review activities are

acted upon by the committee or referred to the appropriate entity for resolution. The JUMC provides education on care and utilization issues to all health care professionals and medical staff at The James.

Practitioner Evaluation Committee (PEC)

Composition:
The Practitioner Evaluation Committee (PEC) is the medical staff peer review committee that provides leadership in overseeing the peer review process. The PEC is composed of the Chair of the Clinical Quality and Patient Safety Committee, medical staff, and advanced practice providers from various business units and clinical areas as appointed by the Chief Medical Officer (CMO) of the Health System and the Director of Medical Affairs/Chief Medical Officer.
Function:

- Provide leadership for the provider clinical quality improvement processes.
- Provide clinical expertise to the practitioner peer review process by thorough and timely review of clinical care and/or patient safety issues referred to the PEC.
- Provide advice and support to the Director of Medical Affairs/CMO at The James regarding action plans to improve the quality and safety of clinical care.
- Provide input to the Director for Advanced Practice Providers when there is an APP Peer Review completed.
- Develop follow up plans to ensure action is successful in improving quality and patient safety.

Health System Information Systems Steering Team (HSISST)

Composition:
The HSISST is a multidisciplinary team chaired by the Chief Medical Information Officer of OSUWMC.
Function:
The HSISST oversees information technology for both The James and OSUWMC. The team is responsible for oversight of information technology and processes currently in place, as well as reviewing replacement and/or introduction of new systems, and related policies/procedures. Individual team members are charged with responsibility to communicate and receive input from their various communities of interest on relevant topics discussed at committee meetings and other forums.

Sentinel Event Committee and Sentinel Event Determination Group (SEDG):

Composition:
The Sentinel Event Team includes membership from both The James and the OSUWMC. Membership from The James includes: the Executive Director Medical Affairs/Chief Medical Officer, the Quality Medical Director for The James, the Quality Medical Director for Perioperative services, and the Director of Quality & Patient Safety and Nursing Quality Director. Members from the Medical Center include: an Administrator, Chief Medical Officer, Chief Quality Officer, Associate Chief Quality and Patient Safety Officer, Associate Executive Director of Quality & Safety, a member of the Physician Executive Council, Quality and Operations Improvement, and Medication Safety Officer. Members from Risk Management are also included.

The Sentinel Event Determination Group (SEDG) is a sub-group of the Sentinel Event Team which is comprised of quality leaders from The James and OSUWMC and are chaired by the Health System Chief Quality Officer. The SEDG membership includes the CQO, Associate CQO, Director of Risk Management, James Quality Medical Director, Directors of Quality & Patient Safety and Nursing Quality Directors of respective business units. The SEDG meets weekly to review sentinel events and significant events. Once an event is determined to be a

significant or sentinel event, SEDG members assign a Root Cause Analysis (RCA) Team who includes Executive Sponsor, RCA Workgroup Leader, and RCA Workgroup Facilitator. The James Director of Quality and Patient Safety serves as the executive sponsor for the RCA, and receives the input from SEDG, collaborates with facilitators and physician leaders to finalize the team membership, initiate team charters, and ensure that team meetings and action plans are completed in accordance with requirements to satisfy regulatory compliance.

Function:

Approve and make recommendations on sentinel event determinations and teams, and action plans as received from the Sentinel Event Determination Group. Results of a sentinel event, significant event or near-miss information are considered confidential according to Ohio Revised Code Section 2305.25 and are not externally reported or released.

The James Continuous Quality Improvement Teams

Composition:

For the purposes of this plan, Quality Improvement Teams are considered as ad-hoc committees, disease specific workgroups, performance improvement teams, taskforces, etc., that function under the quality oversight structure and are time-limited in nature, as well as the new Health System groups that will report up to Q-SEC (an example is the Hospital Acquired Infection group). Continuous Quality Improvement teams are comprised of owners or participants in the process under study. The process may be clinical or non-clinical. The members fill the following roles: team leader, Process Engineer or facilitator, physician advisor, administrative sponsor, and technical experts.

Function:

Improve current practice or processes using traditional continuous process improvement tools such as rapid cycle improvements, LEAN principles and DMAIC/DMADV/PDCA.

Roles and Responsibilities

The management of clinical quality, patient safety and excellence are responsibilities of all faculty, staff, and volunteers.

Chief Executive Officer (CEO)

The CEO for The James reports to the OSUWMC Chief Executive Officer and is responsible for providing leadership and oversight for the overall functions within The James. The CEO has authority over the James Quality, Safety and Experience Council Plan and collaborates with all employees and medical staff to ensure safe care is delivered to our patients to achieve quality outcomes for each encounter.

Director of Medical Affairs/Chief Medical Officer (CMO)

The Director of Medical Affairs is the Chief Medical Officer for The James Cancer Hospital who provides leadership and strategic direction for the faculty, medical staff, and other providers to ensure the delivery of high quality, cost-effective health care consistent with The James mission. The CMO has oversight of the medical staff's responsibilities for progress towards goals and process improvements. The CMO is a member of The James Medical Staff Administrative Committee (MSAC) and is the medical director for provider credentialing within The James.

Quality Medical Director

The James Quality Medical Director reports to the Chief Medical Officer and is responsible for assisting the Quality Department with medical review for all patient safety and quality outcomes. This physician also works

collaboratively with the health system quality medical directors and the Chief Quality and Patient Safety Officer in determining sentinel and significant events, as well as reporting events, when necessary, through the peer review process. The Quality Medical Director is a member of both the James Quality, Safety and Experience Council and a member of The James Medical Staff Administrative Committee (MSAC).

Medical Director

Each business unit Medical Director is responsible for reviewing the recommendations from The Plan and implementing quality goals and plans, along with maintaining oversight in their clinical areas.

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 to and must participate in the functions and expectations set forth in The Plan. In addition, members serve on quality management/patient safety committees and/or continuous quality improvement teams throughout the year.

Executive Director, Clinical Services

The James Executive Director for Clinical Services provides leadership and oversight of The Plan and works collaboratively with the OSUWMC Quality Leadership Council (QLC) initiatives. The Executive Director is integral to the establishment and implementation of The Plan, organization-wide quality goals, and performance improvement achievements.

Chief Nursing Officer

The James CNO reports to the Executive Director of Clinical Services to work and provide senior leadership within the nursing structure to influence the nursing process and practices. The CNO ensures the overall James Quality, Safety and Experience Council Plan is utilized to assist with the development, implementation, and initiation of The James Nursing Strategic Plan. The CNO has oversight of the nursing shared governance model and the nursing leadership which establishes and implements annual nursing-sensitive goals.

Nursing Leadership

The Chief Nursing Officer, as well as the Associate Chief Nursing Officer(s), and Directors of Nursing are responsible to implement, maintain oversight, and incorporate opportunities and goals identified in collaboration with the OSUWMC- QLC Committee.

Nursing directors and managers are to implement recommendations or participate in action plans for individual employees or the department. They provide input regarding committee memberships, and serve as participants in the departmental, hospital and Health System quality/patient safety committees. Clinical Nurse Specialists (CNS) support quality improvement initiatives by providing leadership in the application and use of evidence-based practice. The James nursing staff is responsible for providing the highest standard of care and services within their scope of practice.

Quality and Patient Safety Leadership

The Sr. Director of Quality and Patient Safety, Director for Quality and Patient Safety, and the Director of Clinical Outcomes collaborate directly with the executive leaders as well as with the directors and managers of all areas to evaluate, plan and improve on patient safety and quality outcomes. In addition, the Directors have leadership oversight of quality improvement goals, patient safety improvements, and facilitates team(s) charged for implementation of annual hospital level goals.

The James Quality and Patient Safety Department

The primary responsibilities of The James Quality and Patient Safety Department are to:

- Track and trend quality events, including Sentinel Events.
- Coordinate and facilitate clinical quality management for improved outcomes.
- Monitor patient safety incidents and work with the management teams for elimination or reduction of risk/harm to patients.
- Improve patient care services by assuring the voice of the patient is heard throughout The James.
- Assist managers with evaluations of situations by utilizing Just Culture algorithm and training.

While primary responsibility for the implementation and evaluation of clinical quality, patient safety, and service activities resides within each department/program, The James Quality and Patient Safety staff also serve as internal consultants for the development, evaluation, and on-going monitoring of those activities. The James Quality and Patient Safety Department, James Quality and Clinical Outcomes team including The James Operations Improvement staff, and the Analytics Center of Excellence (ACE) staff, maintain human and technical resources for team facilitation, use of performance improvement tools, data collection, statistical analysis, and reporting.

Hospital Management Team

Each associate executive director, all service line administrators, department directors and managers are responsible to ensure the standards of care and service are maintained or exceeded within their department(s), and are responsible for implementing, monitoring, and evaluating activities in their areas and assisting clinical staff members in developing appropriate mechanisms for data collection and evaluation. Department directors, managers and/or assistant managers participate in action plans for individual employees or the department. All department directors/managers provide input regarding committee memberships and serve as participants on quality management/patient safety committees and/or quality improvement teams. Managers and staff are engaged through formal and informal processes related to quality improvement and clinical patient safety efforts, including but not limited to:

- Suggesting process improvements and reporting medical/health care events and near misses.
- Implementing evidence-based practices.
- Monitoring and responding to activities and processes, such as patient complaints and patient satisfaction.
- Participating in audits, observations and peer-to-peer review and feedback; and,
- Participating in efforts to improve patient outcomes and enhance patient safety.

The James Patient Experience/Guest Services Department

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

materials. Lastly, the department supports system-wide Volunteer efforts, aligning credentialed adult and student volunteers with service opportunities within the medical center.

Philosophy of Patient Care Services

The James provides innovative and patient-focused comprehensive cancer care and services which include the following:

- A mission statement that outlines the relationship between patient care, research, and teaching.
- Long-range, strategic planning conducted by leadership to determine the services to be provided.
- Establishing annual goals and objectives consistent with the hospital mission, and which are based on a collaborative assessment of patient/family and the community's needs.
- Provision of services appropriate to meet the needs of patients.
- Ongoing evaluation of services provided such as: performance assessment and improvement activities, budgeting, and staffing plans.
- Integration of services through the following: continuous quality improvement teams; clinical interdisciplinary quality programs; performance assessment and improvement activities; communications through management operations meetings, nursing shared governance structure, Medical Staff Administrative Committee, administrative staff meetings; participation in OSUWMC and OSU governance structures, special forums; and leadership and employee education/development.
- Maintaining competent patient care leadership and staff by providing education and ongoing competency reviews which are focused towards identified patient care needs.
- Respect for each patient's rights and decisions is an essential component in the planning and provision of care.
- Utilizing the Relationship Based Care principles which encompasses building a caring and healing environment for patients, families and staff by developing caring and therapeutic relationships with the patients/families, colleagues, self and the larger community.
- Embracing the principles of a Just Culture and honoring a Culture of Safety for all team members, faculty, and staff.

The IOM *10 Rules for Redesign* are guiding principles for the provision of safe and quality care. These are:

1. ***Care is based on continuous caring and healing relationships***. Patients should receive care whenever they need it and, in many forms, not just face-to-face visits. This implies that the health care system must be always responsive, and access to care should be provided over the Internet, by telephone, and by other means in addition to in-person visits.
2. ***Care is customized according to patient needs and values***. The system should be designed to meet the most common types of needs but should have the capability to respond to individual patient choices and preferences.
3. ***The patient is the source of control***. Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The system should be able to accommodate differences in patient preferences and encourage shared decision making.
4. ***Knowledge is shared and information flows freely***. Patients should have unfettered access to their own medical information and clinical knowledge. Clinicians and patients should communicate effectively and share information.

5. ***Decision making is evidence-based***. Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.
6. ***Safety is a system property***. Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.
7. ***Transparency is necessary***. The system should make available to patients and their family's information that enables them to make informed decisions when selecting a health plan, hospital, or clinical practice, or when choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.
8. ***Needs are anticipated***. The system should anticipate patient needs, rather than simply react to events.
9. ***Waste is continuously decreased***. The system should not waste resources or patient time.
10. ***Cooperation among clinicians is a priority***. Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

Following these principles, The James has instituted the following guidelines as the approach to quality, safety, and experience services:

- ***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 curricula for quality, safety, and reliability for all faculty, staff, volunteers, and students.
- ***Involvement***: All team members must have mutual respect for the dignity, knowledge, and contributions of others. Everyone is engaged in the improvement of processes where they work.
- ***Data-driven decision making***: Decisions for quality, safety, and reliability are based on the knowledge derived from data.
- ***Continuous Process Improvement***: Analysis of processes for design, redesign and to reduce variations are accomplished by use of an approach using science and LEAN/DMAIC/PDCA. Measures and improvements are ongoing.
- ***Just Culture***: Our framework of quality, safety, and reliability services are based on a culture that is open, honest, transparent, collegial, team-oriented, accountable, and non-punitive when system failures have occurred.
- ***Personalized Health Care***: Begins with developing a therapeutic relationship with the patient and family and incorporating evidence-based medicine which considers the patient's health status, genetics, cultural tradition, personal preferences, and values family and lifestyle situations.
- ***Reducing Health Disparities***: Ongoing commitment to make health care disparities an organizational quality and safety priority by assessing, identifying trends in data, developing, and implementing action plans, and communicating progress to key stakeholders.

Consistent Level of Care

Certain elements of The Plan help to ensure patient care standards for the same or similar services are comparable in all areas. These elements include, but are not limited to:

- Policies and procedures and services provided are not payer driven and are standardized to promote high quality and safe care.
- Application of a single standard for physician credentialing.
- Cancer care delivery is based upon nationally recognized standards of care from the National Comprehensive Cancer Network (NCCN).

- Use of monitoring tools to measure processes in areas of the Health System and The James.

Performance Transparency

The James Medical and Administrative leadership have a long-standing and strong commitment to transparency of performance as it relates to clinical quality, safety, and service performance.
Performance data is shared internally with faculty and staff through a variety of methods. Providing data internally assists faculty and staff in obtaining real-time performance results and enables faculty and staff to use those results to drive change and improve performance. Transparency of the information provided is within the limits of the Ohio law that protects attorney –client privilege, quality inquiries and reviews, as well as peer review. Current quality data is shared on The James internal intranet site. The Analytics Center of Excellence team works with many departments and partners with other reporting groups to build and enhance quality and safety dashboards, as well as display other important metrics to build on the equation of value for our patients.

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, keeping aligned with Ohio Revised Code 121.22 (G)-(5) and Ohio Revised Code 2305.251.

Conflict of Interest

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 a 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 the 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 concerned any action under peer review.

Priority Criteria

The following criteria are used to prioritize clinical value enhancement initiatives and continuous quality improvement opportunities, to ensure the appropriate allocation of resources.

1. Ties to strategic initiatives consistent with the 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 a considerable impact on our community's health status (e.g., morbidity/mortality rate).
4. Address patient experience issues (e.g., access, communication, discharge).
5. Reflects divergence from benchmarks.
6. Addresses variation in practice.
7. Required by an external organization.

8. Represents significant cost/economic implications (e.g., high volume).

Determining Priorities

The James has a process in place to identify and direct resources toward quality management, patient safety, and service excellence activities. The prioritization criteria are reevaluated annually according to the mission and strategic plan. The leaders set performance improvement priorities and reevaluate annually in response to unusual or urgent events. Whenever possible, NCI, ADCC, or other appropriate cancer specific benchmarks are utilized to compare performance metrics for The James, to assist with determination of priorities each year to improve performance.

Design and Evaluation of New Processes

New processes are designed and evaluated according to the organizational mission, vision, values, and 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 perceived 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 to confirm the need and/or by evidence-based practices.

Data Measurement and Assessment

Determination of Needs

Data needs are determined according to improvement priorities and surveillance needs. The James Quality and Patient Safety departments and Analytics Center of Excellence collect and report data for monitoring important processes and outcomes related to patient care. In addition, each department is responsible for identifying 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. Quality and safety monitoring is on-going and reviewed by The James Quality, Safety and Experience Council (Q-SEC) annually.

External Reporting Requirements

The reporting requirements related to quality, safety, and service. These include regulatory, governmental, payer, and specialty certification organizations.

Collection of Data

Data, including patient demographic and diagnosis, are systematically collected by various mechanisms including but not limited to:

- Administrative and clinical databases
- Retrospective and concurrent medical record review
- Reporting systems (e.g., patient safety and patient satisfaction)
- Surveys (e.g., patients, families, and staff)
- External (e.g., Vizient, CDC-NHSN, NDNQI, CMS, or other vendors)

Assessment of Data
Statistical methods are used to identify undesirable variance, trends, and opportunities for improvement. The data are compared to the previous performance, external benchmarks, and accepted standards of care to establish goals and targets. Annual goals are established to evaluate performance.

Surveillance System
The James 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.

The James Key Performance Indicator Scorecard
Patient Safety is the highest priority for all faculty and staff at The James. As a crucial element to caring for our patients, there is an on-going process of monitoring safety events and any untoward trends from patient care. The James Key Performance Indicator Scorecard (hereinafter The Scorecard) is a portal consisting of various dashboards with key performance indicators related to events considered potentially preventable, and which cause a level of harm to the patient. The Scorecard covers areas such as mortality, falls, hospital acquired infections, hospital-acquired pressure ulcers, as well as additional indicators such as patient satisfaction, readmissions, and length of stay.

This information is shared in various quality forums with the medical staff, clinicians, James's administration, and senior staff, and The Quality and Professional Affairs Committee (QPAC) at the Wexner Medical Board. The indicators to be included in The Scorecard are reviewed each year to represent the priorities of the Quality and Patient Safety program. The Patient Safety program evaluates opportunities each month at The James Quality, Safety and Experience Council (Q-SEC), as well as monthly at the Medical Staff Administrative Committee (MSAC). Safety goals are reviewed annually and adjusted as necessary by the use of event trending, regulatory changes, needs identified from the culture of safety surveys and/or national cancer benchmarks.

The James Patient Satisfaction Dashboard
The Patient Satisfaction dashboard is a set of patient experience indicators gathered from surveys after discharge or visit to a system-based clinic or hospital. The dashboard displays performance in areas such as physician communication, nursing responsiveness, admitting, and discharging efficiencies and quality in addition to other service categories. The information from this dashboard is shared in forums with staff, clinicians, administration, including the Board. Performances on these indicators serve as annual goals for leaders and members of clinical and patient experience teams.

Quality and Patient Safety Staff Education
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 and service for all staff, employees, clinicians, patients, and students. There are a variety of forums and venues utilized to enhance the education surrounding quality and patient safety including, but not limited to:

- Online videos
- Newsletters
- Classroom forums
- Simulation training
- Computerized Based Learning Modules (e-learning/CBLs)

- Curriculum Development within College of Medicine
- Websites (internal SharePoint and external OSUMC)
- Patient Safety/Quality Lesson's Learned and Patient Safety Alerts

The James Benchmark Data
Both internal and external benchmarking provide value when evaluating performance.

Internal Benchmarking
Internal benchmarking uses processes and data to compare The James performance to itself over time and provides a gauge of improvement strategies within the organization.
External Benchmarking
The James participates in various database systems and focused benchmarking projects to compare performance with that of cancer hospital - peer institutions. The James Cancer Hospital utilizes and joins other comprehensive cancer centers for benchmarking such as C4QI (Comprehensive Cancer Center Consortium for Quality Improvement) and ADCC (Alliance of Dedicated Cancer Centers), National Cancer Institute (NCI). Also, The James participates in national benchmarking efforts through the following, but not limited to, The Vizient's Clinical Database (CDB), The US News and World Report, Ohio Department of Health, Press Ganey, National Database of Nursing Quality Indicators (NDNQI), Centers for Disease Control – National Healthcare Safety Network (NHSN), The American College of Surgeons (ACoS) and others.

Performance Based Provider Quality & Credentialing

Performance based credentialing ensures processes that assist with promoting 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 three occasions: initial appointment, when a Privileged Practitioner requests a new privilege, and for cause when questions arise regarding the practitioner's ability to provide safe, high quality patient care. Ongoing Professional Practice Evaluation (OPPE) is performed on an ongoing basis (every 6 months).
Profiling Process:

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

Service-Specific Indicators
Indicators are used to profile each physician's performance. The results are included in a physician profile, which is reviewed with the department chair as part of the credentialing process. The definition of service/department-specific indicators is the responsibility of the director/chair of each unit. The performance of 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 related to these indicators and report that information to the Department of Quality and Operations Improvement.

The Medical Staff Evaluation is multi-purpose:

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

Annual and Ongoing Evaluations

The James Quality Safety, and Experience Council Plan is approved annually by The James Quality, Safety and Experience Council (Q-SEC), the Medical Staff and Committee (MSAC), The Quality and Professional Affairs Committee (QPAC), and the Wexner Medical Center Board.

Enterprise-Wide Alignment and Strategic Plan

The James Quality, Safety and Experience Plan has been developed in alignment with the OSUWMC Enterprise-Wide Long Range Quality Plan (Attachment B). The Long-Range Quality Plan focuses on the foundations and three pillars of patient centered care that have been deemed priorities by the OSUWMC Quality Leadership Council (QLC).

Attachment A: The James Quality, Safety and Experience Council Structure

Attachment B: Long Range Quality Plan

August 19, 2025

PLAN FOR PATIENT CARE SERVICES

OHIO STATE UNIVERSITY HOSPITALS d/b/a OSU WEXNER MEDICAL CENTER

Synopsis: Approval of the annual review of the plan for patient care services for the hospitals at the Ohio State University Hospitals d/b/a OSU Wexner Medical Center, including: Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital and The Ohio State University Wexner Medical Center East Hospital, is proposed.

WHEREAS the mission of the Ohio State University Hospitals is to improve people's lives through the provision of high-quality patient care; and

WHEREAS the plan for inpatient and outpatient care services describes the integration of clinical departments and personnel who provide care and services to patients at University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital and Ohio State East Hospital; and

WHEREAS the annual review of the plan for patient care services was approved by the University Hospital Medical Staff Administrative Committee on May 14, 2025; and

WHEREAS on June 24, 2025, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the plan for patient care services:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the plan for patient care services for the Ohio State University Hospitals, including University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital and Ohio State East Hospital as outlined in the attached Plan for Patient Care Services.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Approvals:
MSAC- 5/14/2025
QPAC- 6/24/2025
Wexner Medical Center Board –

TITLE: THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER (INCLUDING UNIVERSITY HOSPITAL, RICHARD M. ROSS HEART HOSPITAL, BRAIN AND SPINE HOSPITAL, DODD REHABILITATION HOSPITAL, HARDING HOSPITAL, AND EAST HOSPITAL) HOSPITAL PLAN FOR PROVIDING PATIENT CARE

University Hospital, Richard M. Ross Heart Hospital, Brain and Spine Hospital, Dodd Rehabilitation Hospital, Harding Hospital, and East Hospital (hereafter referred to as the Hospitals) plan for patient care services describes the integration of departments and personnel who provide care and services to patients based on the Hospitals' mission, vision, shared values and goals. The plan encompasses both inpatient and outpatient services of the Hospitals.

OHIO STATE UNIVERSTY WEXNER MEDICAL CENTER (OSUWMC) MISSION, VISION AND VALUES

Mission Statement:
To improve health in Ohio and across the world through innovations and transformation in research, education, patient care, and community engagement.

Vision Statement:
By pushing the boundaries of discovery and knowledge, we will solve significant health problems and deliver unparalleled care.

Values:
Inclusiveness, Determination, Empathy, Sincerity, Ownership and Innovation

The mission, vision and values statements, developed by our staff members, physicians, governing body members and administration team members, complements and reflects the unique role the hospitals fulfill within The Ohio State University.

PHILOSOPHY OF PATIENT CARE SERVICES

In collaboration with the community, the Hospitals will provide innovative, personalized, and person centered care through:

a) A mission statement that outlines the synergistic relationship between patient care, research, and education;
b) Long-range strategic planning with medical center leadership to determine the services to be provided; including, but not limited to essential services as well as special areas of concentration;
c) Establishing annual goals and objectives consistent with the mission, which are based on a collaborative assessment of needs;
d) Planning and design conducted by medical center leadership, which involves the potential communities to be served;
e) Provision of services that are appropriate to the scope and level required by the patients to be served based on assessment of need;
f) Ongoing evaluation of services provided through formalized processes; e.g., performance assessment and improvement activities, budgeting and staffing plans;
g) Integration of services through the following mechanisms: continuous quality improvement teams; clinical interdisciplinary quality programs; performance assessment and improvement activities; communications through management team meetings, administrative staff meetings, special forums, and leadership and employee education/development;
h) Maintaining competent patient care leadership and staff by providing education designed to meet identified needs;

i) Respect for each patient's rights and decisions as an essential component in the planning and provision of care; and,
j) Staff member behaviors that reflect a philosophical foundation based on the values of The Ohio State University Wexner Medical Center.

THE HOSPITAL LEADERSHIP

The Hospital leadership is defined as the governing board, CEO/Executive Vice President, administrative staff, physicians and nurses in appointed or elected leadership positions. The Hospital leadership is responsible for the framework of planning health care services provided by the organization based on the hospital's mission and for developing and implementing an effective planning process that allows for defining timely and clear goals.

The planning process includes a collaborative assessment of our customer and community needs, defining a long range strategic plan, developing operational plans, establishing annual operating budgets and monitoring compliance, establishing annual capital budgets, monitoring and establishing resource allocation and policies, and ongoing evaluation of the plans' implementation and success. The planning process addresses both patient care functions (e.g. patient rights, patient assessment, patient care, patient and family education, coordination of care, and discharge planning) and organizational support functions (e.g. information management, human resource management, infection control, quality and safety, the environment of care, and the improvement of organizational performance).

The Hospital leadership works collaboratively with all operational and clinical managers and leaders to ensure integration in the planning, evaluation, and communication processes within and between departments to enhance patient care services and support. This occurs informally on a daily basis and formally via interdisciplinary leadership meetings. The leadership involves department heads in evaluating, planning and recommending annual budget expenses and capital objectives, based on the expected resource needs of their departments. Department leaders are held accountable for managing and justifying their budgets and resource utilization. This includes, but is not limited to identifying, investigating and budgeting for new technologies and resources which are expected to improve the delivery of patient care and services.

Other leadership responsibilities include:

a) Communication of the organization's mission, vision, goals, objectives and strategic plans across the organization;
b) Ensuring appropriate and competent direction, management and leadership of all services and/or departments;
c) Collaborating with community leaders and organizations to ensure services are designed to be appropriate for the scope and level of care required by the patients and communities served;
d) Supporting the patient's continuum of care by integrating systems and services to improve efficiencies and care from the patient's viewpoint and diversity, equity and inclusion;
e) Ensuring staffing resources are available to appropriately and effectively meet the needs of the patients served and to provide a comparable level of care to patients in all areas where patient care is provided;
f) Ensuring the provision of a uniform standard of patient care throughout the organization;
g) Providing appropriate job enrichment, employee development and continuing education opportunities which serve to promote retention of staff and to foster excellence in care delivery and support services;
h) Establishing standards of care that all patients can expect and which can be monitored through the hospital's quality assurance and performance improvement (QAPI) process;

i) Approving the organizational plan to prioritize areas for improvement, developing mechanisms to provide appropriate follow up actions and/or reprioritizing in response to untoward and unexpected events;
j) Implementing an effective and continuous program to improve patient safety;
k) Appointing appropriate committees, task forces, and other forums to ensure interdepartmental collaboration on issues of mutual concerns and requiring interdisciplinary input; and,
l) Supporting patient rights and ethical considerations.

ROLE OF THE CHIEF NURSING OFFICER

The Chief Nursing Officer is responsible for the practice of nursing by ensuring consistency in the standard of nursing practice across the clinical settings. The CNO supports and facilitates an interdisciplinary team approach to the overall delivery of care to patients, families, and the community. This includes creating an environment in which collaboration is valued and excellence in clinical care, education, and research is promoted and achieved. The CNO leads quality, safety, and innovation initiatives in partnership with the Hospital Executive Directors.

The CNO is responsible for developing and driving the nursing strategic plan to deliver excellent patient care. The role will include responsibility for nursing performance improvement, program management, business operations, budgets, resource utilization, financial stewardship and maintenance of the professional contracts with the Ohio State University Nursing Organization and the International Association of Machinists and Aerospace Workers. The CNO ensures the vision, strategic direction, and the advancement of the profession of nursing at OSUWMC.

ROLE OF THE ASSOCIATE CHIEF NURSING OFFICER

The Associate Chief Nursing Officer (ACNO) is a member of the Nursing Executive Leadership team. The ACNO works collaboratively with both the CNO and Executive Director of their business entities. The ACNO has the authority and responsibility for directing the activities related to the provision of nursing care in those departments defined as providing nursing care to patients.

The ACNO is responsible to plan, develop, implement, and oversee programs and projects designed to evaluate and improve clinical quality, safety, resource utilization and operations in all areas staffed by nurses. The role includes implementation of patient care services strategies to support efficiency, clinical effectiveness, clinical operations and quality improvement with interdisciplinary team members. The ACNO works with teams to develop projects, programs and implement system changes that promote care coordination across the health care continuum.

FUNCTIONS OF NURSING LEADERSHIP

The Chief Nursing Officer and ACNOs ensure the following functions are addressed:

a) Evaluating patient care programs, policies, and procedures describing how patients' nursing care needs are assessed, evaluated and met throughout the organization;
b) Developing and implementing the plan for the provision of patient care through evidence-based practice and nursing research;
c) Participating with leaders from the governing body, management, medical staff and clinical areas in organizational decision-making, strategic planning and in planning and conducting performance improvement activities throughout the organization;
d) Implementing an effective, ongoing program to assess, measure and improve the quality of nursing care delivered to patients; developing, approving, and implementing standards of nursing practice,

standards of patient care, and patient care policies and procedures that include current research/ literature findings that are evidence based;

e) Participating with organizational leaders to ensure that resources are allocated to provide a sufficient number of qualified nursing staff to provide patient care;

f) Ensuring that nursing services are available to patients on a continuous, timely basis.

DEFINITION OF PATIENT SERVICES, PATIENT CARE AND PATIENT SUPPORT

Patient Services are limited to those departments that have direct contact with patients. Patient services occur through organized and systematic throughput processes designed to ensure the delivery of appropriate, safe, effective and timely care and treatment. The patient throughput process includes those activities designed to coordinate patient care before admission, during the admission process, in the hospital, before discharge and at discharge. This process includes:

- *Access in*: emergency process, admission decision, transfer or admission process, registration and information gathering, placement;
- *Treatment and evaluation:* full scope of services; and,
- *Access out:* discharge decision, patient/family teaching and counseling, arrangements for continuing care and discharge.

Patient Care encompasses the recognition of disease and health, patient teaching, patient advocacy, spirituality and research. The full scope of patient care is provided by professionals who are charged with the additional functions of patient assessment and planning patient care based on findings from the assessment. Providing patient services and the delivery of patient care requires specialized knowledge, judgment, and skill derived from the principles of biological, chemical, physical, behavioral, psychosocial and medical sciences. As such, patient care and services are planned, coordinated, provided, delegated, and supervised by professional health care providers who recognize the unique physical, emotional and spiritual (body, mind and spirit) needs of each person. Under the auspices of the Hospitals, medical staff, registered nurses and allied health care professionals function collaboratively as part of an interdisciplinary, personalized patient-focused care team to achieve positive patient outcomes.

Competency for patient caregivers is determined in orientation and at least annually through performance evaluations and other department specific assessment processes. Credentialed providers direct all medical aspects of patient care as delineated through the clinical privileging process and in accordance with the Medical Staff By-Laws. Registered nurses support the medical aspect of care by directing, coordinating, and providing nursing care consistent with statutory requirements and according to American Nurses Association Nursing Scope and Standards of Practice book as well as hospital-wide policies and procedures. Allied health care professionals provide patient care and services in keeping with their licensure requirements and in collaboration with physicians and registered nurses. Unlicensed staff may provide aspects of patient care or services at the direction of and under the supervision of licensed professionals.

Nursing Care (nursing practice) is defined as competently providing all aspects of the nursing process in accordance with Chapter 4723 of the Ohio Revised Code (ORC), which is the law regulating the Practice of Nursing in Ohio. The law gives the Ohio Board of Nursing the authority to establish and enforce the requirements for licensure of nurses in Ohio. This law also defines the practice of both registered nurses and licensed practical nurses. All of the activities listed in the definitions, including the supervision of nursing care, constitute the practice of nursing and therefore require the nurse to have a current valid license to practice nursing in Ohio.

Patient Support is provided by a variety of individuals and departments which might not have direct contact with patients, but which support the integration and continuity of care provided throughout the continuum of care by the hands-on care providers.

SCOPE OF SERVICES / STAFFING PLANS

Each patient care service department has a defined scope of service approved by the hospital's administration and medical staff, as appropriate. The scope of service includes:

- the types and age ranges of patients served;
- methods used to assess and meet patient care needs (includes services most frequently provided such as procedures, etc.);
- the scope and complexity of patient care needs (such as most frequent diagnosis);
- support services provided directly or through referral contact;
- the extent to which the level of care or service meets patient need (hours of operation if other than 24 hours a day/7days a week and method used for ensuring hours of operation meet the needs of the patients to be served with regard to availability and timeliness);
- the availability of necessary staff (staffing plans) and;
- recognized standards or practice guidelines, when available (the complex or high level technical skills that might be expected of the care providers).

Additional operational details and staffing plans may also be found in department policies, procedures and operational/performance improvement plans.

Staffing plans for patient care service departments are developed based on the level and scope of care provided, the frequency of the care to be provided, and a determination of the level of staff that can most appropriately (competently and confidently) provide the type of care needed. Nursing units are staffed to accommodate a projected average daily patient census. Unit management (including nurse manager and/or charge nurse) reviews patient demands to plan for adequate staffing. Staffing can be increased or decreased to meet patient needs. When the number of patients is high or the need is great, float staff assist in providing care. When staff availability is projected to be low, the unit manager and director may request temporary agency nurses. The Ohio State University Wexner Medical Center follows the Staffing Guidelines set by the American Nurses Association. In addition, we utilize staffing recommendations from various specialty nursing organizations, including: ENA, ANCC, AACN, AORN, ASPN, NDNQI, AWHONN, and others.

The Administrative Team, in conjunction with the budget and performance measurement process, reviews all patient care areas staffing and monitors ongoing regulatory requirements. Each department staffing plan is formally reviewed during the budget cycle and takes into consideration workload measures, utilization review, employee turnover, performance assessment, improvement activities, and changes in customer needs/expectations. A variety of workload measurement tools may be utilized to help assess the effectiveness of staffing plans.

STANDARDS OF CARE

Patients of the Hospitals can expect that:

1) Staff will do the correct procedures, treatments, interventions, and care following the policies, procedures, and protocols that have been established. Efficacy and appropriateness of procedures, treatment, interventions and care provided will be demonstrated based on patient assessments/reassessments, standard practice, and with respect for patient's rights and confidentiality.
2) Staff will provide a uniform standard of care and services throughout the organization.
3) Staff will design, implement and evaluate systems and services for care delivery (assessments, procedures, treatments, interventions) which are consistent with a personalized health care focus and which will be delivered:

a. With compassion, courtesy, respect and dignity for each individual without bias using a patient centered approach;
b. In a manner that best meets the individualized needs of the patient;
c. Coordinated through interdisciplinary collaboration, to ensure continuity and seamless delivery of care to the greatest extent possible; and,
d. In a manner that maximizes the efficient use of financial and human resources, streamlines processes, decentralizes services, enhances communication, supports technological advancements and maintains patient safety.

Patient Assessment:

Individual patient care requirements are determined by assessments (and reassessments) performed by qualified health professionals. Each service within the organization providing patient care has defined the scope of assessment provided. This assessment (and reassessment) of patient care needs continues throughout the patient's contact with the hospital.

Coordination of Care:

Patients are identified who require discharge planning to facilitate continuity of medical care, social determinant needs, and/or other care to meet identified needs. Discharge planning is timely, is addressed at a minimum during initial assessment as well as during discharge planning processes and can be initiated by any member of the interdisciplinary team. Case Managers coordinate patient care between multiple delivery sites and multiple caregivers; collaborate with physicians and other members of the care team to assure appropriate treatment plan and discharge care.

STANDARDS OF COMPETENT PERFORMANCE/STAFF EDUCATION

All employees receive an orientation consistent with the scope of responsibilities defined by their job description and the patient population to whom they are assigned to provide care. Ongoing education (such as in-services) is provided within each department. In addition, the Educational Development and Resource Department provides annual mandatory education and provides appropriate staff education associated with performance improvement initiatives and regulatory requirements. Performance appraisals are conducted at least annually between employees and managers to review areas of strength and to identify skills and expectations that require further development.

CARE DELIVERY MODEL

The care delivery model is guided by the following goals:

- The patient and family will experience the benefits of the AACN Synergy model for patient care. This model is driven by the core concept that the patient and family needs influence the competencies and characteristics of the nursing care provided. The benefits include enhanced quality of care, improved service, appropriate length of hospitalization and minimized cost.
- Hospital employees will demonstrate values and behaviors consistent with the OSUWMC Buckeye Spirit set of core values. The philosophical foundation reflects a culture of inclusiveness, sincerity, determination, ownership, empathy and innovation.
- Effective communication will impact patient care by ensuring timeliness of services, utilizing staff resources appropriately, and maximizing the patient's involvement in his/her own plan of care.
- Configuring departmental and physician services to accommodate the care needs of the patient in a timely manner will maximize quality of patient care and patient satisfaction.
- The Synergy professional nursing practice model is a framework which reflects our underlying philosophy and vision of providing care to patients based on their unique needs and characteristics. Aspects of the professional model support:

(1) matching nurses with specific skills to patients with specific needs to ensure "safe passage" to achieve the optimal outcome of their hospital stay;
(2) the ability of the nurse to establish and maintain a therapeutic relationship with their patients;
(3) the presence of an interdisciplinary team approach to patient care delivery. The knowledge and expertise of all caregivers is utilized to restore a patient to the optimal level of wellness based on the patient's definition;
(4) physicians, nurses, pharmacists, respiratory therapists, case managers, dietitians and many other disciplines collaborate and provide input to patient care.

- The patient and family will be involved in establishing the plan of care to ensure services that accommodate their needs, goals and requests.
- Streamlining the documentation process will enhance patient care.

PATIENT RIGHTS AND ORGANIZATIONAL ETHICS

Patient Rights

In order to promote effective and compassionate care, the Hospitals' systems, policies, and programs are designed to reflect an overall concern and commitment to each person's dignity. All Hospital employees, physicians and staff have an ethical obligation to respect and support the rights of every patient in all interactions. It is the responsibility of all employees, physicians and staff of the Hospitals to support the efforts of the health care team, while ensuring that the patient's rights are respected. Each patient (and/or family member as appropriate) is provided a list of patient rights and responsibilities upon admission and copies of this list are posted in conspicuous places throughout the Hospitals.

Organizational Ethics

The Hospitals have an ethics policy established in recognition of the organization's responsibility to patients, staff, physicians and the community served. General principles that guide behavior are:

- Services and capabilities offered meet identified patient and community needs and are fairly and accurately represented to the public.
- Adherence to a uniform standard of care throughout the organization, providing services only to those patients for whom we can safely care for within this organization. The Hospitals do not discriminate based age, ancestry, color, disability, gender identity or expression, genetic information, HIV/AIDS status, military status, national origin, race, religion, sex, gender, sexual orientation, pregnancy, protected veteran status or any other basis under the law.
- Patients will be billed only for care and services provided.

Biomedical Ethics

A biomedical ethical issue arises when there is uncertainty or disagreement regarding medical decisions, involving moral, social, or economic situations that impact human life. A mechanism is in place to provide consultation in the area of biomedical ethics in order to:

- improve patient care and ensure patient safety;
- clarify any uncertainties regarding medical decisions;
- explore the values and principles underlying disagreements;
- facilitate communication between the attending physician, the patient, members of the treatment team and the patient's family (as appropriate); and,
- mediate and resolve disagreements.

INTEGRATION OF PATIENT CARE, ANCILLARY AND SUPPORT SERVICES

The importance of a collaborative interdisciplinary team approach, which takes into account the unique knowledge, judgment and skills of a variety of disciplines in achieving desired patient outcomes, serves as a foundation for integration. See Appendix A for a listing of ancillary and support services.

Open lines of communication exist between all departments providing patient care, patient services and support services within the hospitals, and as appropriate with community agencies to ensure efficient, effective and continuous patient care. Functional relationships between departments are evidenced by cross-departmental Performance Improvement initiatives as well as the development of policies, procedures, protocols, and clinical pathways and algorithms.

To facilitate effective interdepartmental relationships, problem solving is encouraged at the level closest to the problem at hand. Staff is receptive to addressing one another's issues and concerns and work to achieve mutually acceptable solutions. Supervisors and managers have the responsibility and authority to mutually solve problems and seek solutions within their spans of control; positive interdepartmental communications are strongly encouraged. Employees from departments providing patient care services maintain open communication channels and forums with one another, as well as with service support departments to ensure continuity of patient care, maintenance of a safe patient environment and positive outcomes.

CONSULTATIONS AND REFERRALS FOR PATIENT SERVICES

The Hospitals provide services as identified in the Hospital Plan for Providing Patient Care to meet the needs of our community. Patients whose assessed needs require services not offered are transferred to the member hospitals of The Ohio State University Wexner Medical Center or another quality facility (e.g., Nationwide Children's Hospital) in a timely manner after stabilization. Safe transportation is provided by air or ground ambulance with staff and equipment appropriate to the required level of care. Physician consultation occurs prior to transfer to ensure continuity of care. Referrals for outpatient care occur based on patient need.

INFORMATION MANAGEMENT PLAN

The overall goal for information management is to support the mission of The Ohio State University Wexner Medical Center. Specific information management goals related to patient care include:

- Develop and maintain an integrated information and communication network linking research, academic and clinical activities.
- Develop computer-based patient records with integrated clinical management and decision support.
- Support administrative and business functions with information technologies that enable improved quality of services, cost effectiveness, and flexibility.
- Build an information infrastructure that supports the continuous improvement initiatives of the organization.
- Ensure the integrity and security of the Hospital's information resources and protect patient confidentiality.

PATIENT CARE ORGANIZATIONAL IMPROVEMENT ACTIVITIES

All departments are responsible for following the Hospitals' Quality Assurance and Performance Improvement (QAPI) plan. Departments utilize the QAPI plan and cascade the hospital's goals to service line quality plans to ensure proper alignment to support the overall hospital quality goals.

PLAN REVIEW

The Hospital Plan for Providing Patient Care will be reviewed regularly by the Hospitals' leadership to ensure the plan is adequate, current and that the Hospitals are in compliance with the plan. Interim adjustments to the overall plan are made to accommodate changes in patient population, redesign of the care delivery systems or processes that affect the delivery, level or amount of patient care required.

Appendix A: Scope of Services: Patient Ancillary and Support Services

Other hospital services that support the comfort and safety of patients are coordinated and provided in a manner that ensures direct patient care and services are maintained in an uninterrupted, efficient, and continuous manner. These support and ancillary services will be fully integrated with the patient care departments of the Hospitals:

DEPARTMENT	SERVICE
BEHAVIORAL EMERGENCY RESPONSE TEAM (BERT)	Expert team that provides innovative and quality care to patients with complex behavioral symptoms while working collaboratively with staff through consultation, education, and early intervention
CARDIAC PROCEDURAL	Cardiac procedural areas include both cardiac catheterization and electrophysiology. Procedures may be diagnostic or interventional.
CARDIOVASCULAR IMAGING SERVICES	Diagnostic and therapeutic procedures in cardiac MR/CT, Nuclear Medicine, Echocardiography, Vascular Imaging Stress Test. Cardiovascular Imaging Services can be provided at inpatient, outpatient, and emergency locations.
CARE MANAGEMENT	As part of the health care team, provides personalized care coordination and resource management with patients and families.
CENTRAL STERILE SUPPLY (CSS)	Responsible for supporting all instrument cleaning and sterilization needs across the organization In addition, CSS is responsible for providing case carts to the operating rooms which contain all of the instrumentation and disposable supply needs for each surgical case.
CHAPLAINCY AND CLINICAL PASTORAL EDUCATION	Assists patients, their families and hospital personnel in meeting spiritual needs through professional pastoral and spiritual care and education.
CLINICAL ENGINEERING	Routine equipment evaluation, maintenance, and repair of electronic equipment owned or used by the hospital; evaluation of patient owned equipment.
CLINICAL INFORMATICS	A subset of IT services that focuses on appropriately integrating the clinical care provided to the patient into the Electronic Health Record (EHR) through the specialized knowledge of clinical care and informatics. Additionally, direct work with the clinicians occurs through this team to ensure the EHR is adopted and aligns with the clinical work occurring in the organization and provides an accurate depiction of the patients' clinical course while being cared for in the organization.
CLINICAL LABORATORY	Responsible for pre-analytic, analytic and post-analytic functions on clinical specimens in order to obtain information about the health of a patient as pertaining to the diagnosis, treatment, and prevention of disease; assisting care providers with clinical information related to patient care, education, and research.
COMMUNICATIONS AND MARKETING	Responsible for developing strategies and programs to promote the organization's overall image and specific products and services to targeted internal and external audiences. Handles all media relations, advertising, internal communications, special events and publications.
DECEDENT AFFAIRS	Provide support to families of patients who died & assist them with completing required disposition decisions. Ensure notification of the CMS designated Organ Procurement Agency (OPO) – Lifeline of Ohio (Lifeline). Promote & facilitate organ/eye/tissue donation by serving as the OSU hospital Lifeline Liaison. Analyze data provided by Lifeline regarding organ/tissue/eye donation.
DIAGNOSTIC TRANSPORTATION	Provision of on-site transportation services for patients requiring diagnostic, operative or other ancillary services.
DIALYSIS	Dialysis is provided for inpatients of the medical center within a dedicated unit unless the patient cannot be moved. In those instances, bedside dialysis will be administered.

DEPARTMENT	SERVICE
EARLY RESPONSE TEAM (ERT)	Provides timely diagnostic and therapeutic intervention before there is a cardiac or respiratory arrest or an unplanned transfer to the Intensive Care Unit. Consists of a Critical Care RN and Respiratory Therapist who are trained to help patient care staff when there are signs that a patient's health is declining.
EDUCATION, DEVELOPMENT & RESOURCES	Provides and promotes ongoing development and training experiences to all member of the OSUWMC community; provides staff enrichment programs, organizational development, leadership development, orientation and training, skills training, continuing education, competency assessment and development, literacy programs and student affiliations.
ENDOSCOPY	Provides services to patients requiring a nonsurgical review of their digestive tract.
ENVIRONMENTAL SERVICES	Provides routine housekeeping and quality monitoring of such. Additional services upon request: extermination, wall cleaning, etc.
EPIDEMIOLOGY	Enhance the quality of patient care and the work environment by minimizing the risk of acquiring infection within the hospital setting.
FACILITIES OPERATIONS	Provide oversight, maintenance and repair of the building's life safety, fire safety, and utility systems. Provide preventative, repair and routine maintenance in all areas of all buildings serving patients, guests, and staff. This would include items such as electrical, heating and ventilation, plumbing, and other such items. Also providing maintenance and repair to basic building components such as walls, floors, roofs, and building envelope. Additional services available upon request.
FISCAL SERVICES	Works with departments/units to prepare capital and operational budgets. Monitors and reports on financial performance monthly.
HUMAN RESOURCES	Serves as a liaison for managers regarding all Human Resources information and services; assists departments with restructuring efforts; provides proactive strategies for managing planned change within the Health System; assists with Employee/Labor Relations issues; assists with performance management process; develops compensation strategies; develops hiring strategies and coordinates process for placements; provides strategies to facilitate sensitivity to issues of cultural diversity; provides HR information to employees, and establishes equity for payroll.
INFORMATION SYSTEMS	Work as a team assisting departments to explore, deploy and integrate reliable, state of the art Information Systems technology solutions to assist in the provision and documentation of care and services and to manage change of such systems.
MATERIALS MANAGEMENT	Routinely stocks supplies in patient care areas, distributes linen. Sterile Central Supply, Storeroom - upon request, distributes supplies/equipment not stocked on units.
MEDICAL INFORMATION MANAGEMENT	Maintains patient records serving the needs of the patient, provider, institution, and various third parties to health care.
NUTRITION SERVICES	Provides nutrition care and food service for Medical Center patients, staff, students, and visitors. Clinical nutrition assessment, care plan development, and consultation are available in both inpatient and outpatient settings. The Department provides food service to inpatients and selected outpatient settings in addition to operating a variety of retail café locations and acts as a liaison for vending and sub-contracted food services providers. Serve as dietetic education preceptors.
PATIENT ACCESS SERVICES	Coordinates registration/admissions with nursing management.
PATIENT EXPERIENCE	Develops programs for support of patient relations and customer service, and includes front-line services such as information desks.
PATIENT FINANCIAL SERVICES	Provides financial assistance upon request from patient/family. Also responsible for posting payments from patients and insurance companies among others to a patient's bill for services.

DEPARTMENT	SERVICE
PATIENT FLOW DEPARTMENT	Monitors and supports all admissions, discharges, and transfers across OSUWMC. Ensures timely, safe, and individualized access to all patients and families through collaboration with the healthcare team.
PERIOPERATIVE SERVICES	Perioperative Services include preoperative, intraoperative and postoperative care.
PHARMACY	Provides comprehensive pharmaceutical care through operational and clinical services. Responsible for medication distribution via central and satellite pharmacies, as well as 797 compliant IV compounding room and automated dispensing cabinets. Some of the many clinical services include pharmacokinetic monitoring, renal and hepatic dose adjustments, and patient education. Specialist pharmacists also round with patient care teams to optimize medication regimens and serve as the team's primary medication information resource.
QUALITY AND OPERATIONS IMPROVEMENT	Provides an integrated quality management program and facilitates continuous quality improvement efforts throughout the medical center.
RADIOLOGIC SERVICES	Diagnostic and therapeutic procedures in MR, CT, X-ray, Fluoroscopy, Interventional Radiology, Ultrasonography. Radiologic Services can be provided at inpatient, outpatient, and emergency locations.
RESPIRATORY THERAPY	Provide all types of respiratory therapeutic interventions and diagnostic testing, by physician order, mainly to critically ill adults and neonates, requiring some type of ventilator support, bronchodilator therapy, or pulmonary hygiene, due to chronic lung disease, multiple trauma, pneumonia, surgical intervention, or prematurity. Provides pulmonary function testing and diagnostic inpatient and outpatient testing to assess the functional status of the respiratory system. Bronchoscopy and other diagnostic/interventional pulmonology procedures are performed to diagnose and/or treat abnormalities that exist in the airways, lung parenchyma or pleural space.
REHABILITATION SERVICES	Physical therapists, occupational therapists, speech and language pathologists, and recreational therapists evaluate and develop a plan of care and provide treatment based on the physician's referral. The professional works with each patient/family/caregiver, along with the interdisciplinary medical team, to identify and provide the appropriate therapy/treatment and education needed for the established discharge plan and facilitates safe and timely movement through the continuum of care.
RISK MANAGEMENT	Protect resources of the hospital by performing the duties of loss prevention and claims management. Programs include: Risk Identification, Risk Analysis, Risk Control, Risk Financing, Claims Management and Medical-Legal Consultation.
SAFETY and EMERGENCY PREPAREDNESS	Manages programs related to general safety, life safety and emergency preparedness. Maintains compliance with regulatory agencies including, The Joint Commission, Centers for Medicare and Medicaid Services, Ohio Department of Health, State Fire Marshal, Environmental Protection Agency and other authorities having jurisdiction over hospital operations.
SECURITY	Provides a safe and secure environment for patients, visitors, and staff members by responding to all emergencies such as workplace violence, fires, bomb threats, visitor/staff/patient falls, Code Blues (cardiac arrests) in public places, internal and external disasters, armed aggressors, or any other incident that needs an emergency response.
SOCIAL WORK SERVICES	Social Work services are provided to patients/families to meet their medically related social and emotional needs as they impact on their medical condition, treatment, recovery and safe transition from one care environment to another. Social workers provide psychosocial assessment and intervention, crisis intervention, financial counseling, discharge planning, health education, provision of material resources

DEPARTMENT	SERVICE
	and linkage with community agencies. Consults can be requested by members of the treatment team, patients or family members.
VOLUNTEER SERVICES	Volunteer Services credential and place volunteers to fill departmental requests. Volunteers serve in wayfinding, host visitors in waiting areas, serve as patient / family advisors, and assist staff.
WOUND CARE	Wound Care includes diagnosis and management for skin impairments.

August 19, 2025

PLAN FOR PATIENT CARE SERVICES

THE OHIO STATE UNIVERSITY COMPREHENSIVE CANCER CENTER
ARTHUR G. JAMES CANCER HOSPITAL AND
RICHARD J. SOLOVE RESEARCH INSTITUTE

Synopsis: Approval of the annual review of the plan for patient care services for the Ohio State Comprehensive Cancer Center — James Cancer Hospital and Solove Research Institute, is proposed.

WHEREAS the mission of The James is to eradicate cancer from individuals' lives by generating knowledge and integrating groundbreaking research with excellence in education and patient-centered care; and

WHEREAS The James plan for patient care services describes the integration of clinical departments and personnel who provide care and services to patients at The James; and

WHEREAS the annual review of the plan for patient care services was approved by The James Medical Staff Administrative Committee on April 18, 2025; and

WHEREAS on June 24, 2025 the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the plan for patient care services:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the plan for patient care services for The James as outlined in the attached Plan for Patient Care Services.

The James
THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Approvals:
MSAC: April 18, 2025
QPAC: June 24, 2025
Wexner Medical Center Board:

Title: Arthur G. James Cancer Hospital and Richard J.Solove Research Institute Plan for Patient Care Services

The Plan for Providing Patient Care Services is described herein. The Plan is based on the mission, vision, values, and goals. The plan encompasses both inpatient and outpatient services delivered by the teams who provide comprehensive care, treatment, and services to patients with cancer diagnoses and their loved ones. The plan encompasses both inpatient and outpatient services of the hospital.

The Mission, Vision, and Values:

Mission: To eradicate cancer from individuals' lives by creating knowledge and integrating ground-breaking research with excellence in education and patient-centered care.

Vision: Create a cancer-free world, one person, and one discovery at a time.

Values: World class, empowered, compassionate, accountable, respectful, and expert.

At The James, no cancer is routine. Our researchers and oncologists study the unique genetic makeup of each patient's cancer, understand what drives it to develop, and then deliver the most advanced and targeted treatment for the individual patient. The James' patient centered, and relationship-based care is enhanced by our teaching and research programs. Our mission, and staff are dedicated to the fulfillment and success and distinguishes The Arthur G. James Cancer Hospital and Richard J. Solove Research Institute as one of the nation's premier comprehensive cancer centers.

Philosophy of Patient Care Services

The James Cancer Hospital and Solove Research Institute, in collaboration with the community, provides innovative and patient-focused multi-disciplinary cancer care through:

- Maintaining a mission which outlines the synergistic relationship between patient care, research, and teaching.
- Developing a long-range strategic plan with input from hospital leaders to determine the services and levels of care to be provided.
- Establishing annual goals and objectives consistent with the hospital mission and

strategic plan, which are based on a collaborative assessment of patient/family and community needs.

- Planning and designing from the hospital leadership, involving the communities served.
- Providing individualized care, treatment, and services appropriate to the scope and level required by each patient based on professional assessments of need.
- Evaluating ongoing services provided through formalized processes such as: performance assessment and improvement activities, budgeting, and staffing plans.
- Integrating services through the following mechanisms: continuous quality improvement teams; clinical interdisciplinary quality programs; communications through management and operations meetings, Division of Nursing shared governance structure, Medical Staff Administrative Committee, administrative staff meetings, participation in Ohio State University Wexner Medical Center (OSUWMC) governance structures, special forums, leadership and employee education and professional/development.
- Maintaining competent patient care leadership and staff by providing education designed to meet identified needs.
- Respecting each patient's rights and their decisions as an essential component in theplanning and provision of care.
- Assuring every staff member demonstrates behaviors which reflect the philosophical foundation based on the values of The James Cancer Hospital and Solove Research Institute.

Hospital Leadership

The hospital leadership is defined as the governing Board of Trustees, the University President, Executive Vice President/Chief Executive Officer, administrative staff, faculty, physicians, nurses, clinical, and operational leaders in both appointed and elected positions. The hospital's leadership team is responsible for producing a framework to plan health care services which are to be provided by the organization, based on the hospital's mission and strategic planning. These responsibilities include developing and implementing a planning process that allows for defining timely and clear goals.

The planning process also includes an assessment of our customer and community needs. Thisprocess begins with:

- Developing a long-range strategic plan.
- Developing annual operational plans.
- Establishing annual operating and capital budgets, and monitoring compliance.
- Establishing resource allocations and policies.

- Ongoing evaluation of every plan's implementation and ongoing success.

The planning process addresses both patient care functions (patient: rights, assessment, care, safety, patient and family education, coordination of care, and discharge planning) and organizational support functions (information management, human resource management, infection control, quality, the environment of care, and the improvement of organization performance).

The hospital leadership team works collaboratively with all operational and clinical leaders to ensure integration of planning, evaluation, and communication processes within and between departments, to enhance patient care services and support. This occurs informally, daily, and formally, via multi-disciplinary leadership meetings. The leadership team works with each department manager to evaluate, plan, and recommend annual budget expenses and capital objectives, based on the expected resource needs of the department. Department leaders are accountable for managing, justifying their budgets and resource utilization. This includes, but is not limited to identifying, investigating, budgeting for modern technologies, and resources that are expected to improve the delivery of patient care and services.

Other leadership responsibilities include but are not limited to:

- Communicating the organization's mission, vision, goals, objectives, and strategic plans across the organization.
- Ensuring appropriate, competent management and leadership of all services and/or departments.
- Collaborating with community leaders and organizations to ensure services are designed to be appropriate for the scope and level of care required by the patients and communities served.
- Supporting the continuum of care by integrating systems and services to improve efficiencies and care from a patient's viewpoint.
- Ensuring staff resources are available and competent to effectively meet the needs of the patients and to provide a high level of care to patients in all clinical areas.
- Ensuring the provision of uniform standards of patient care are delivered throughout the continuum of care in accordance with each respective disciplines' approved standards of practice and organizational policy/procedure.
- Providing appropriate job enrichment, employee development, continuing education opportunities that serve to promote retention of staff and to foster excellence in care delivery and support services.
- Establishing standards of care for all patients, and which can be monitored through the hospital's performance assessment and improvement plan.
- Approving the organizational plan to prioritize areas for improvement, developing mechanisms to provide appropriate follow up actions and/or reprioritizing in response to unexpected events.
- Implementing an effective and continuous program to monitor and improve patient safety.

- Appointing appropriate committees, task forces, and other forums to ensure interdepartmental collaboration on issues of mutual concerns and requiring interdisciplinary input.
- Supporting patient rights and ethical considerations.
- Support of evidence-based practice (EBP) to drive patient care decision-making.

Role of the Executive Director of Clinical Services, and the Chief Nursing Officer

The Executive Director of Clinical Services, and the Chief Nursing Officer are members of the Executive Leadership Team who has the requisite authority and responsibility for directing activities related to the provision of care, treatment and services in those departments defined as providing care to patients.

The Executive Director of Clinical Services ensures the following functions are addressed:

- Evaluating patient care programs, policies, and procedures which describe how patients' care needs are assessed, evaluated, and met throughout the organization.
- Implementing the plan for the provision of patient care.
- Participating with leaders from the governing body, medical staff, and clinical areas in organizational decision-making. Strategic planning and conducting performance improvement activities through the organization.
- Implementing an effective, ongoing program to assess, measure and improve the quality of care and safe outcomes of care provided for patients.
- Participating with organizational leaders to ensure that resources are allocated to provide enough qualified and competent staff to provide patient care.
- Ensuring services are available to patients on a continuous, timely basis.
- Reviewing the plan for the providing patient care services on an annual basis.

The Chief Nursing Officer (CNO) ensures the following functions are addressed:

- Implementing standards of nursing practice, standards of patient care, patient care policies, and procedures that include current research and evidence-based practice.
- Supports and facilitates a multi-disciplinary team approach to the overall delivery of care to patients, families, and the community.
- Promotes relationship-based care (RBC), leads quality, safety, and innovation initiatives in partnership with the Executive Director of Clinical Services.
- Responsible for driving nursing strategic plan to deliver excellent patient care.
- Responsible for nursing performance improvement, program management, business operations, budgets, resource, utilization, and maintenance of the professional contract with the Ohio State University Nursing Organization (OSUNO).

Definition of Patient Services, Patient Care, Nursing Care, and Patient Support

Patient Services

Defined as those departments and care providers with direct contact with patients. These services occur through organized and systematic through-put processes designed to ensure the delivery of appropriate, safe, effective, and timely care and treatment. The patient through-put process includes those activities designed to coordinate patient care before admission, during the admission process, in the hospital, in the ambulatory exam or treatment clinics before discharge and at discharge. This process includes:

- Access in emergency process, admission decision, transfer or admission process,registration and information gathering, placement in the appropriate care areas.
- Treatment and evaluation: full scope of service from the care service department.
- Access out: discharge decision, patient/family education, counseling,arrangements for continuing care, and discharge.

Patient Care:

Encompasses the recognition of disease, health, and patient education, which allows the patient to participate in their care, advocacy, and spirituality. The full scope of patient care is provided by professionals who perform the functions of assessing, planning patient care based on information gathered from the assessment, as well as past medical history, social history, and other pertinent findings. Patient care and services are planned, coordinated, provided, delegated, and supervised by professional health care providers who recognize the unique physical, emotional, and spiritual (body, mind, and spirit) needs of each person. Under the auspices of the hospital medical staff, registered nurses, and allied health professionals function collaboratively as part of an interdisciplinary, patient-focused care team to achieve positive patient outcomes and personalized care.

Competency is determined during the initial orientation period and at least annually through performance evaluations and other department specific assessment processes. Physicians direct all aspects of a patient’s medical care as delineated through the clinical privileging process and in accordance with the Medical Staff By-Laws. Registered Nurses support the medical aspect of care by assessing, directing, coordinating, providing nursing care consistent with statutory requirements, according to the organization’s approved Nursing Standards of Practice and hospital-wide policies and procedures. Allied health professionals provide patient care and services keeping within their licensure requirements and in collaboration with physicians and registered nurses. Unlicensed staff may provide aspects of patient care or services at the direction of and under the supervision of licensed professionals.

Nursing Care and Practice:
Defined as competently providing all aspects of the nursing process in accordance with Chapter 4723 of the Ohio Revised Code (ORC), which is the law regulating the Practice of Nursing in Ohio. This law gives the Ohio Board of Nursing the authority to establish and enforce the requirements for licensure of nurses in Ohio. This law defines the practice of both registered nurses and licensed practical nurses. All activities listed in the definitions, including the supervision of nursing care, constitute the practice of nursing and therefore require the nurse to have a current valid license to practice nursing in Ohio.

Patient Support:
Provided by individuals and departments which may not have direct contact with patients, but which support the integration and continuity of care provided throughout the continuum of care by the direct care providers.

Scope of Services and Staffing Plans

Each patient care service department has a defined scope of service approved annually by administration and medical staff, as appropriate. The scope of service includes:

- The type and age ranges of patients served.
- Methods used to assess and meet patient care needs (including services most frequently provided such as procedures, medication administration, surgery, etc.).
- The scope and complexity of patient care needs.
- The appropriateness, clinical necessity, and timeliness of support services provided directly or through referral contact.
- The extent to which the level of care or service meets patient needs, hours of operation if other than 24 hours a day/7days a week, and a method used to ensure hours of operation meet the needs of the patients to be served regarding availability and timeliness.
- The availability of necessary staff.
- Recognized standards or practice guidelines.

Staffing plans for patient care service departments are developed based on the level and scope of care provided, the frequency of the care to be provided, determination of the level and mix of staff that can most appropriately, competently, and confidently provide the type of care needed. Patient care units are staffed to accommodate a projected average daily patient census based on historical data.

Unit management (including nurse manager, assistant nurse manager, charge nurse or the administrative nursing supervisor (ANS)) provide 24/7 on-site oversight and review the

demand for patient care to plan for adequate staffing. Staffing can be increased or decreased to meet patient needs or changes in volume. When the census is high or the need is great, float/resource staff are available to assist in providing care.

Administrative leaders, in conjunction with budget and performance measurements, review staffing within all patient care areas and monitor ongoing regulatory requirements. Each department staffing plan is formally reviewed during the budget cycle and takes into consideration workload measures, utilization review, employee turnover, performance assessment, improvement activities, and changes in patient needs or expectations. A variety of workload measurement tools are utilized to help assess the effectiveness of staffing plan.

Standards of Care

Individualized health care at The James is the integrated practice of medicine and support of patients based upon the individual's unique biology, behavior, and environment. It is envisioned we will utilize gene-based information to understand each person's individual requirements for the maintenance of their health, prevention of disease, and therapy tailored to their genetic uniqueness. The direction of personalized health care is to be predictive and preventive.

Patients of The James Cancer Hospital and Solove Research Institute can expect that:

- Hospital staff provide the correct procedures, treatments, interventions, and care. The efficacy and appropriateness of care will be demonstrated based on patient assessment and reassessments, evidence-based practices, and achievement of desired outcomes.
- Hospital leadership staff design, implement and evaluate care delivery systems and services which are consistently focused on patient-centered care that is delivered with compassion, respect, and dignity for everyone, without bias, and in a manner that best meets the individual needs of the patients and their support system.
- Staff provide a uniform standard of care and service throughout the organization.
- Patient care is coordinated through interdisciplinary collaboration to ensure continuity and seamless delivery of care to the greatest extent possible.
- Efficient use of finances, human resources, streamlined processes, enhanced communication, and supportive technological advancements all while focused on quality of care and patient safety.

Patient Assessment:
The care requirements of the Individual patient and their support system are determined

by on-going assessments performed by qualified health professionals. Each service providing patient care within the organization has a defined scope of assessment provided. This assessment and reassessment of patient care needs continues throughout the continuum and the patient's contact.

Coordination of Care:
Staff provide patient discharge planning to facilitate continuity of medical care and/or other care to meet identified needs. Discharge planning is timely, addressed during initial assessment and/or upon admission, as well as during the discharge planning process, and can be initiated by any member of the multidisciplinary team. Registered nurses, patient care resource managers, advanced practice nurses, and social workers coordinate and maintain close contact with the healthcare team members to finalize an individualized discharge plan.

The medical staff is assigned by clinical department or division. Each clinical department has an appointed chair responsible for a variety of administrative duties, including development and implementation of policies that support the provision of departmental services, maintaining the proper number of qualified, and competent personnel needed to provide care.

Care Delivery Model

Individualized, patient-focused care is the model in which teams deliver care for similar cancer patient populations, intricately linking the physician and other caregivers for optimal communication and service delivery. Personalized patient-focused care is guided by the following principles:

- The patient and their support system will experience the benefits of individualized care that integrates skills of all care team members. These benefits include enhanced quality of care, improved service, appropriate length of hospitalization, value-based cost related to quality outcomes, and patient safety.
- Hospital employees will demonstrate behaviors consistent with the philosophy of personalized health care. This philosophical foundation reflects a culture of collaboration, enthusiasm, and mutual respect.
- Effective communication will impact patient care by ensuring timeliness of services, utilizing staff resources appropriately, and maximize the patient's involvement in their own plan of care.
- Configuring departmental and physician services to accommodate the care needs of the patient in a timely manner will maximize quality of patient care and patient satisfaction.
- Primary nursing characteristics, such as relationship-based care, conceptual framework supporting the professional practice model are used to reflect the guiding philosophy and vision of providing individualized care.
- The patient and their support system will be involved in establishing the plan

of care to ensure services that accommodate their needs, goals, and requests.

Patient Rights and Organizational Ethics

Patient Rights:
To promote effective and compassionate care, systems, processes, policies, and programs are designed to reflect an overall concern and commitment to each person's dignity and privacy. All hospital employees, physicians, and staff have an ethical obligation to respect and support the rights of every patient in all interactions. It is the responsibility of all employees, physicians, and staff to support the efforts of the health care team, to ensure the patient's rights are respected. Each patient (and/or their support system) is given a list of patient rights and responsibilities upon admission and copies of this list are posted in conspicuous places throughout the hospital.

Organizational Ethics:
The James utilizes an ethics policy to articulate the organization's responsibility to patients,staff, physicians, and community served. General guiding principles include:

- Services and capabilities offered meet identified patient and community needs and are fairly and accurately represented to the public.
- The hospital adheres to a uniform standard of care throughout the organization, providing services to those patients for whom we can safely provide care. The James does not discriminate based upon age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity or expression, or source of payment.
- Patients are only billed for care and services received.

Biomedical Ethics:
A biomedical ethical issue arises when there is uncertainty or disagreement regarding medical decisions involving moral, social, or economic situations that impact human life. A mechanism is in place to provide consultation in biomedical ethics to:

- Improve patient care and ensure patient safety.
- Clarify any uncertainties regarding medical decisions.
- Explore the values and principles of underlying disagreements.
- Facilitate communication between the attending physician, the patient, members of the treatment team, and the patient's family or support system (as appropriate).
- Mediate and resolve disagreements.

Integration of Patient Care and Support Services

A collaborative, interdisciplinary team approach, that considers the unique knowledge, judgment, and skills is utilized. A variety of disciplines are involved to achieve the desired

patient outcomes and serves as a foundation for integration of patient care. Continual process improvement initiatives support effective integration of hospital and health system policies, procedures, protocols, and relationships between departments. See appendix A (Page 11) for a listing of support services.

An open line of communication exists between all departments providing patient care, patient services, support services within the hospital, and as appropriate with community agencies to ensure efficient, effective, and continuous patient care. To facilitate effective interdepartmental relationships, problem solving is encouraged at the level closest to the problem. The staff is receptive to addressing one another's issues and concerns and work to achieve mutually acceptable solutions. Supervisors and managers have the responsibility and authority to mutually solve problems and seek solutions within their scope. Positive interdepartmental communications are strongly encouraged. Direct patient care services maintain open communication with each other in alignment with organizational Code of Conduct, as well as with service support departments to ensure continuity of patient care, maintenance of a safe patient environment, and positive outcomes.

Consultations and Referrals for Patient Services

The James provides services as identified in this plan to meet the needs of our community. Patients with assessed needs requiring services not offered at The James are transferred in a timely manner after stabilization; and/or transfers are arranged with another quality facility.

Safe transportation is provided by air or ground ambulance with staff and equipment appropriate to the required level of care. Physician consultation occurs prior to transfer to ensure continuity of care. Referrals for outpatient care occur based on patient need.

Information Management Plan

The overall goal for information management is to support the mission of The James. Specific information management goals related to patient care and include:

- Ensuring the integrity and security of the hospital's information resources and protect patient confidentiality.
- Developing and maintaining an integrated information, communication network linking research, academic and clinical activities.
- Developing and updating computer-based patient records with integrated clinical management and decision support.
- Supporting administrative and business functions with information

technologies that enable improved quality of services, cost effectiveness, and flexibility.
- Building an information infrastructure that supports continuous improvement of the organization.

Patient Organization Improvement Activities

All departments participate in the hospital's plan for improving organizational performance.

Plan Review

The hospital's plan for providing patient care is reviewed regularly by leadership to ensure the plan is adequate, current and compliance is maintained with the plan. Interim adjustments to the plan are made as necessary to accommodate changes in patient population, care delivery systems, processes that affect the delivery, and level of patient care required.

Appendix A: Scope of Services for Ancillary and Support Services

Other hospital services that support the comfort and safety of patients are coordinated and provided in a manner that ensures direct patient care and services are maintained in an uninterrupted, efficient, and continuous manner. These support services will be fully integrated with the patient services departments of the hospital:

Department	Service
Cancer Diagnostic Center	Offers a platform for expert evaluation and access to the appropriate diagnostic testing so that a timely and precise cancer diagnosis can be made from the beginning. The center is staffed by a team of oncology-trained advanced practice providers and nurses. Starting with initial consultation, the team will manage each patient's entire diagnostic journey. This includes identifying and prioritizing the patient's needs and concerns and coordinating the appropriate testing and evaluation. If cancer is confirmed, the team will schedule the patient with the appropriate James multidisciplinary, subspecialized cancer team based on his or her type of cancer.
Central Sterile Supply	Coordinates the comprehensive cleaning, decontamination, assembly and dispensing of surgical instruments, equipment, and supplies needed for regular surgical procedures in related departments.
Chaplaincy and Clinical Pastoral Education	Assist patients, their support system, and hospital personnel in meeting spiritual needs through professional pastoral and spiritual care and education.

Clinical Engineering	Routine equipment evaluation, maintenance, and repair of electronic equipment, evaluation of patient owned equipment.
Cell Therapy Laboratory	Responsible for the processing, cryopreservation, and storage of cells for patients undergoing bone marrow or peripheral blood stem cell transplantation or receiving CAR-T therapy.
Clinical Call Center	Nurse-run telephone triage department that receives and manages telephone calls for established James patients outside normal business hours. The call center operates 24 hours a day and seven days of the week inclusive of holidays.
Communications and Marketing	Responsible for developing strategies and programs to promote the organization's overall image, brand, reputation, and specific products and services to targeted internal and external audiences. Manages all media relations, advertising, internal communications, special events, digital and social properties, collateral materials, and publications for the hospital.
Decedent Affairs	Provide support to the support system of patients who have died and assist them with completing required disposition decisions. Ensure notification of the CMS designated Organ Procurement Agency – Lifeline of Ohio (Lifeline). Promote and facilitate organ/eye/tissue donation by serving as the OSU Hospital Lifeline Liaison. Analyze data provided by Lifeline regarding organ/tissue/eye donation.
Diagnostic Testing Areas	Provide tests based on verbal, electronic, or written consult requests. Final reports are included in the patient record.
Early Response Team (ERT)	Provide timely diagnostic and therapeutic intervention before there is a cardiac or respiratory arrest or an unplanned transfer to the Intensive Care Unit. The team is comprised of rapid response RNs trained in ACLS and Respiratory Therapist who are trained to assist patient care staff when there are signs that a patient's health is declining.
Educational Development and Resources	Provide and promote ongoing development and training experiences to all members of The James Cancer Hospital community, provide staff enrichment programs, organizational development, leadership development, orientation and training, skills training, continuing education, competency assessment and development, literacy programs and student affiliations.
Endoscopy	Provide services to patients requiring a nonsurgical review of their digestive tract.
Environmental Services (EVS)	Provide housekeeping/cleaning and disinfecting of all areas of the hospital, including ORs, patient rooms, and nursing unit environments.
Epidemiology	Enhance the quality of patient care and the work environment by minimizing the risk of acquiring infection within the hospital and ambulatory settings.
Facilities Operations	Provide oversight, maintenance and repair of the building's life safety, fire

	safety, and utility systems. Provides preventative, repair, and routine maintenance in all areas of all buildings serving patients, guests, and staff.
Financial Services	Support leaders in preparation and management of capital and operational budgets; provide comprehensive patient billing services and collaborates with patients and payers to facilitate meeting all payer requirements for payment.
Human Resources (HR)	Serve as a liaison for managers regarding all human resources information and services; assist departments with restructuring efforts; provide proactive strategies for managing planned change within the health system; assist with Employee/Labor Relations issues; assists with performance management process; develops compensation strategies; develop hiring strategies and coordinates process for placements; provide strategies to facilitate sensitivity to issues of cultural diversity; provide human resources information to employees, and established equity for payroll.
Immediate Care Center (ICC)	Patients are evaluated for symptom management related to their disease, or treatment of their disease, and any acute needs requiring evaluation by an advanced practice provider (APP), subsequent treatments, and/or supportive care infusion therapy. Patient visits may include diagnostic, interpretive analysis, and minor invasive procedures. Referrals to other physicians, home care and hospice agencies, dieticians etc. are made by our APPs in collaboration with the primary team.
Information Systems	Support departments to evaluate information technology needs, deploy and integrate reliable, state-of-the-art information systems technology solutions to manage change.
Laboratory Services	Responsible for performing testing on patient specimens to obtain information about the health of patient as pertaining to the diagnosis, treatment, and prevention of disease. Laboratory reports are included in the patient record.
Materials Management	Supply, stock, and monitor PAR levels in patient care areas.
Medical Information Management (MIM)	Maintain patient records serving the needs of the patient, provider, institution and various third parties to health care in the inpatient and ambulatory setting.
Nutrition Services	Provide nutritional care and food service to The James inpatient and ambulatory site patients, staff, and visitors. Clinical nutrition assessment and consultation services are available in both inpatient and outpatient settings.
Pathology	Pathology receives, triages, and accessions gross (macroscopic) examination of all complexity of surgical resections and biopsies. Final reports are included in the patient record.
James Patient Access Services (JPAS)	Coordinate registration/admissions.

Patient Care Resource Management (PCRM) and Social Services	Provide personalized care coordination and resource management. with patients and their support systems. Provide discharge planning, coordination of external agency contacts for patient care needs and crisis intervention and support for patients and their support system. Provide services upon phone/consult request of physician, nurse or the patient or patient support system.
Patient Education	Provide educational resources that facilitate patient learning and encourage the patient to take an active role in their care. These resources are evidence- based, comply with national standards for health literacy/plain language/accessibility and meet Joint Commission and organizational standards. Based on their assessment, clinicians use patient education resources to assist in patient and caregiver understanding and to reinforce the learning provided during their hospital stay or clinic visit.
Patient Experience	Develop programs for support of patient relations and customer service and information desk. Volunteers do wayfinding, host visitors in waiting areas, serve as patient/family advisors and advocates, and assist staff. Volunteer Services serves as a liaison for the Service Board auxiliary, which annually grants money to department-initiated projects, enhancing the patient and family experience.
Perioperative Services	Provide personalized care of the patient receiving surgical services, from pre-anesthesia through recovery, for the ambulatory and inpatient surgical patients.
Pharmacy	Patient care services are delivered via specialty practice pharmacists and clinical generalists. Each practitioner promotes optimal medication use and assists in achieving the therapeutic goals of the patients.
Operations Improvement/Process Engineers	Operations Improvement Process Engineers utilize industrial engineering knowledge and skills, as well as LEAN and Six Sigma methods to provide internal consulting, coaching, and training services for all departments across all parts of The James Cancer Hospital to develop, implement, and monitor more efficient, cost-effective business processes and strategies.
Observation Unit	Provide additional bed capacity to expand care for oncology patients needing a non-inpatient level of care.
Pulmonary Diagnostics Lab	Provide services to patients requiring an evaluation of the respiratory system including pulmonary function testing, bronchoscopy, and other diagnostic/interventional pulmonary procedures.
Quality and Patient Safety	Provide integrated quality management and facilitate continuous quality improvement efforts throughout the hospital. Focus on the culture of safety and work with teams to provide information on trends and improvement opportunities.
Radiation Oncology	Responsible for clinical care related to the application of radiation treatments and radiation safety which include, but is not limited to photon, proton, gamma knife, and brachytherapy.

Radiology Services	Provide state-of-the-art radiological diagnostic and therapeutic testing and treatment. Services offered by the Radiology Imaging Department range from general radiography and fluoroscopy to new and advanced interventional procedures, contrast imaging, which include, but not limited to CT, MRI, IVP, etc., in which contrast agents are administered by IV certified radiology technologists.
Rehabilitation Services	Physical therapists, occupational therapists, speech and language pathologists and recreational therapists, evaluate, formulate a plan of care, and provide treatment based on physician referral and along with the interdisciplinary medical team for appropriate treatment and education needed for the established discharge plan.
Respiratory Therapy (RT)	Provide respiratory therapeutic interventions and diagnostic testing, by physician order including ventilator support, bronchodilator therapy, and pulmonary hygiene.
Safety	Hospital safety personnel handle issues associated with regulations, such as EPA, OSHA, and fire safety.
Security	Provide a safe and secure environment for patients, visitors, and staff members by responding to emergencies such as workplace violence, fires, bomb threats, internal and external disasters, armed aggressors, or any other incident that requires emergency response.
Social Work Services	Social Work Services are provided to patients/families to meet their medically related social and emotional needs as they impact their medical condition, treatment, recovery, and safe transition from one care environment to another. Social workers provide psychosocial assessment and intervention, crisis intervention, financial counseling, discharge planning, health education, provision of material resources and linkage with community agencies. Members of the treatment team can request consults for patients, or their support system.
Staff Development and Education	Provide and promote ongoing employee development and training related to oncology care, provides clinical orientation, and continuing education of staff.
Transfer Center	Coordinate with inpatient units and ancillary departments to ensure patient flow efficiency and timely access for patients who seek care. Provide transparency real-time across the Medical Center on capacity and all ADT (Admission, Discharge, and Transfer) activity. Timely and accurate patient placement based on level of care and service line is expedited through a capacity management technology platform.
Transportation	Supply patients with a secure and proficient transport within the Wexner Medical Center by transferring patients between rooms/floors within the hospital, taking patients to and from test sites, and discharging patients to Dodd Rehabilitation Center, on-site hospice, and the morgue.
Wound Care	Wound care services including but are not limited to the diagnosis and

	management for skin impairments, on-going wound management, treatment, and prevention.

August 19, 2025

SCOPE OF CARE
THE OHIO STATE UNIVERSITY AMBULATORY SURGERY CENTER
OUTPATIENT CARE NEW ALBANY

Synopsis: Approval of the annual review of the scope of patient care services for The Ohio State University Ambulatory Surgery Center — Outpatient Care New Albany, is proposed.

WHEREAS the mission of the Ohio State University Hospitals is to improve people's lives through the provision of high-quality patient care; and

WHEREAS the scope of care describes services related to elective outpatient procedures at The Ohio State University Ambulatory Surgery Center — Outpatient Care New Albany; and

WHEREAS ON June 24, 2025, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the scope of patient care services for The Ohio State University Ambulatory Surgery Center — Outpatient Care New Albany:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the scope of care for The Ohio State University Ambulatory Surgery Center — Outpatient Care New Albany.

OSU AMBULATORY SURGERY CENTER
Scope of Care – Outpatient Care New Albany
Clinical Departments

Approved By:

X Jarrett A. Heard 5/23/25
Dr. J. Heard, MD, MBA
Medical Director, Ambulatory Peri-Operative Services

X Sheryl Burtch 5.23.25
Sheryl Burtch, DNP, MA, RN, NEA-BC
Sr. Director, Peri-Operative Services

Department/ Patient Care Unit Name: The Ohio State University Ambulatory Surgery Center – Outpatient Care New Albany. The Center is an Ambulatory Surgery Center which provides services related to elective outpatient procedures.

Types (and age range) of patients served:

- 18 or more years of age.
- Patients aged 13 to 17 with the following requirements please follow below approval process:
  1. Treating physician has admitting privileges at an age-appropriate inpatient center
  2. Permission from Medical Director or Designee
  3. Minimum Height/ Weight requirements: 5'0" and 100 pounds. Variance shall require medical director (or designee) approval.
  4. All patients will have an anesthesia evaluation, either ComPAC or OPAC. Variance shall require medical director (or designee) approval.
  5. Pediatric BMI limit is 40.0.

6. An accompanying responsible adult, preferably the custodial parent or legal guardian, must remain present in the building. A custodial parent or legal guardian must be available by phone during the surgery admission. For the Extended Recovery Unit, an accompanying responsible adult must remain present in the building overnight with the patient.

Physical Status:

- ASA I-II.
- ASA III without signs or symptoms of uncontrolled or decompensated conditions.
- ASA IV without signs or symptoms of uncontrolled or decompensated conditions.
- ASA IV patients may not have straight Local without Anesthesia care; they may have MAC or General Anesthesia at the discretion of the Anesthesiologist.
- General and MAC Anesthesia will be administered by Department of Anesthesia providers. Conscious sedation will be administered by any individual provider credentialed to do so.

Procedure Length

- Procedures requiring more than 6 hours of total OR time will need prior authorization by the Medical Director or designee.
- Patients anticipated to have an extended PACU length of stay will need prior authorization by the Medical Director or designee.
- These cases will be scheduled no later than the first case in a physician's block and will be scheduled to end by 3:00pm.

DNR:

- For patient admitted to the surgery center with an active DNR order, the advance directive should be discussed with the patient and/or their family members or caregivers, the surgeon/proceduralist and anesthesia providers to determine whether the do-not-resuscitate orders are suspended or maintained for the surgery or procedure. **Ideally, this should occur before the day of surgery, after the ComPAC or OPAC visit has been completed.**
- Suspending a DNR will be in accordance with the OSUWMC policy for surgery center patients.

  < https://osumc.policytech.com/docview/?app=pt&source=unspecified&docid=118044>

Malignant Hyperthermia:
Patients with a personal or family history of MH must be reviewed by the Medical Director or Designee.

Morbid Obesity OR's:

Patients will be considered with identified criteria - Variance shall require medical director (or designee) approval.

- All patients must have current height & weight in IHIS before scheduled at the ASC.
- Patients with BMI > 40.0 may not be performed in the prone position if anesthetized and unable to move themselves into that position.
- Patients with BMI > 45.0 may not be performed in the lateral position if anesthetized and unable to move themselves into that position.
- Patients with a BMI 45.0-55.0 will be considered for general anesthesia, needing review and final approval from the medical director or designee. If BMI is greater than 55.0, procedure planned should require minimal sedation. Elective conversion to General Anesthesia will not be an option. If General Anesthesia conversion is an anticipated option, the surgery/procedure should not be scheduled at the ASC.
- No patient with BMI > 65.0 will be accepted at the ASC.
- No pediatric (age < 18 years) patient with BMI > 40.0 will be accepted at the ASC.
- Recorded BMI at the time of the ComPAC or OPAC appointment will be considered in evaluation of cases being cancelled on day of surgery by Attending Surgeon/Proceduralist and Anesthesia.

Morbid Obesity Endoscopy

- Patients with BMI > 45 may not have conscious/moderate sedation
- Patients with BMI between 45-55 will need review and final approval from the medical director or designee.
- Endoscopy patient BMI limit is 55.0 regardless of positioning.
- Recorded BMI at the time of the ComPAC or OPAC appointment will be considered in evaluation of cases being cancelled on day of surgery by Attending Surgeon/Proceduralist and Anesthesia.

Hemodialysis:

Hemodialysis patients cannot have procedure/surgery and hemodialysis scheduled on the same day. Either the date of procedure/surgery or dialysis must be changed if they are scheduled for the same day. Variance shall require medical director (or designee) approval.

Ambulation:

Patients must be able to ambulate with minimal assistance including ability to stand up and pivot to cart.

- Procedures will not be performed with patient's personal medical equipment (i.e. wheelchairs).

Anesthesia:

General and MAC Anesthesia will be administered by Department of Anesthesia providers. Conscious sedation will be administered by any individual provider credentialed to do so.

Difficult Airway:

Patients with a history of difficult airway / intubation must complete a ComPAC or OPAC evaluation and be approved by the Medical Director or Designee.

Pacemakers / Defibrillators:

- Patients with isolated pacemakers must have the device evaluated by their Cardiologist within twelve (12) months prior to Date of Service. Documentation of interrogation must be readily available.
- Patients with pacemakers will not be considered for ESWL procedures without OSU Pacer Clinic personnel on site throughout the surgical procedure.
- Patients with AICD's are considered for MAC Anesthesia/conscious sedation only. Patients must be evaluated by their cardiologist within six (6) months prior to Date of Service. Documentation of interrogation must be readily available and there should be no change in patient's clinical status since last cardiac evaluation. If placing a magnet would deprogram the AICD, these patients would not be candidates for the ASC.

Reference:

Crossley, George H. et al "The Heart Rhythm Society (HRS)/American Society of." *Heart Rhythm* 8.7 (2011): 1114-140. Print.
Michael, Platonov A., MD, Anne Gillis, MD, and Katherine M. Kavanagh, MD. "Pacemakers, Implantable Cardioverter/Defibrillators." *Journal of Endourology* 22.2 (2008): 243-47. Print.

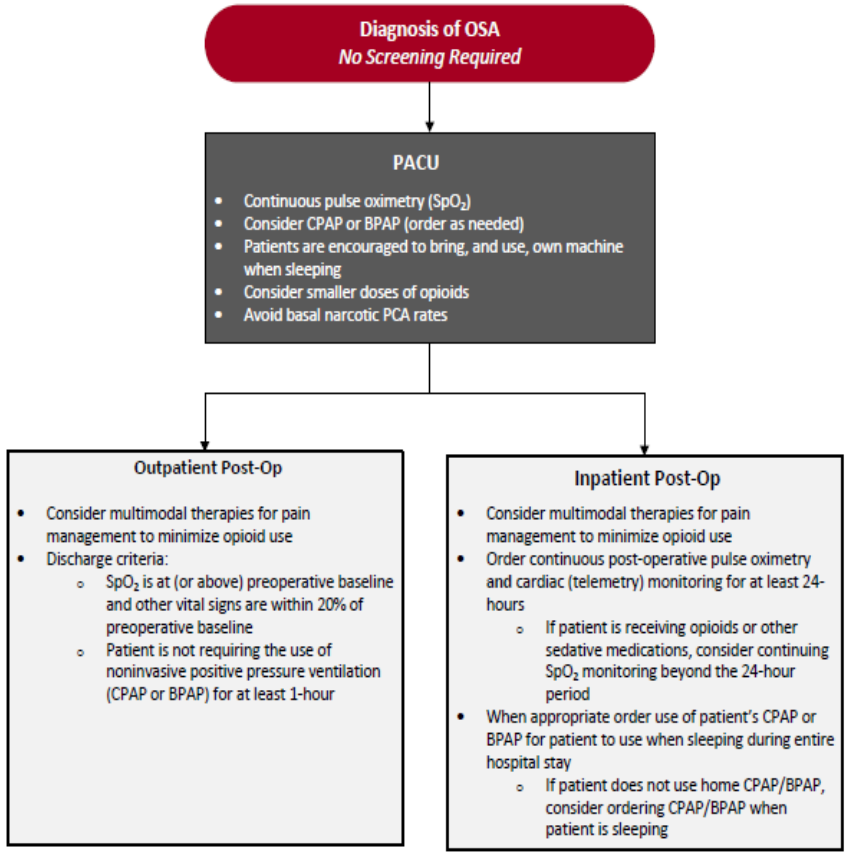
Obstructive Sleep Apnea:

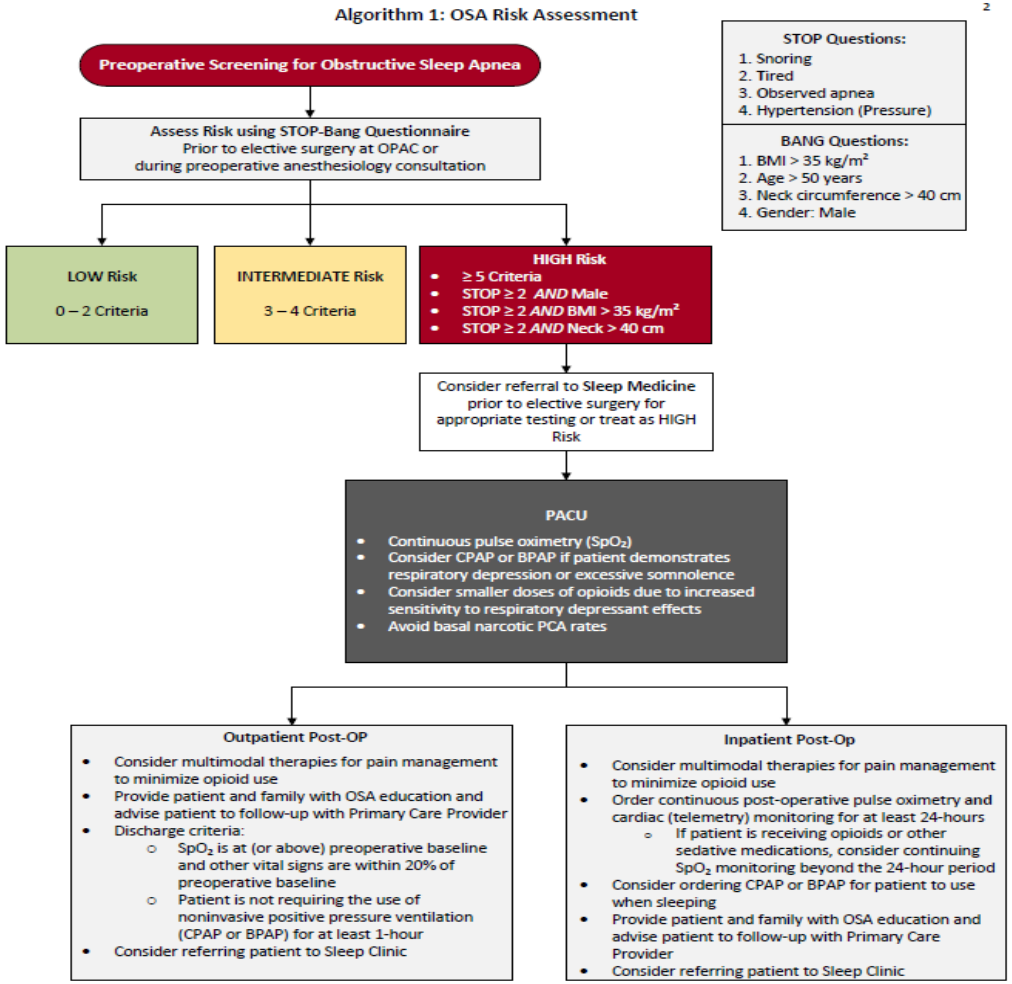
Anesthesiology services will evaluate the appropriateness of outpatient procedures/surgery, given the patient's OSA history, the proposed procedure and the patient's co-morbidities.

- Patients with known diagnosis of OSA that have optimized co-morbid medical conditions will be considered.
- Patients with a presumed diagnosis of OSA based on screening (STOP Bang) questionnaire, and with optimized co-morbid conditions, will be considered for the OSC if postoperative pain can be managed predominantly with non-opioid analgesia.

Reference:

Stein, E., Das, A., Guertin, M., Dalton, R., Springer, A., Rogers, B., & Heavener, D. (2021). *Perioperative assessment and management of obstructive sleep apnea (OSA): OSUWMC Clinical Practice Guideline.* https://onesource.osumc.edu/sites/ebm/Documents/Guidelines/ObstructiveSleepApnea





Isolation Patients/ Infection Prevention:

Patients requiring isolation precautions (droplet, airborne) as defined by medical center guidelines will need approval by the Medical Director or Designee.

Patients requiring contact isolation precautions may be considered as defined by medical center guidelines using appropriate PPE.

Patients with wounds that are bleeding or draining will have sites contained with an occlusive dressing and treated with standard precautions.

Management of MRSA in Ambulatory Surgical Facilities. (n.d.). *Management of MRSA in Ambulatory Surgical Facilities*. Retrieved from http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/Jun7%282%29/Pages/61.aspx

Guide to Infection Prevention In Outpatient Settings: Minimum Expectations for Safe Care. (n.d.). *CDC.Gov*. Retrieved from

Pregnancy:

- No patient with a known pregnancy may be treated at the ASC.
- All patients of childbearing age with female reproductive organs will submit a urine pregnancy test on the day of surgery. Every attempt will be made to collect urine specimen. If the patient is unable to void, refuses to void, or the patient's legal guardian refuses the pregnancy test, a pregnancy test waiver consent form may be signed by the patient or the patient's legal guardian after a discussion of risks and signature from the anesthesiologist and attending proceduralist.

Developmental Disabilities/Special Needs:
The ASC will be provided an updated History & Physical that includes diagnosis of specific conditions/ syndromes. Along with the H&P, the "Functional Ability Assessment" will be completed. All Developmentally Disabled/ Special Needs patients require Anesthesia approval prior to scheduling.

Toxicology Screen:
All patients who appear to be intoxicated and who test positive on Date of Service for methamphetamines, amphetamines, cocaine &/or alcohol will have their procedure cancelled. Patients testing positive for other drugs will be evaluated on an individual basis.

Preoperative Evaluation:

Patients may undergo pre-operative testing according to the current Pre-Anesthetic Testing Algorithm. Complete pre-operative services are available by a ComPAC or OPAC appointment.

Accompanying Adult:

Patients who have undergone minor, superficial procedures ***without sedation*** may be discharged at the discretion of their admitting physician. If the procedure performed involves the hand, eye, or foot & impairs their visual acuity, or hand/ foot dexterity to the degree that they cannot operate a motor vehicle, the patient will not be permitted to drive when discharged.

All other patients will require an accompanying adult (18 or more years of age) to provide patient transportation upon discharge. The ASC will recommend that the adult representative remain at the ASC throughout the procedure. Patients will be made aware that the absence of an accompanying adult may result in their procedure being cancelled. Patients found to be without transportation after their procedure will be discharged according to current medical center policy.

Scope and complexity of patient's care needs:

Four operating rooms located on the second floor of The Ohio State University Outpatient Care New Albany servicing the following specialties: General Surgery, Colorectal, Gynecology, Ophthalmology, Plastic Surgery and Urology. Four endoscopy procedure rooms located on the second floor of The Ohio State University Outpatient Care New Albany servicing from Gastroenterology, Hepatology and Nutrition (GHN), General Surgery and open access referrals.

The Center is staffed from 0600AM-to 1700PM Monday through Friday, primarily for adult patients requiring surgical intervention under local anesthesia, conscious sedation, monitored anesthesia care, regional anesthesia or general anesthesia.

Patients are admitted to the Center on an ambulatory basis. Patients are required to have the ability to understand and carry out their discharge instructions or have a responsible adult which will assist them in fulfilling these needs.

All procedures performed at the Ambulatory Surgery Center are part of the Core Privileges approved by Ohio State University Wexner Medical Center.

The following types of procedures are not performed at the Center:

- Are associated with the risk of extensive blood loss.
- Require major or prolonged invasion of body cavities.
- Directly involve major blood vessels.
- Are an emergency or life threatening in nature.
- Noted on the CMS Inpatient Only List. This list will be reviewed and updated annually.

Methods used to assess and meet patient's care needs:

Care of all patients experiencing surgical intervention is based on the nursing process and standards from AORN, ASPSN, SGNA and other National Peri-operative organizations supporting the service lines of the Center. Preoperatively, the RN verifies the patient, identifies the patient's special needs, completes a patient assessment and develops a plan of care. Intra-operatively, the RN implements the patient's plan of care and documents on the appropriate medical records (e.g.: Op-Time and hospital approved documents).

Methods used to determine the appropriateness, clinical necessity and timeliness of support services provided directly or through referral

The Circulating RN works collaboratively with the proceduralists, surgeons, anesthesiologists, PACU RN, and the Pre-op Holding RN in assessing, prioritizing and meeting the patient's individual needs. Based on the scheduled procedure and communication with the physician/surgeon and anesthesia, specific patient concerns regarding safety, infection control, positioning, and psychosocial needs are anticipated and met (e.g.: preparation of OR environment for latex allergy patient, isolation protocols implemented, limitation of patients range of motion, need for an interpreter or caregiver for MR/DD patients). The continued need for support is communicated to the receiving unit via the oral transfer report and IHIS documentation. A collaborative effort to improve this communication is ongoing. The success of this method is determined by the achievement of positive patient outcomes, reflected by PI monitors and retrospective chart reviews.

In the event of an identified patient need to receive services not provided at the ASC, the patient will be transferred to the Wexner Medical Center for subsequent evaluation.

Standards of practice/ practice guidelines, when available

The Ambulatory Surgery Center provides services related to elective outpatient procedures in the fields of General Surgery, GHN, Gynecology, Ophthalmology, Plastic Surgery, Urology, and Vascular at 6100 N. Hamilton Road, Westerville Ohio 43081. The OSUWMC Board of Directors, the OSUWMC Medical Staff, in conjunction with the Ambulatory Executive Director, Ambulatory Medical Director, Senior Director, Associate and Administrative Directors & Nurse Manager assess, plan, implement, and evaluate the delivery of care and services. The Ambulatory leadership team is responsible for ensuring that the delivery of care provided is consistent with the mission, standards, and policies established for patient care. The Ambulatory leadership team promotes an environment that fosters empowerment through active participation in strategic planning and development of processes that ensure adequacy of services and resources to meet the current and projected community needs, policy establishment, and professional growth.

The objective of The Ohio State University Ambulatory Surgery Center is to deliver excellent surgical, procedural, and anesthesia services to those we serve in accordance with the standards set forth by The Joint Commission, CMS Conditions of Participations for Hospitals and The Vision and Mission statements of The Ohio State University Wexner Medical Center. The Scope of Care is designed to provide appropriate care and services for all patients in a timely manner.

Utilizing a multi-disciplinary approach in the delivery of patient care, our services promote continuous quality and performance improvement activities provided in an environment where collaboration and multi-disciplinary approaches to problem identification and resolution are the expectation. Important criteria and thresholds are measured and continuously monitored through our Quality and Performance Improvement process to optimize patient outcomes and assure the highest level of satisfaction for all our customers. Results of our Quality and Performance Improvement activities are used to improve patient outcomes enhance our services and our staff performance.

Understanding that the provision of health care services is dynamic and fluid; the Scope of Care will be ***reviewed at least annually*** and revised as needed to reflect the changing patient needs, community changes, and or facility needs and initiatives.

August 19, 2025

SCOPE OF CARE
THE OHIO STATE UNIVERSITY AMBULATORY SURGERY CENTER
OUTPATIENT CARE DUBLIN

Synopsis: Approval of the annual review of the scope of patient care services for The Ohio State University Ambulatory Surgery Center — Outpatient Care Dublin, is proposed.

WHEREAS the mission of the Ohio State University Hospitals is to improve people's lives through the provision of high-quality patient care; and

WHEREAS the scope of care describes services related to elective outpatient procedures at The Ohio State University Ambulatory Surgery Center — Outpatient Care Dublin; and

WHEREAS ON June 24, 2025, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the scope of patient care services for The Ohio State University Ambulatory Surgery Center — Outpatient Care Dublin:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the scope of care for The Ohio State University Ambulatory Surgery Center — Outpatient Care Dublin.

OSU AMBULATORY SURGERY CENTER
Scope of Care – Outpatient Care Dublin
Clinical Departments

Approved By:

X Jarrett A. Heard 5/23/25
Dr. J. Heard, MD, MBA
Medical Director, Ambulatory Peri-Operative Services

X Sheryl Burtch 5.23.25
Sheryl Burtch, DNP, MA, RN, NEA-BC
Sr. Director, Peri-Operative Services

Department/ Patient Care Unit Name: The Ohio State University Outpatient Care Dublin - Ambulatory Surgery Center. The Center is an Ambulatory Surgery Center of OSUWMC which provides services related to elective outpatient procedures.

Types (and age range) of patients served:

- 18 or more years of age.
- Patients aged 13 to 17 with the following requirements please follow below approval process:
  1. Treating physician has admitting privileges at an age-appropriate inpatient center
  2. Permission from Medical Director or Designee
  3. Minimum Height/ Weight requirements: 5'0" and 100 pounds. Variance shall require medical director (or designee) approval.
  4. All patients will have an anesthesia evaluation, either ComPAC or OPAC. Variance shall require medical director (or designee) approval.
  5. Pediatric BMI limit is 40.0.

6. An accompanying responsible adult, preferably the custodial parent or legal guardian, must remain present in the building. A custodial parent or legal guardian must be available by phone during the surgery admission. For the Extended Recovery Unit, an accompanying responsible adult must remain present in the building overnight with the patient.

Physical Status:

- ASA I-II.
- ASA III without signs or symptoms of uncontrolled or decompensated conditions.
- ASA IV without signs or symptoms of uncontrolled or decompensated conditions.
- ASA IV patients may not have straight Local without Anesthesia care; they may have MAC or General Anesthesia at the discretion of the Anesthesiologist.
- General and MAC Anesthesia will be administered by Department of Anesthesia providers. Conscious sedation will be administered by any individual provider credentialed to do so.

Procedure Length

- Procedures requiring more than 6 hours of total OR time will need prior authorization by the Medical Director or designee.
- Patients anticipated to have an extended PACU length of stay will need prior authorization by the Medical Director or designee.
- These cases will be scheduled no later than the first case in a surgeon's block and will be scheduled to end by 3:00pm

DNR:

- For patient admitted to the surgery center with an active DNR order, the advance directive should be discussed with the patient and/or their family members or caregivers, the surgeon/proceduralist and anesthesia providers to determine whether the do-not-resuscitate orders are suspended or maintained for the surgery or procedure. **Ideally, this should occur before the day of surgery, after the ComPAC or OPAC visit has been completed.**
- Suspending a DNR will be in accordance with the OSUWMC policy for surgery center patients.

< **https://osumc.policytech.com/docview/?app=pt&source=unspecified&docid=118044**>

Malignant Hyperthermia:
Patients with a personal or family history of MH must be reviewed by the Medical Director or Designee.

Morbid Obesity OR's:
Patients will be considered with identified criteria - Variance shall require medical director (or designee) approval.

- All patients must have current height & weight in IHIS before scheduled at the ASC.
- Patients with BMI > 40.0 may not be performed in the prone position if anesthetized and unable to move themselves into that position.

Date Last Revised: 3/8/2023
Date Last Reviewed:

- Patients with BMI > 45.0 may not be performed in the lateral position if anesthetized and unable to move themselves into that position.
- Shoulder patients must have a BMI ≤ 45.
- Patients with a BMI 45.0-55.0 will be considered for general anesthesia, needing review and final approval from the medical director or designee. If BMI is greater than 55.0, procedure planned should require minimal sedation. Elective conversion to General Anesthesia will not be an option. If General Anesthesia conversion is an anticipated option, the surgery/procedure should not be scheduled at the ASC.
- No patient with BMI > 65.0 will be accepted at the ASC.
- No pediatric (age < 18 years) patient with BMI > 40.0 will be accepted at the ASC.
- Recorded BMI at the time of the ComPAC or OPAC appointment will be considered in evaluation of cases being cancelled on day of surgery by Attending Surgeon/Proceduralist and Anesthesia.

Morbid Obesity Endoscopy

- Patients with BMI > 45 may not have conscious/moderate sedation
- Patients with BMI between 45-55 will need review and final approval from the medical director or designee.
- Endoscopy patient BMI limit is 55.0 regardless of positioning.

Recorded BMI at the time of the ComPAC or OPAC appointment will be considered in evaluation of cases being cancelled on day of surgery by Attending Surgeon/Proceduralist and Anesthesia.

Hemodialysis:

Hemodialysis patients cannot have surgery and hemodialysis scheduled on the same day. Either the date of surgery or dialysis must be changed if they are scheduled for the same day. Variance shall require medical director (or designee) approval.

Ambulation:

Patients must be able to ambulate with minimal assistance including ability to stand up and pivot to cart

- Procedures will not be performed with patient's personal medical equipment (i.e. wheelchairs)
- Physical Therapy will be available for patients in Extended Recovery for total joint procedures.

Anesthesia:

General and MAC Anesthesia will be administered by providers from Department of Anesthesiology. Conscious sedation will be administered by any individual provider credentialed to do so.

Difficult Airway:

Patients with a history of difficult airway / intubation must complete a ComPAC or OPAC evaluation and approved by the Medical Director or Designee.

Date Last Revised: 3/8/2023
Date Last Reviewed:

Pacemakers / Defibrillators:

- Patients with isolated pacemakers must have the device evaluated by their Cardiologist within twelve (12) months prior to Date of Service. Documentation of interrogation must be readily available.
- Patients with pacemakers will not be considered for ESWL procedures without OSU Pacer Clinic personnel on site throughout the surgical procedure.
- Patients with AICD's are considered for MAC Anesthesia/conscious sedation only. Patients must be evaluated by their cardiologist within six (6) months prior to Date of Service. Documentation of interrogation must be readily available and there should be no change in patient's clinical status since last cardiac evaluation. If placing a magnet would deprogram the AICD, these patients would not be candidates for the ASC.

Reference:

Crossley, George H. et al "The Heart Rhythm Society (HRS)/American Society of." *Heart Rhythm* 8.7 (2011): 1114-140. Print.

Michael, Platonov A., MD, Anne Gillis, MD, and Katherine M. Kavanagh, MD. "Pacemakers, Implantable Cardioverter/Defibrillators." *Journal of Endourology* 22.2 (2008): 243-47. Print.

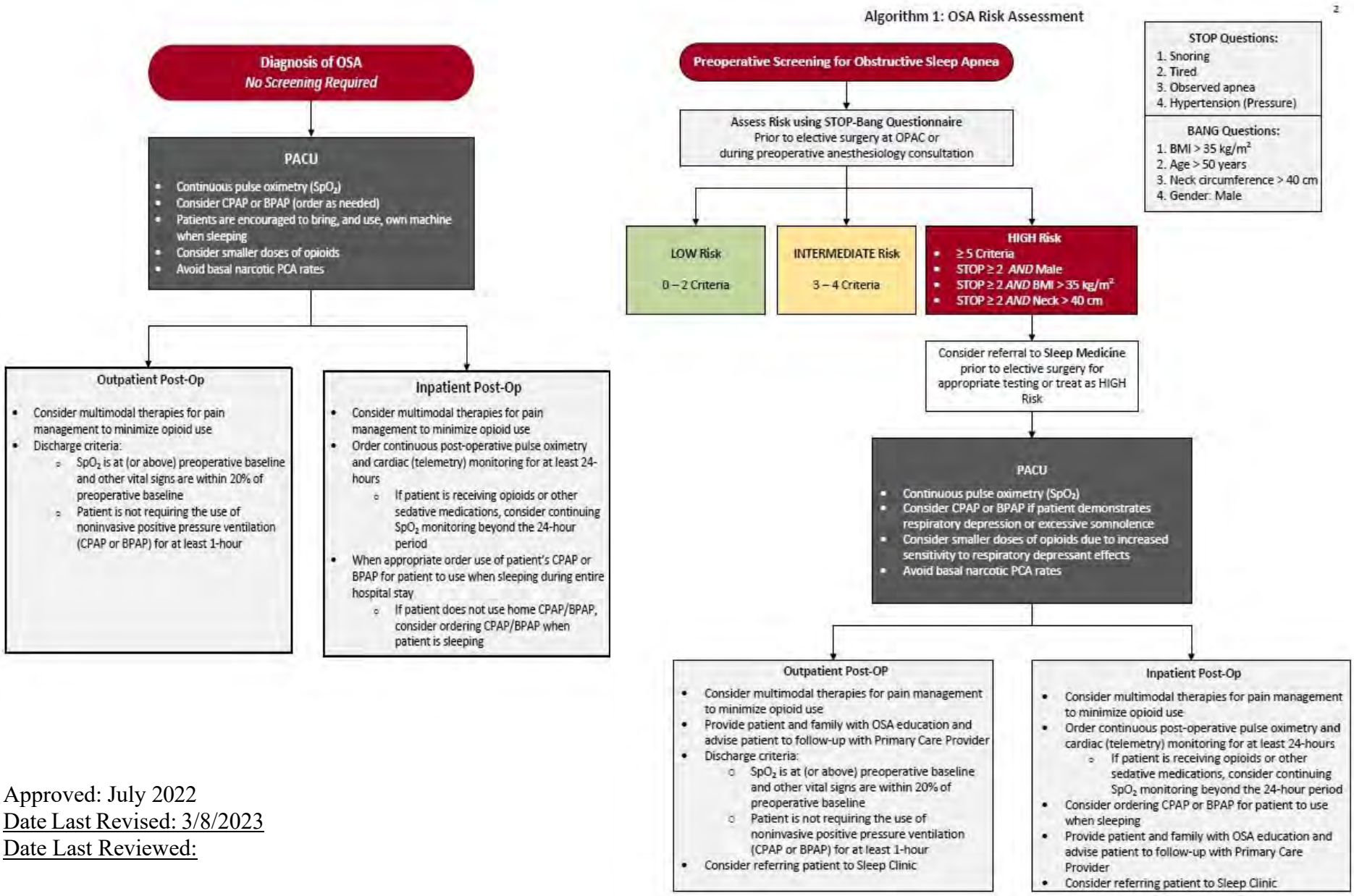
Obstructive Sleep Apnea:

Anesthesiology services will evaluate the appropriateness of outpatient procedures/surgery, given the patient's OSA history, the proposed procedure, and the patient's co-morbidities.

- Patients with known diagnosis of OSA that have optimized co-morbid medical conditions will be considered.
- Patients with a presumed diagnosis of OSA based on screening (STOP Bang) questionnaire, and with optimized co-morbid conditions, will be considered for the OSC if postoperative pain can be managed predominantly with non-opioid analgesia.

Reference:

Stein, E., Das, A., Guertin, M., Dalton, R., Springer, A., Rogers, B., & Heavener, D. (2021). *Perioperative assessment and management of obstructive sleep apnea (OSA): OSUWMC Clinical Practice Guideline.* https://onesource.osumc.edu/sites/ebm/Documents/Guidelines/ObstructiveSleepApnea



Approved: July 2022
Date Last Revised: 3/8/2023
Date Last Reviewed:

Isolation Patients/ Infection Prevention:

Patients requiring isolation precautions (droplet, airborne) as defined by medical center guidelines will need approval by the Medical Director or Designee.

Patients requiring contact isolation precautions may be considered as defined by medical center guidelines using appropriate PPE.

Patients with wounds that are bleeding or draining will have sites contained with an occlusive dressing and treated with standard precautions.

Management of MRSA in Ambulatory Surgical Facilities. (n.d.). *Management of MRSA in Ambulatory Surgical Facilities*. Retrieved from http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/Jun7%282%29/Pages/61.aspx

Guide to Infection Prevention In Outpatient Settings: Minimum Expectations for Safe Care. (n.d.). *CDC.Gov*. Retrieved from

Pregnancy:

- No patient with a known pregnancy may be treated at the ASC.
- All patients of childbearing age with female reproductive organs will submit a urine pregnancy test on the day of surgery. Every attempt will be made to collect urine specimen. If the patient is unable to void, refuses to void, or the patient's legal guardian refuses the pregnancy test, a pregnancy test waiver consent form may be signed by the patient or the patient's legal guardian after a discussion of risks and signature from the anesthesiologist and attending proceduralist.

Developmental Disabilities/Special Needs:
The ASC will be provided an updated History & Physical that includes diagnosis of specific conditions/ syndromes. Along with the H&P, the "Functional Ability Assessment" will be completed. All Developmentally Disabled/ Special Needs patients require Anesthesia approval prior to scheduling.

Toxicology Screen:
All patients who appear to be intoxicated and who test positive on Date of Service for methamphetamines, amphetamines, cocaine &/or alcohol will have their procedure cancelled. Patients testing positive for other drugs will be evaluated on an individual basis.

Preoperative Evaluation:
Patients may undergo pre-operative testing according to the current Pre-Anesthetic Testing Algorithm. Complete pre-operative services are available by a ComPAC or OPAC appointment.

Accompanying Adult:
Patients who have undergone minor, superficial procedures ***without sedation*** may be discharged at the discretion of their admitting physician. If the procedure performed involves the hand, eye, or foot & impairs their visual acuity, or hand/ foot dexterity to the degree that they cannot operate a motor vehicle, the patient will not be permitted to drive when discharged.

All other patients will require an accompanying adult (18 or more years of age) to provide patient transportation upon discharge. The ASC will recommend that the adult representative remain at the ASC throughout the procedure. Patients will be made aware that the absence of an accompanying adult may result in their procedure being cancelled. Patients found to be without transportation after their procedure will be discharged according to current medical center policy.

Scope and complexity of patient's care needs:
Six operating rooms located on the second floor of The Ohio State University Outpatient Care Dublin Ambulatory Surgery Center servicing the following specialties: Urology, Vascular, Otolaryngology, Hand & Upper Extremity, Orthopaedic Joints, Orthopaedic Spine, Endoscopy and Interventional Radiology, Pain Management, and Podiatry. Six endoscopy procedure rooms located on the second floor of The Ohio State University Outpatient Care New Albany servicing from Gastroenterology, Hepatology and Nutrition (GHN), and open access referrals.
The Center is staffed from 0600AM to 1700PM Monday through Friday, primarily for adult patients requiring surgical intervention under local anesthesia, conscious sedation, monitored anesthesia care, regional anesthesia or general anesthesia.

Patients are admitted to the ASC on an ambulatory basis. The patients are required to have the ability to understand and carry out their discharge instructions or have a responsible adult which will assist them in fulfilling these needs.

All procedures performed at the Ambulatory Surgery Center are part of the Core Privileges approved by Ohio State University Wexner Medical Center.

The following types of procedures are not performed at the Center:

- Are associated with the risk of extensive blood loss.
- Require major or prolonged invasion of body cavities.
- Directly involve major blood vessels.
- Are an emergency or life threatening in nature
- Noted on the CMS Inpatient Only List. This list will be reviewed and updated annually.

Methods used to assess and meet patient's care needs:
Care of all patients experiencing surgical intervention is based on the nursing process and standards from AORN, ASPSN, SGNA and other National Peri-operative organizations supporting the service lines of the Center. Preoperatively, the RN verifies the patient, identifies the patient's special needs, completes a patient assessment and develops a plan of care. Intra-operatively, the RN implements the patient's plan of care and documents on the appropriate medical records (e.g.: Op-Time and hospital approved documents).

Methods used to determine the appropriateness, clinical necessity and timeliness of support services provided directly or through referral
The Circulating RN works collaboratively with the proceduralists, surgeons, anesthesiologists, PACU RN, and the Pre-op Holding RN in assessing, prioritizing and meeting the patient's individual needs. Based on the scheduled procedure and communication with the physician/surgeon and anesthesia, specific patient concerns regarding safety, infection control, positioning, and psychosocial needs are anticipated and met (e.g.: preparation of OR environment for latex allergy patient, isolation protocols implemented, limitation of patients range of motion, need for an interpreter or caregiver for MR/DD patients). The continued need for support is communicated to the receiving unit via the oral transfer report and IHIS documentation. A collaborative effort to improve this communication is ongoing. The success of this method is determined by the achievement of positive patient outcomes, reflected by PI monitors and retrospective chart reviews.

In the event of an identified patient need to receive services not provided at the ASC, the patient will be transferred to the Wexner Medical Center for subsequent evaluation.

Standards of practice/ practice guidelines, when available
The Ambulatory Surgery Center provides services related to elective outpatient procedures in the fields of Urology, Vascular, Otolaryngology, Hand & Upper Extremity, Orthopaedic Joints, Orthopaedic Spine, Endoscopy and Interventional Radiology, Pain Management, and Podiatry in Outpatient Care at Dublin Ambulatory Surgery Center - 6700 University Blvd, Dublin, Ohio 43016. The OSUWMC Board of Directors, the OSUWMC Medical Staff, in conjunction with the Ambulatory Executive Director, Ambulatory Medical Director, Senior Director, Associate and Administrative Directors, & Nurse Manager assess, plan, implement, and evaluate the delivery of care and services. The Ambulatory leadership team is responsible for ensuring that the delivery of care provided is consistent with the mission, standards, and policies established for patient care. The Ambulatory leadership team promotes an environment that fosters empowerment through active participation in strategic planning and development of processes that ensure adequacy of services and resources to meet the current and projected community needs, policy establishment, and professional growth.

The objective of the Outpatient Care Dublin Ambulatory Surgery Center is to deliver excellent surgical, procedural, and anesthesia services to those we serve in accordance with the standards set forth by The Joint Commission, CMS Conditions of Participations for Hospitals and The

Vision and Mission statements of The Ohio State University Wexner Medical Center. The Scope of Care is designed to provide appropriate care and services for all patients in a timely manner.

Utilizing a multi-disciplinary approach in the delivery of patient care, our services promote continuous quality and performance improvement activities provided in an environment where collaboration and multi-disciplinary approaches to problem identification and resolution are the expectation. Important criteria and thresholds are measured and continuously monitored through our Quality and Performance Improvement process to optimize patient outcomes and assure the highest level of satisfaction for all our customers. Results of our Quality and Performance Improvement activities are used to improve patient outcomes enhance our services and our staff performance.

Understanding that the provision of health care services is dynamic and fluid; the Scope of Care will be ***reviewed at least annually*** and revised as needed to reflect the changing patient needs, community changes, and or facility needs and initiatives.

PATIENT COMPLAINT AND GRIEVANCE MANAGEMENT

OHIO STATE UNIVERSITY HOSPITALS d/b/a OSU WEXNER MEDICAL CENTER

Synopsis: Approval of the review of the Patient Complaint and Grievance Management policy for FY26 for the hospitals at the Ohio State University Hospitals d/b/a OSU Wexner Medical Center, including: Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital, is proposed.

WHEREAS the mission of the Ohio State University Hospitals is to improve people's lives through the provision of high-quality patient care; and

WHEREAS in order to promote patient satisfaction, the Wexner Medical Center is committed to resolving any patient complaints and grievances that may arise in a timely and effective manner, and as set forth in the attached Patient Complaint and Grievance Management policy; and

WHEREAS the review of the Patient Complaint and Grievance Management policy was approved by the Ohio State University Hospitals Medical Staff Administrative Committee on June 11, 2025; and

WHEREAS on June 24, 2025, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the Patient Complaint and Grievance Management policy, including the delegation of the responsibility for reviewing and resolving grievances to the Ohio State University Hospitals Grievance Committee:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the Patient Complaint and Grievance Management policy for the OSU Wexner Medical Center, including delegation of the responsibility for reviewing and resolving grievances to the Ohio State University Hospitals Grievance Committee.

Policy Name: Patient Complaint and Grievance Management 03-28

Applies to:		
☒ OSU Wexner Medical Center [University Hospital, East Hospital, Brain and Spine Hospital, Richard M. Ross Heart Hospital, Harding Hospital, Dodd Rehabilitation Hospital, Ambulatory Clinics and Services]	☒ Ambulatory Surgery Centers [New Albany, Dublin]	☒ Arthur G. James Cancer Hospital and Richard J. Solove Research Institute and Outreach Sites

Policy Objective

The Ohio State University Wexner Medical Center (OSUWMC) and Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (The James) is committed to promptly resolving complaints at the first level of contact whenever possible.

The purpose of this policy is to provide guidelines for staff to respond and manage complaints and grievances; and to define the process for responding to grievances according to The Joint Commission and CMS Hospital Conditions of Participation.

The Ohio State University Wexner Medical Center Board has delegated the responsibility for review and resolution of all grievances received from patients of University Hospital, East Hospital, Brain and Spine Hospital, Richard M. Ross Heart Hospital (Ross Hospital), Harding Hospital, Dodd Rehabilitation Hospital, Ambulatory Clinics and Services and Ambulatory Surgery Centers to the OSU Wexner Medical Center Grievance Committee and Arthur G. James and Richard J. Solove Research Institute (The James) Grievance Committee for grievances received from patients of the James Cancer Hospital and Outreach Sites.

The Patient Experience Department is responsible for supporting the complaint management process and assuring patients are adequately educated regarding their rights to register complaints and concerns.

In order to achieve the highest level of satisfaction possible, and to provide protection of their rights, patients will be encouraged to report concerns.

Concerns from patients, families, visitors, or other members of the community will be received courteously, treated seriously, and dealt with promptly. The act of voicing concern will not jeopardize the care a patient is currently receiving, nor any future access to appropriate care.

It is expected that the OSUWMC and The James staff will respond to patient concerns promptly and offer reasonable and appropriate solutions.

Definitions

Term	Definition
Staff Present	1. Includes any hospital staff present at the time of the complaint or who can quickly be at the patients location (i.e. nursing, administration, nursing supervisors, patient advocate, etc.) to resolve the patient's complaint.
Complaint	1. A clinical care issue that is verbally conveyed by a patient or the patient's representative to staff and generally resolved within forty eight (48)~~twenty-four (24)~~ hours. 2. A complaint regarding discrimination on the basis of race, color, national origin, age, disability or sex (including gender identity, pregnancy or related conditions, sexual orientation, sex stereotypes, or sex characteristics, including intersex traits)~~age, ancestry, color, disability, gender identity or expression, genetic information, HIV/AIDS status, military status, national origin, race, religion, sex, gender, sexual orientation, pregnancy, veteran status~~ or ability to pay, unless unable to resolve within forty-eight (48) hours. 3. A complaint such as not having a qualified interpreter available for a patient, patients spouse, family, and/or partner, even if the patient does not require an interpreter.

	4. Minor service complaints such as housekeeping, bedding, billing issues and food. 5. Complaints regarding property loss. 6. Privacy and HIPAA complaints, unless unable to be resolved within forty-eight (48) hours
Grievance	1. Any written complaint received from a patient or the patient's representative regarding clinical care, whether from an inpatient, outpatient or released/discharged patient. An e-mail or facsimile (fax) will be considered to be "written". 2. Verbal complaints about clinical care that are not resolved by staff at the time of the complaint, generally within forty-eight (48), and made by a patient or the patient's representative. 3. All verbal or written complaints regarding: • Abuse, neglect, patient harm; • Hospital compliance with CMS Hospital Conditions of Participation (CoP); and • Medicare Beneficiary Billing complaints related to rights and limitations provided by 42CFR§489. 4. Any complaint that the patient, or their representative, requests be handled as a formal grievance. 5. Any complaint where a written response from the hospital is requested by the patient or their representative. 6. Post-discharge complaints, made by a patient or their representative, related to clinical care or services during a stay shall be considered grievances, unless the complaint would have routinely been handled by staff generally within forty-eight (48) hours had the communication occurred during the stay or visit. In this instance, the communication will be considered a complaint.

Policy Details

1. Staff Reporting Complaints via the Hospital's Intranet Site (MyTools)
    1. Staff members are encouraged to enter non-clinical complaints directly into the Complaint Management Database on the hospital's intranet site, MyTools.
    2. The Complaint Management Database provides a mechanism for tracking and reporting complaint data, as well as coordinating timely follow-up.
    3. All verbal or written complaints regarding quality of care issues, abuse, neglect or patient harm shall be entered into the Patient Safety Reporting System for appropriate investigation and follow-up.

2. Patients or Visitors Reporting Complaints via Telephone
    1. Complaints about care delivered at University Hospital, Ross Hospital, Dodd Rehabilitation and Brain and Spain Hospital, or Ambulatory ~~or the Specialty Primary Care Network~~ may be directed to the Patient Experience Department at 1-614-293-8944.
    2. Complaints about care delivered at The James may be directed to James Patient Experience at 1-614- 293-8609.
    3. Complaints about care delivered at East Hospital and Outpatient Care East may be directed to East Patient Experience at 1-614- 257-2310.
    4. Complaints about care delivered at Harding Hospital may be directed to Harding Patient Experience at 1-614-688-8941.
    5. After regular business hours, complaints may be escalated to the Hospital Administrative Manager or Nursing Supervisor for each location.

3. Procedures for Complaints
    1. All clinical care complaints handled within forty-eight (48)~~24 hours~~ should be referred to the attending physician or manager for appropriate follow-up and entered in the Complaint Management Database.
    2. All non-clinical complaints should be referred to the appropriate department manager for follow-up.
    3. Patient Experience will forward all issues regarding property loss to the Property Loss Committee and enter the issue into the Complaint Management Database.
    4. Privacy and HIPAA complaints will be forwarded to the HIPAA Privacy Officer.
    5. When complaints cannot be immediately resolved by the staff member to whom they were reported, the complaint should be reported to the supervisor or manager for resolution and entered into the Complaint Management Database.
    6. Patient Experience staff will act as a liaison for the patient by representing their interests and facilitating communication with appropriate individuals within the Medical Center.
    7. Any complaints under the protected classes (race, color, national origin, age, disability or sex (including gender identity, pregnancy or related conditions, sexual orientation, sex stereotypes, or sex characteristics, including intersex traits) ~~age, ancestry, color, disability, gender identity or expression, genetic information, HIV/AIDS status, military status, national origin, race, religion, sex, gender, sexual orientation, pregnancy, or veteran status~~) will be sent over to the Ohio State University Civil Rights Compliance Office ~~of Institutional Equity (OIE)~~ for further collaborative review in accordance with the university Affirmative Action and Equal Employment Opportunity & Non-Discrimination, Harassment and Sexual Misconduct policies.

CRCO~~OIE~~ will serve as the primary contact for any further investigation outside of the OSUWMC/The James complaint process.

4. Procedures for Grievances
    1. When notified, Patient Experience or the appropriate manager will respond and investigate grievances regarding patients who are currently located within the hospital setting.
    2. Situations that endanger (e.g. neglect or abuse) the patient should be addressed immediately by the appropriate staff member.
    3. When appropriate, Risk Management may initiate a review of a grievance.
    4. Patient Experience will serve as the primary liaison to the patient, and may consult Risk Management as needed.
    5. If the grievance is from a written source, or reported after the patient has left the facility, Patient Experience will initiate contact with the complainant.
    6. Clinical Care Grievances
        a. Clinical care grievances should be entered in the Patient Safety Reporting System, in accordance with the Patient Safety & Event Reporting 04-05.
        b. Following initial contact with the complainant, Patient Experience will address the grievance between the patient, or their representative, and the appropriate hospital representatives based on the nature of the grievance (e.g. attending physician, nurse manager, clinic manager) to assure that the patient's concerns have been addressed.
    7. Non-Clinical Care Grievances
        a. Non-clinical grievances should be entered into the Complaint Management Database.
        b. Following initial contact with the complainant, Patient Experience will facilitate communication and dialogue between the patient, or their representative, and the appropriate hospital representatives based on the nature of the non-clinical care grievance (e.g. attending physician, nurse manager, clinic manager) to assure that the patient's concerns have been addressed.
    8. Typically, a grievance will be considered resolved when the patient is satisfied with the actions taken on their behalf.
        a. However, there may be situations where the Hospital has taken appropriate and reasonable actions on the patient's behalf in order to resolve the patient's grievance and the patient or the patient's representative remains unsatisfied with the Hospital's actions. In these situations, the Hospital may consider the grievance to be closed.
        b. Patient Experience must maintain documentation of its efforts and demonstrate compliance with this policy.
    9. A written response to all grievances shall be submitted to the patient, or their representative, by the Patient Experience representative or other appropriate individual within seven (7) business days regarding the disposition of the grievance.
        a. Included in the written response will be:
            i. The name of the hospital;
            ii. The steps taken on behalf of the patient to investigate and resolve the grievance;
            iii. The results of the grievance process; and
            iv. The date of completion.
        b. All grievance response letters will be mailed to the patient's or patient's representative's home address unless otherwise indicated.
        c. If the grievance is received via email, the response may be sent via email.
    10. There may be complications or circumstances, which will not allow every grievance to be resolved during the seven (7) day timeframe.
        a. If a response will take longer than seven (7) business days, the patient should be contacted by Patient Experience and advised that the hospital is still working to resolve the grievance.
        b. The patient or the patient's representative should be contacted a minimum of every fourteen (14) business days by Patient Experience until the grievance is responded to in writing.
        c. If the grievance is not resolved within 30 days, it must be reviewed by the OSU Wexner Medical Center Grievance Committee or The James Grievance Committee.
    11. A copy of the written response shall be retained by Patient Experience.
    12. Any grievances under the protected classes (~~age, ancestry, color, disability, gender identity or expression, genetic information, HIV/AIDS status, military status, national origin, race, religion, sex,~~race, color, national origin, age, disability or sex (including gender identity, pregnancy or related conditions, sexual orientation, sex stereotypes, or sex characteristics, including intersex traits)

    ~~gender, sexual orientation, pregnancy, or veteran status)~~ will be sent over to the ~~Office of Institutional Equity~~ Ohio State University Civil Rights Compliance Office for further collaborative review in accordance with the university

Affirmative Action and Equal Employment Opportunity & Non-Discrimination, Harassment and Sexual Misconduct policies. ~~OC~~RCO~~IE~~ will serve as the primary contact for any further investigation outside of the OSUWMC/The James grievance process.

5. Reporting Complaints via Patient Satisfaction Surveys
    1. Information obtained from patient satisfaction surveys will not be considered a grievance, except:
        a. If an identified patient writes or attaches a written complaint on the survey and requests resolution (i.e. requests an act or response), then the complaint shall be considered a grievance.
        b. If an identified patient writes or attaches a written complaint on the survey and does not request resolution, then the hospital shall treat this as a grievance if the hospital would usually treat such a complaint a grievance.
    2. Patient Experience will work collaboratively with the patient, or their representative, and the appropriate business unit to resolve the grievance when resolution has been requested by the patient.

6. Grievance Committees
    1. The Ohio State University Wexner Medical Center Board has delegated oversight of the grievance management process to the Grievance Committees of the OSU Wexner Medical Center and the James Cancer Hospital to review and resolve the grievances of the hospital where the patient is receiving care.
    2. The OSU Wexner Medical Center Grievance Committee is comprised of the Wexner Medical Center Chief Quality Officer, Chief Clinical Officer and the hospital Chief Executive Officer or their respective designees to review and resolve the grievances the hospital receives.
    3. The James Grievance Committee is comprised of the James Executive Director of Patient Services, James Chief Medical Officer, Chief Nursing Officer, Director of James Quality and Patient Safety, Director of Patient Experience, or their respective designees to review and resolve grievances the hospital receives.
    4. The OSU Wexner Medical Center and The James Hospital Grievance Committees functions to:
        a. Facilitate grievance resolution when necessary;
        b. Review grievances quarterly to evaluate effectiveness of the resolution process;
        c. Complete an OSU Wexner Medical Center and James Cancer Hospital annual summary report for presentation to the Ohio State University Wexner Medical Center Board;
        d. Submit patterns and trends to the Quality and Patient Safety Department for possible incorporation into a hospital performance improvement plan; and
        e. Recommend operational modifications to senior hospital leadership in the event an immediate correction is necessary as a result of a patient grievance.
7. Complaints and grievances entered in the OSUWMC/The James Patient Advocacy Reporting System (PARS) may be analyzed for patterns related to professionals' behavior and performance. Refer to the Patient Advocacy Reporting System policy.

Resources

Related Policies

Affirmative Action and Equal Employment Opportunity
Non-Discrimination, Harassment, and Sexual Misconduct
Patient Advocacy Reporting System
Patient Rights and Responsibilities 03-23
Patient Safety & Event Reporting 04-05

Related References

CFR §482.13 (a)(2)

Staff Reporting Resources on MyTools~~OneSource~~

Complaint Management Database Patient
Safety Reporting System

Patient Reporting Resources

Patients may choose to go directly to one of the reporting agencies listed below:

The Ohio Department of Health (ODH)
http://www.odh.ohio.gov/contactus.aspx
Complaints – Healthcare Facilities and Nursing Homes 246 North High Street
Columbus, Ohio 43215
Toll Free: 1-800-342-0553
E-Mail: HCComplaints@odh.ohio.gov

The Ohio Department of Health
Complaints – Health Care Facility Complaint Hotline Toll
Free: 1-800-669-3534

KePRO Inc.
http://www.ohiokepro.com/aboutus/contacts.aspx Ohio
KePRO Rock Run Center, Suite 100
5700 Lombardo Center
Seven Hills, Ohio 44131 Phone: 1-216-447-9604 E-
Mail: webmaster@ohiokepro.com

The Joint Commission
http://www.jointcommission.org Office
of Quality Monitoring
1 Renaissance Boulevard Oakbrook
Terrace, Illinois 60181
Office of Quality Monitoring Toll Free: 1-800-444-6610
To File a Complaint: https://www.jointcommission.org/resources/patient-safety-topics/report-a-patient-safety-concern-or-complaint/ ~~http://www.jointcommission.org/report_a_complaint.aspx~~

U.S. Department of Health and Human Services- Office for Civil Rights Region V- Ohio
http://www.hhs.gov/ocr Office
for Civil Rights
233 N. Michigan Avenue, Suite 240
Chicago, Illinois 60601
Phone: (800) 368-101~~91-312-886-2359~~
To File a Complaint: http://www.hhs.gov/ocr/civilrights/complaints/index.html

Ohio Department of Mental Health & Addiction Services
http://mha.ohio.gov/
Ohio Department of Mental Health 30 E. Broad Street, 36~~8~~th Floor Columbus,
Ohio 43215
Phone: 1-614-466-2596
~~E-Mail: questions@mha.ohio.gov~~Contact Us
For Information about Client Rights and Resources: http://mha.ohio.gov/Default.aspx?tabid=157

Disability Rights Ohio
http://www.disabilityrightsohio.org ~~50 W. Broad Street, Suite 1400~~200 Civic
Center Drive, Suite 300
Columbus, Ohio 43215~~-5923~~
Phone: 1-614-466-7264
For Assistance: ~~http://www.disabilityrighsohio.org/get-help-now~~Get Help Now

Patient Experience

For further questions regarding the hospital's policy on Patient Complaint Management, please contact either:

James Cancer Hospital Patient Experience

Phone: 1-614-293-8609 Toll Free: 1-866-993-8609
E-Mail: James.PatientExperience@osumc.edu

University Hospital and Ambulatory Surgery Center Patient Experience Phone:
1-614-293-8944

East Hospital Patient Experience Phone:

1-614-257-2310

Harding Hospital Patient Experience
Phone: 1-614-688-8941

Contacts

Office	Telephone
Patient Experience: University Hospital	614-293-8944
Patient Experience: East Hospital	614-257-2310
Patient Experience: The James	614-293-8609

History

The Ohio State University Wexner Medical Center		
Approved By (List All Committees): 1. Policy Oversight Committee 2. Health System Operations Committee 3. UH Medical Staff Administrative Committee 4. Quality Professional Affairs Committee	*Approval Date:* 1. ~~3/29/2022~~4/24/2025 2. 4/7/2022 3. 4/13/2022 4. ~~5/26/2022~~6/24/2025	*Issue Date:* 10/14/1991 *Effective Date:* 5/27/2022
Review Cycle: ☐ 2 years ☒ 3 years	*Prior Approval Date(s)*: 9/10/2014; 10/5/2017; 5/29/2019; 8/26/2021, 3/29/2022	

Arthur G. James Cancer Hospital and Richard J. Solove Research Institute		
Approved By (List All Committees): 1. Policy Oversight Committee 2. Health System Operations Committee 3. The James Medical Staff Administrative Committee 4. Quality Professional Affairs Committee	*Approval Date:* 1. ~~3/29/2022~~4/24/2025 2. 4/7/2022 3. 4/15/2022 4. ~~5/26/2022~~6/24/2025	*Issue Date:* 10/14/1991 *Effective Date:* 5/27/2022
Review Cycle: ☐ 2 years ☒ 3 years	*Prior Approval Date(s)*: 9/10/2014; 10/5/2017; 5/29/2019; 8/21/2021, 3/29/2022	

August 19, 2025

PATIENT COMPLAINT AND GRIEVANCE MANAGEMENT

THE OHIO STATE UNIVERSITY COMPREHENSIVE CANCER CENTER
THE ARTHUR G. JAMES CANCER HOSPITAL AND
RICHARD J. SOLOVE RESEARCH INSTITUTE

Synopsis: Approval of the review of Patient Complaint and Grievance Management policy for the Ohio State Comprehensive Cancer Center — James Cancer Hospital and Solove Research Institute, is proposed.

WHEREAS the mission of The James is to eradicate cancer from individuals' lives by generating knowledge and integrating groundbreaking research with excellence in education and patient-centered care; and

WHEREAS in order to promote patient satisfaction, The James is committed to resolving any patient complaints and grievances that may arise in a timely and effective manner; and as set forth in the attached Patient Complaint and Grievance Management policy; and

WHEREAS the review of the Patient Complaint and Grievance Management policy was approved by The James Medical Staff Administrative Committee on June 20, 2025:

WHEREAS on June 24, 2025, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the Patient Complaint and Grievance Management policy, including delegation of the responsibility for reviewing and resolving grievances to The James Grievance Committee:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the Patient Complaint and Grievance Management policy, including delegation of the responsibility for reviewing and resolving grievances to The James Grievance Committee.

Policy Name: Patient Complaint and Grievance Management 03-28

Applies to:		
☒ OSU Wexner Medical Center [University Hospital, East Hospital, Brain and Spine Hospital, Richard M. Ross Heart Hospital, Harding Hospital, Dodd Rehabilitation Hospital, Ambulatory Clinics and Services]	☒ Ambulatory Surgery Centers [New Albany, Dublin]	☒ Arthur G. James Cancer Hospital and Richard J. Solove Research Institute and Outreach Sites

Policy Objective

The Ohio State University Wexner Medical Center (OSUWMC) and Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (The James) is committed to promptly resolving complaints at the first level of contact whenever possible.

The purpose of this policy is to provide guidelines for staff to respond and manage complaints and grievances; and to define the process for responding to grievances according to The Joint Commission and CMS Hospital Conditions of Participation.

The Ohio State University Wexner Medical Center Board has delegated the responsibility for review and resolution of all grievances received from patients of University Hospital, East Hospital, Brain and Spine Hospital, Richard M. Ross Heart Hospital (Ross Hospital), Harding Hospital, Dodd Rehabilitation Hospital, Ambulatory Clinics and Services and Ambulatory Surgery Centers to the OSU Wexner Medical Center Grievance Committee and Arthur G. James and Richard J. Solove Research Institute (The James) Grievance Committee for grievances received from patients of the James Cancer Hospital and Outreach Sites.

The Patient Experience Department is responsible for supporting the complaint management process and assuring patients are adequately educated regarding their rights to register complaints and concerns.

In order to achieve the highest level of satisfaction possible, and to provide protection of their rights, patients will be encouraged to report concerns.

Concerns from patients, families, visitors, or other members of the community will be received courteously, treated seriously, and dealt with promptly. The act of voicing concern will not jeopardize the care a patient is currently receiving, nor any future access to appropriate care.

It is expected that the OSUWMC and The James staff will respond to patient concerns promptly and offer reasonable and appropriate solutions.

Definitions

Term	Definition
Staff Present	1. Includes any hospital staff present at the time of the complaint or who can quickly be at the patients location (i.e. nursing, administration, nursing supervisors, patient advocate, etc.) to resolve the patient's complaint.
Complaint	1. A clinical care issue that is verbally conveyed by a patient or the patient's representative to staff and generally resolved within forty eight (48)~~twenty-four (24)~~ hours. 2. A complaint regarding discrimination on the basis of race, color, national origin, age, disability or sex (including gender identity, pregnancy or related conditions, sexual orientation, sex stereotypes, or sex characteristics, including intersex traits)~~age, ancestry, color, disability, gender identity or expression, genetic information, HIV/AIDS status, military status, national origin, race, religion, sex, gender, sexual orientation, pregnancy, veteran status~~ or ability to pay, unless unable to resolve within forty-eight (48) hours. 3. A complaint such as not having a qualified interpreter available for a patient, patients spouse, family, and/or partner, even if the patient does not require an interpreter.

	4. Minor service complaints such as housekeeping, bedding, billing issues and food. 5. Complaints regarding property loss. 6. Privacy and HIPAA complaints, unless unable to be resolved within forty-eight (48) hours
Grievance	1. Any written complaint received from a patient or the patient's representative regarding clinical care, whether from an inpatient, outpatient or released/discharged patient. An e-mail or facsimile (fax) will be considered to be "written". 2. Verbal complaints about clinical care that are not resolved by staff at the time of the complaint, generally within forty-eight (48), and made by a patient or the patient's representative. 3. All verbal or written complaints regarding: • Abuse, neglect, patient harm; • Hospital compliance with CMS Hospital Conditions of Participation (CoP); and • Medicare Beneficiary Billing complaints related to rights and limitations provided by 42CFR§489. 4. Any complaint that the patient, or their representative, requests be handled as a formal grievance. 5. Any complaint where a written response from the hospital is requested by the patient or their representative. 6. Post-discharge complaints, made by a patient or their representative, related to clinical care or services during a stay shall be considered grievances, unless the complaint would have routinely been handled by staff generally within forty-eight (48) hours had the communication occurred during the stay or visit. In this instance, the communication will be considered a complaint.

Policy Details

1. Staff Reporting Complaints via the Hospital's Intranet Site (MyTools)
    1. Staff members are encouraged to enter non-clinical complaints directly into the Complaint Management Database on the hospital's intranet site, MyTools.
    2. The Complaint Management Database provides a mechanism for tracking and reporting complaint data, as well as coordinating timely follow-up.
    3. All verbal or written complaints regarding quality of care issues, abuse, neglect or patient harm shall be entered into the Patient Safety Reporting System for appropriate investigation and follow-up.

2. Patients or Visitors Reporting Complaints via Telephone
    1. Complaints about care delivered at University Hospital, Ross Hospital, Dodd Rehabilitation and Brain and Spain Hospital, or Ambulatory ~~or the Specialty Primary Care Network~~ may be directed to the Patient Experience Department at 1-614-293-8944.
    2. Complaints about care delivered at The James may be directed to James Patient Experience at 1-614- 293-8609.
    3. Complaints about care delivered at East Hospital and Outpatient Care East may be directed to East Patient Experience at 1-614- 257-2310.
    4. Complaints about care delivered at Harding Hospital may be directed to Harding Patient Experience at 1-614-688-8941.
    5. After regular business hours, complaints may be escalated to the Hospital Administrative Manager or Nursing Supervisor for each location.

3. Procedures for Complaints
    1. All clinical care complaints handled within forty-eight (48)~~24 hours~~ should be referred to the attending physician or manager for appropriate follow-up and entered in the Complaint Management Database.
    2. All non-clinical complaints should be referred to the appropriate department manager for follow-up.
    3. Patient Experience will forward all issues regarding property loss to the Property Loss Committee and enter the issue into the Complaint Management Database.
    4. Privacy and HIPAA complaints will be forwarded to the HIPAA Privacy Officer.
    5. When complaints cannot be immediately resolved by the staff member to whom they were reported, the complaint should be reported to the supervisor or manager for resolution and entered into the Complaint Management Database.
    6. Patient Experience staff will act as a liaison for the patient by representing their interests and facilitating communication with appropriate individuals within the Medical Center.
    7. Any complaints under the protected classes (race, color, national origin, age, disability or sex (including gender identity, pregnancy or related conditions, sexual orientation, sex stereotypes, or sex characteristics, including intersex traits) ~~age, ancestry, color, disability, gender identity or expression, genetic information, HIV/AIDS status, military status, national origin, race, religion, sex, gender, sexual orientation, pregnancy, or veteran status~~) will be sent over to the Ohio State University Civil Rights Compliance Office ~~of Institutional Equity (OIE)~~ for further collaborative review in accordance with the university Affirmative Action and Equal Employment Opportunity & Non-Discrimination, Harassment and Sexual Misconduct policies.

CRCO~~OIE~~ will serve as the primary contact for any further investigation outside of the OSUWMC/The James complaint process.

4. Procedures for Grievances
    1. When notified, Patient Experience or the appropriate manager will respond and investigate grievances regarding patients who are currently located within the hospital setting.
    2. Situations that endanger (e.g. neglect or abuse) the patient should be addressed immediately by the appropriate staff member.
    3. When appropriate, Risk Management may initiate a review of a grievance.
    4. Patient Experience will serve as the primary liaison to the patient, and may consult Risk Management as needed.
    5. If the grievance is from a written source, or reported after the patient has left the facility, Patient Experience will initiate contact with the complainant.
    6. Clinical Care Grievances
        a. Clinical care grievances should be entered in the Patient Safety Reporting System, in accordance with the Patient Safety & Event Reporting 04-05.
        b. Following initial contact with the complainant, Patient Experience will address the grievance between the patient, or their representative, and the appropriate hospital representatives based on the nature of the grievance (e.g. attending physician, nurse manager, clinic manager) to assure that the patient's concerns have been addressed.
    7. Non-Clinical Care Grievances
        a. Non-clinical grievances should be entered into the Complaint Management Database.
        b. Following initial contact with the complainant, Patient Experience will facilitate communication and dialogue between the patient, or their representative, and the appropriate hospital representatives based on the nature of the non-clinical care grievance (e.g. attending physician, nurse manager, clinic manager) to assure that the patient's concerns have been addressed.
    8. Typically, a grievance will be considered resolved when the patient is satisfied with the actions taken on their behalf.
        a. However, there may be situations where the Hospital has taken appropriate and reasonable actions on the patient's behalf in order to resolve the patient's grievance and the patient or the patient's representative remains unsatisfied with the Hospital's actions. In these situations, the Hospital may consider the grievance to be closed.
        b. Patient Experience must maintain documentation of its efforts and demonstrate compliance with this policy.
    9. A written response to all grievances shall be submitted to the patient, or their representative, by the Patient Experience representative or other appropriate individual within seven (7) business days regarding the disposition of the grievance.
        a. Included in the written response will be:
            i. The name of the hospital;
            ii. The steps taken on behalf of the patient to investigate and resolve the grievance;
            iii. The results of the grievance process; and
            iv. The date of completion.
        b. All grievance response letters will be mailed to the patient's or patient's representative's home address unless otherwise indicated.
        c. If the grievance is received via email, the response may be sent via email.
    10. There may be complications or circumstances, which will not allow every grievance to be resolved during the seven (7) day timeframe.
        a. If a response will take longer than seven (7) business days, the patient should be contacted by Patient Experience and advised that the hospital is still working to resolve the grievance.
        b. The patient or the patient's representative should be contacted a minimum of every fourteen (14) business days by Patient Experience until the grievance is responded to in writing.
        c. If the grievance is not resolved within 30 days, it must be reviewed by the OSU Wexner Medical Center Grievance Committee or The James Grievance Committee.
    11. A copy of the written response shall be retained by Patient Experience.
    12. Any grievances under the protected classes (~~age, ancestry, color, disability, gender identity or expression, genetic information, HIV/AIDS status, military status, national origin, race, religion, sex,~~race, color, national origin, age, disability or sex (including gender identity, pregnancy or related conditions, sexual orientation, sex stereotypes, or sex characteristics, including intersex traits)

    ~~gender, sexual orientation, pregnancy, or veteran status)~~ will be sent over to the ~~Office of Institutional Equity~~ Ohio State University Civil Rights Compliance Office for further collaborative review in accordance with the university

Affirmative Action and Equal Employment Opportunity & Non-Discrimination, Harassment and Sexual Misconduct policies. ~~OC~~RCO~~IE~~ will serve as the primary contact for any further investigation outside of the OSUWMC/The James grievance process.

5. Reporting Complaints via Patient Satisfaction Surveys
    1. Information obtained from patient satisfaction surveys will not be considered a grievance, except:
        a. If an identified patient writes or attaches a written complaint on the survey and requests resolution (i.e. requests an act or response), then the complaint shall be considered a grievance.
        b. If an identified patient writes or attaches a written complaint on the survey and does not request resolution, then the hospital shall treat this as a grievance if the hospital would usually treat such a complaint a grievance.
    2. Patient Experience will work collaboratively with the patient, or their representative, and the appropriate business unit to resolve the grievance when resolution has been requested by the patient.

6. Grievance Committees
    1. The Ohio State University Wexner Medical Center Board has delegated oversight of the grievance management process to the Grievance Committees of the OSU Wexner Medical Center and the James Cancer Hospital to review and resolve the grievances of the hospital where the patient is receiving care.
    2. The OSU Wexner Medical Center Grievance Committee is comprised of the Wexner Medical Center Chief Quality Officer, Chief Clinical Officer and the hospital Chief Executive Officer or their respective designees to review and resolve the grievances the hospital receives.
    3. The James Grievance Committee is comprised of the James Executive Director of Patient Services, James Chief Medical Officer, Chief Nursing Officer, Director of James Quality and Patient Safety, Director of Patient Experience, or their respective designees to review and resolve grievances the hospital receives.
    4. The OSU Wexner Medical Center and The James Hospital Grievance Committees functions to:
        a. Facilitate grievance resolution when necessary;
        b. Review grievances quarterly to evaluate effectiveness of the resolution process;
        c. Complete an OSU Wexner Medical Center and James Cancer Hospital annual summary report for presentation to the Ohio State University Wexner Medical Center Board;
        d. Submit patterns and trends to the Quality and Patient Safety Department for possible incorporation into a hospital performance improvement plan; and
        e. Recommend operational modifications to senior hospital leadership in the event an immediate correction is necessary as a result of a patient grievance.
7. Complaints and grievances entered in the OSUWMC/The James Patient Advocacy Reporting System (PARS) may be analyzed for patterns related to professionals' behavior and performance. Refer to the Patient Advocacy Reporting System policy.

Resources

Related Policies

Affirmative Action and Equal Employment Opportunity
Non-Discrimination, Harassment, and Sexual Misconduct
Patient Advocacy Reporting System
Patient Rights and Responsibilities 03-23
Patient Safety & Event Reporting 04-05

Related References

CFR §482.13 (a)(2)

Staff Reporting Resources on MyTools~~OneSource~~

Complaint Management Database Patient
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http://www.ohiokepro.com/aboutus/contacts.aspx Ohio
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5700 Lombardo Center
Seven Hills, Ohio 44131 Phone: 1-216-447-9604 E-
Mail: webmaster@ohiokepro.com

The Joint Commission
http://www.jointcommission.org Office
of Quality Monitoring
1 Renaissance Boulevard Oakbrook
Terrace, Illinois 60181
Office of Quality Monitoring Toll Free: 1-800-444-6610
To File a Complaint: https://www.jointcommission.org/resources/patient-safety-topics/report-a-patient-safety-concern-or-complaint/ ~~http://www.jointcommission.org/report_a_complaint.aspx~~

U.S. Department of Health and Human Services- Office for Civil Rights Region V- Ohio
http://www.hhs.gov/ocr Office
for Civil Rights
233 N. Michigan Avenue, Suite 240
Chicago, Illinois 60601
Phone: (800) 368-101~~91-312-886-2359~~
To File a Complaint: http://www.hhs.gov/ocr/civilrights/complaints/index.html

Ohio Department of Mental Health & Addiction Services
http://mha.ohio.gov/
Ohio Department of Mental Health 30 E. Broad Street, 36~~8~~th Floor Columbus,
Ohio 43215
Phone: 1-614-466-2596
~~E-Mail: questions@mha.ohio.gov~~Contact Us
For Information about Client Rights and Resources: http://mha.ohio.gov/Default.aspx?tabid=157

Disability Rights Ohio
http://www.disabilityrightsohio.org ~~50 W. Broad Street, Suite 1400~~200 Civic
Center Drive, Suite 300
Columbus, Ohio 43215~~-5923~~
Phone: 1-614-466-7264
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Harding Hospital Patient Experience
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History

The Ohio State University Wexner Medical Center		
Approved By (List All Committees): 1. Policy Oversight Committee 2. Health System Operations Committee 3. UH Medical Staff Administrative Committee 4. Quality Professional Affairs Committee	*Approval Date:* 1. ~~3/29/2022~~4/24/2025 2. 4/7/2022 3. 4/13/2022 4. ~~5/26/2022~~6/24/2025	*Issue Date:* 10/14/1991 *Effective Date:* 5/27/2022
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Arthur G. James Cancer Hospital and Richard J. Solove Research Institute		
Approved By (List All Committees): 1. Policy Oversight Committee 2. Health System Operations Committee 3. The James Medical Staff Administrative Committee 4. Quality Professional Affairs Committee	*Approval Date:* 1. ~~3/29/2022~~4/24/2025 2. 4/7/2022 3. 4/15/2022 4. ~~5/26/2022~~6/24/2025	*Issue Date:* 10/14/1991 *Effective Date:* 5/27/2022
Review Cycle: ☐ 2 years ☒ 3 years	*Prior Approval Date(s)*: 9/10/2014; 10/5/2017; 5/29/2019; 8/21/2021, 3/29/2022	

August 19, 2025

DIRECT PATIENT CARE SERVICES CONTRACTS AND PATIENT IMPACT SERVICE CONTRACTS EVALUATION

OHIO STATE UNIVERSITY HOSPITALS d/b/a OSU WEXNER MEDICAL CENTER

Synopsis: Approval of the annual review of the direct patient care service contracts and patient impact service contracts for the hospitals at the Ohio State University Hospitals d/b/a OSU Wexner Medical Center, including: Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital, is proposed.

WHEREAS the mission of the Ohio State University Hospitals is to improve people's lives through the provision of high-quality patient care; and

WHEREAS the Ohio State University Hospitals direct patient care services contracts and patient impact service contracts are evaluated annually to review the scope, nature, and quality of services provided to clinical departments and personnel who provide care and services for inpatient and outpatient care at University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital; and

WHEREAS the annual review of these contracts was approved by the Ohio State University Hospital Medical Staff Administrative Committee on June 11, 2025; and

WHEREAS on June 24, 2025, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the annual review of the direct patient care service contracts and patient impact service contracts for University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the annual review of the direct patient care service contracts and patient impact service contracts for University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital as outlined in the attached University Hospitals Contracted Services Annual Evaluation Report.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Hospitals Administration
Accreditation

168 Doan Hall
410 W 10th Ave
Columbus, OH 43210

617-293-9700 Phone
wexnermedical.osu.edu

CONTRACTED SERVICES EVALUATION
COMPLETED: CALENDAR YEAR 2024

CONTENTS

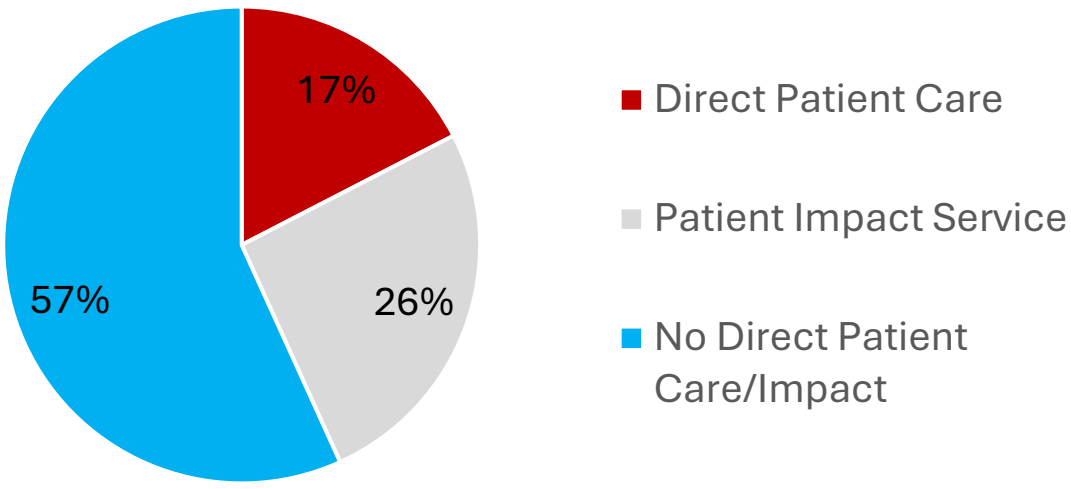
OVERVIEW

Annually, The Ohio State University Wexner Medical Center (OSUWMC) and Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (The James) complete an evaluation for contracted services. Evaluations are completed for compliance with The Joint Commission's (TJC) Leadership standard – LD.04.03.09 – which states 'Care, treatment, and services provided through contractual agreement are provided safely and effectively' and the Centers for Medicaid and Medicare Services' (CMS) Condition of Participation - 482.12(e) – which states 'The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services.

Evaluations are completed for contracts that fall into direct patient care or patient impact service. Direct Patient Care Service is defined as 'Health care that involves the examination of patients, treatment of patients, and/or preparation for diagnostic tests and procedures, including services used in the clinical management/diagnosis of the patient'. Patient Impact Service is defined as 'Suppliers of services that effect a patient's environment, typically in the hospital room'. Evaluations are not completed for contracts falling into the supply (suppliers of goods) or no direct patient care impact (suppliers of business services that the hospital and/or clinic use to help manage a specific part of their business but do not have a direct impact on the patient) as these are monitored through normal supply chain processes per policy: Contract Evaluation Policy.

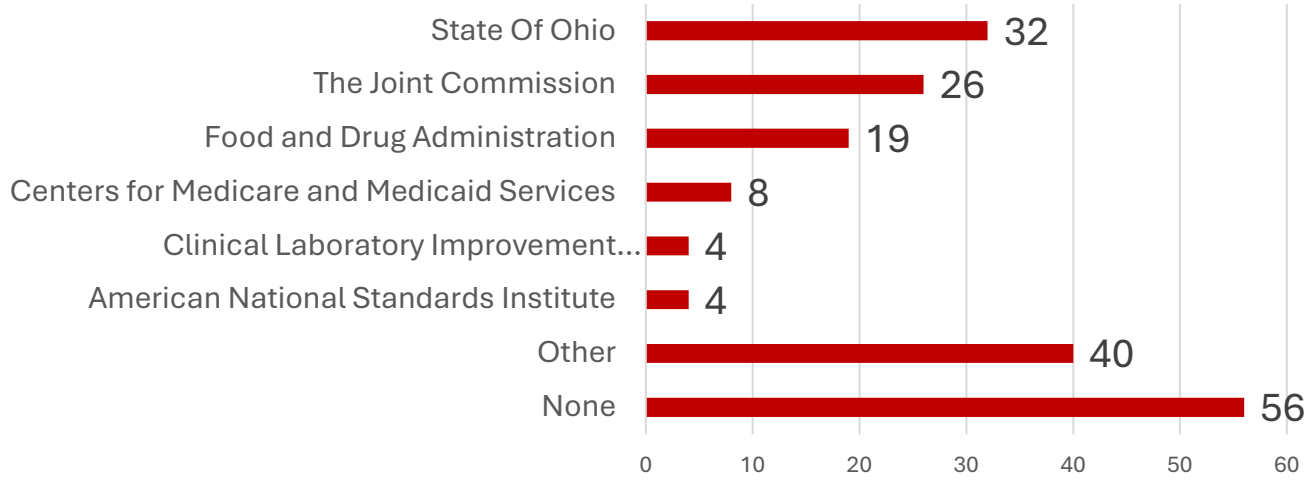
Operational owners were identified and asked to complete a Qualtrics survey for each contract under their oversight. Questions on the survey included overall satisfaction, accrediting bodies, metrics being collected, and if follow up was needed by Supply Chain or Legal Services.

CONTRACTS BY CATEGORY



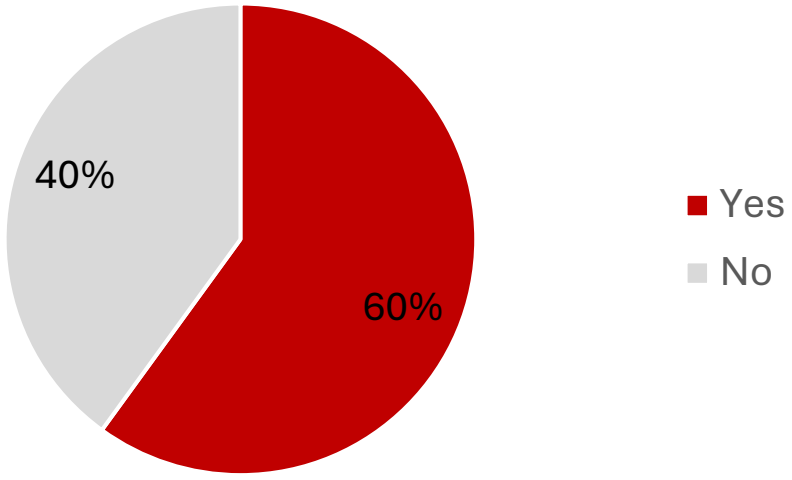
For calendar year 2024, completed evaluations totaled 155. The overall evaluation completion rate (56%) is a 22% increase from 2023 (46%). The remaining incomplete evaluations have been escalated to leadership for follow-up.

REGULATION OF CONTRACTED SERVICES



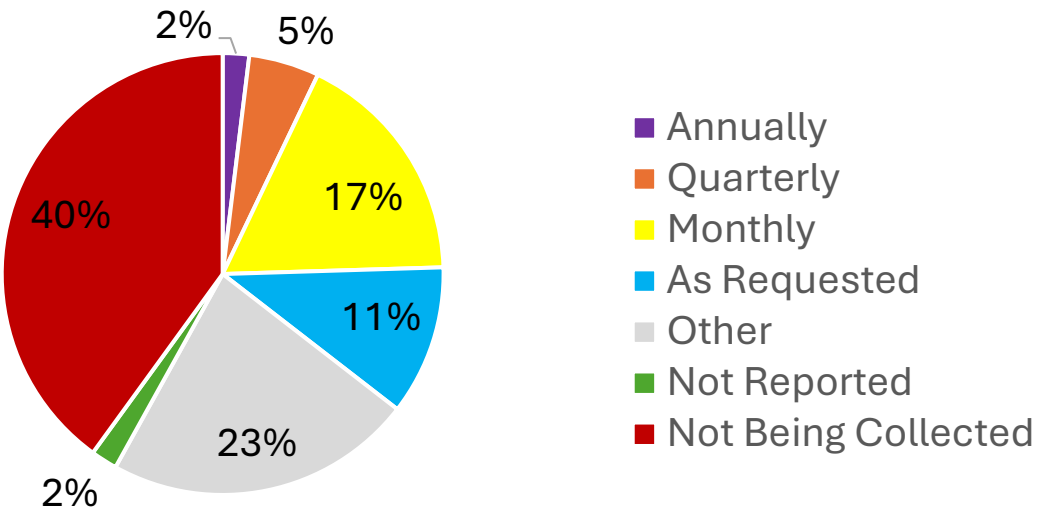
Other regulatory bodies included the Art Therapy Credentials Board, Board of Embalmers and Funeral Directors, Ohio Board of Pharmacy, and local health departments.

COMPLIANCE ACTIVITIES



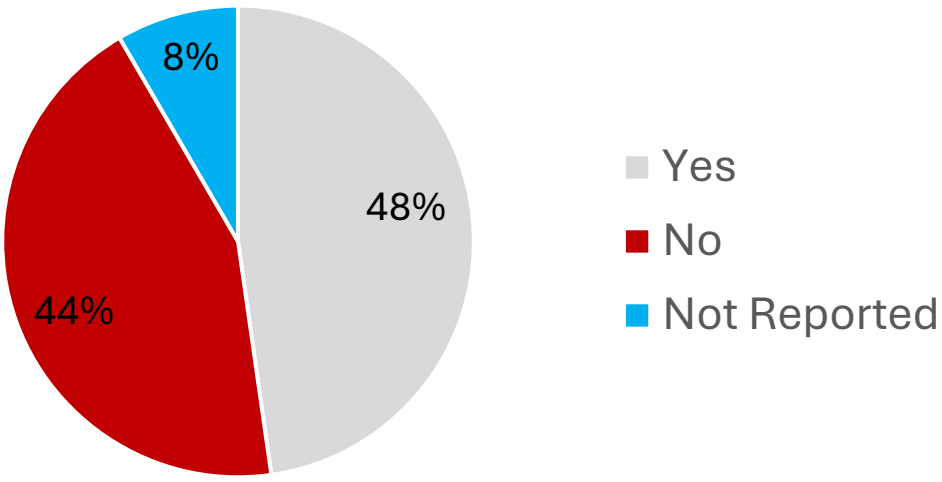
Per the Contract Evaluation policy, operational owners of direct patient care services contracts shall provide and attest to maintain position descriptions, assure licensure, registration, or certification requirements, provide orientation, provide competency assessments, provide and certify on-going education, conduct performance appraisals, and conduct competency evaluations. A secondary review is underway for questions in this section with a "No" response to determine if that answer is appropriate based on the type of service provided (e.g. Otis Elevator).

DATA COLLECTION



Due to the number and variety of contracts, data collection methods and time periods vary across the enterprise. Operational owners are tasked with determining the best method and time period to optimize evaluation of each contract. As shown in the above chart, data collection is largely monthly or another method determined by the operational owner and vendor. Follow up with contract owners will include emphasis on The Joint Commission LD. 04.03.09, element of performance 6 requirement that "Leaders monitor contracted services by evaluating these services in relation to the hospital's expectations."

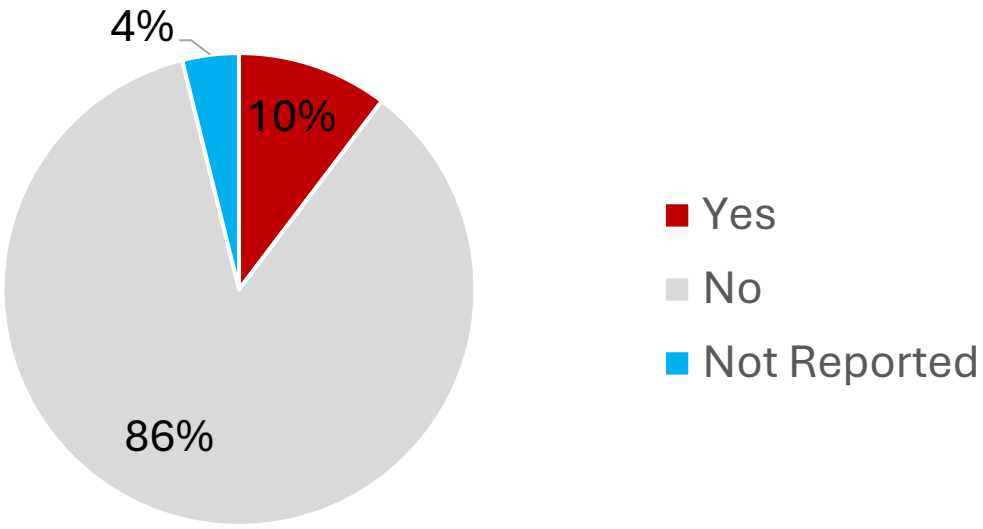
IMPROVEMENTS MADE WITHIN THE PAST YEAR



Overall, 44% of respondents reported improvements within the past year, which is an increase of 6 percentage points from 2023. Improvements included online training modules, forced feedback

technology, increased staffing, improved traffic lane devices, reduced computer crashes, increased coverage rates, and inclusion into a work order database.

FOLLOW UP NEEDED



The most requested follow-up was assistance with receiving quality data and improving performance of the vendor. A list of the departments that requested follow-up is listed in Appendix A.

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CONCLUSION

Compliance activities and data collection is taking place for most contracts with oversight from a regulatory body. Efforts continue to standardize the reporting cadence and type of data being collected.

Almost half of the respondents reported improvements within the past year which represented a significant increase from last year's evaluation.

Follow up has been requested for a small portion of the contracts evaluated.

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Scottcare	Scottcare was purchased by 91 Life and remote adjudication has improved.
SDG Partners, LLC	New flavors for guest satisfaction
Soloinsight	Reduced computer crashes, improved search capability, improved visitor badge picture quality, and decreased CPU spikes
STRYKER SALES CORPORATION	The vendor has adjusted the testing schedule and communicates any issues identified to their research lab. They provide recommendations for repairs, replacements, and upcoming changes as needed.
Teladoc (formerly InTouch)	New devices for use, upgrades to current cart models.
Teleflex	Provide online training modules now for competencies in addition to in person training.
Thai Palace, Inc	Menu upgrades
Towne Park Holdings	Improved lane traffic devices, Podiums at location and key rooms in multiple garages. Staffing increases, along with management level increases.
Us Together	Increased the amount of coverage they can provide. Even though they have the same percentage overall, since our requests have increased by 15%, they have been able to provide more coverage for appointments then they have in previous years in overall numbers. They have also added new languages such as Haitian creole to keep up with our changing patient population and needs.
Veris Health, Inc.	Resolved software bug in thermometer during pilot phase, also improved patient information input fields on web-based portal
Vernon Inc	We have reinvested in the company getting some new vans and we purchased new washers and new buggies. The greatest improvement has been our infrastructure, like the performance installer KPI's mentioned above. We are in the process of transitioning to a new HRIS internal system with onboarding, training and performance tracking programs
Versiti Blood Center	Request to review the standing order and make adjustment to the amount of products received weekly was made. Versiti presented historical ad hoc orders and pitch an increase for each product type for review. Adjustments made 9/1/24.
VIDATAK, LLC	Adding Language Line availability to allow translation services through the app
VIZ AI, Inc	Added modalities

August 19, 2025

**DIRECT PATIENT CARE SERVICES CONTRACTS AND
PATIENT IMPACT SERVICE CONTRACTS EVALUATION**

THE OHIO STATE UNIVERSITY COMPREHENSIVE CANCER CENTER
ARTHUR G. JAMES CANCER HOSPITAL AND
RICHARD J. SOLOVE RESEARCH INSTITUTE

Synopsis: Approval of the annual review of the direct patient care services contracts and patient impact service contracts for the Ohio State Comprehensive Cancer Center — James Cancer Hospital and Solove Research Institute, is proposed.

WHEREAS the mission of The James is to eradicate cancer from individuals' lives by generating knowledge and integrating groundbreaking research with excellence in education and patient-centered care; and

WHEREAS The James direct patient care services contracts and patient impact service contracts are evaluated annually to review the scope, nature, and quality of services provided to clinical departments and personnel who provide care and services for inpatient and outpatient care at The James; and

WHEREAS the annual review of these contracts was approved by The James Medical Staff Administrative Committee on June 20, 2025; and

WHEREAS on June 24, 2025, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the annual review of the direct patient care service contracts and patient impact service contracts for The James:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the annual review of the direct patient care service contracts and patient impact service contracts for The James as outlined in the attached The James Contracted Services Annual Evaluation Report.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Hospitals Administration
Accreditation

168 Doan Hall
410 W 10th Ave
Columbus, OH 43210

617-293-9700 Phone
wexnermedical.osu.edu

CONTRACTED SERVICES EVALUATION
COMPLETED: CALENDAR YEAR 2024

CONTENTS

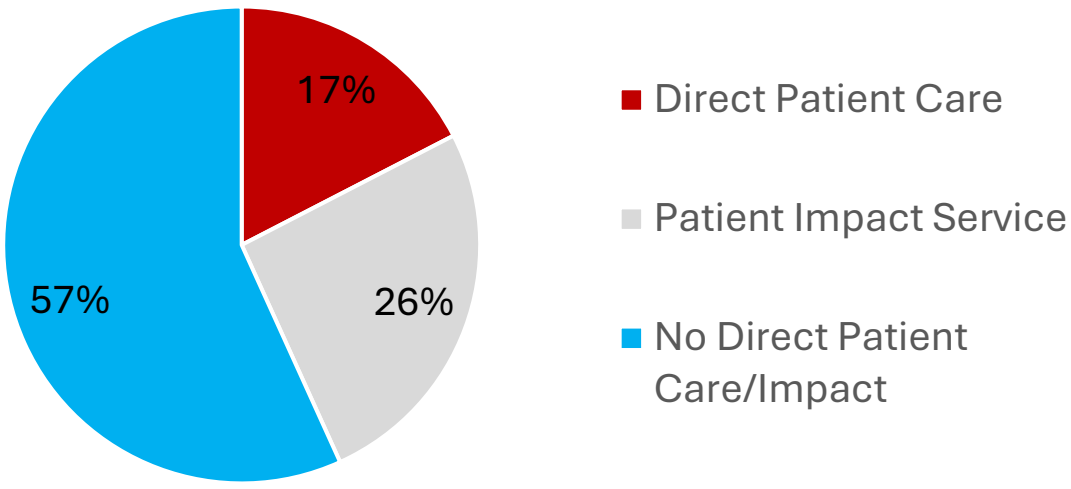
OVERVIEW

Annually, The Ohio State University Wexner Medical Center (OSUWMC) and Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (The James) complete an evaluation for contracted services. Evaluations are completed for compliance with The Joint Commission's (TJC) Leadership standard – LD.04.03.09 – which states 'Care, treatment, and services provided through contractual agreement are provided safely and effectively' and the Centers for Medicaid and Medicare Services' (CMS) Condition of Participation - 482.12(e) – which states 'The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services.

Evaluations are completed for contracts that fall into direct patient care or patient impact service. Direct Patient Care Service is defined as 'Health care that involves the examination of patients, treatment of patients, and/or preparation for diagnostic tests and procedures, including services used in the clinical management/diagnosis of the patient'. Patient Impact Service is defined as 'Suppliers of services that effect a patient's environment, typically in the hospital room'. Evaluations are not completed for contracts falling into the supply (suppliers of goods) or no direct patient care impact (suppliers of business services that the hospital and/or clinic use to help manage a specific part of their business but do not have a direct impact on the patient) as these are monitored through normal supply chain processes per policy: Contract Evaluation Policy.

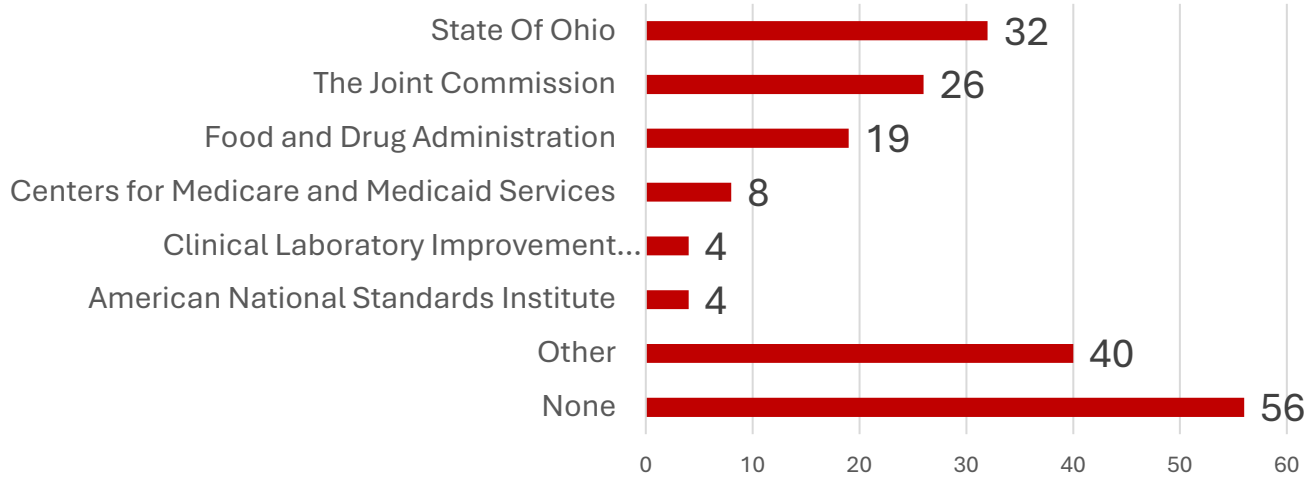
Operational owners were identified and asked to complete a Qualtrics survey for each contract under their oversight. Questions on the survey included overall satisfaction, accrediting bodies, metrics being collected, and if follow up was needed by Supply Chain or Legal Services.

CONTRACTS BY CATEGORY



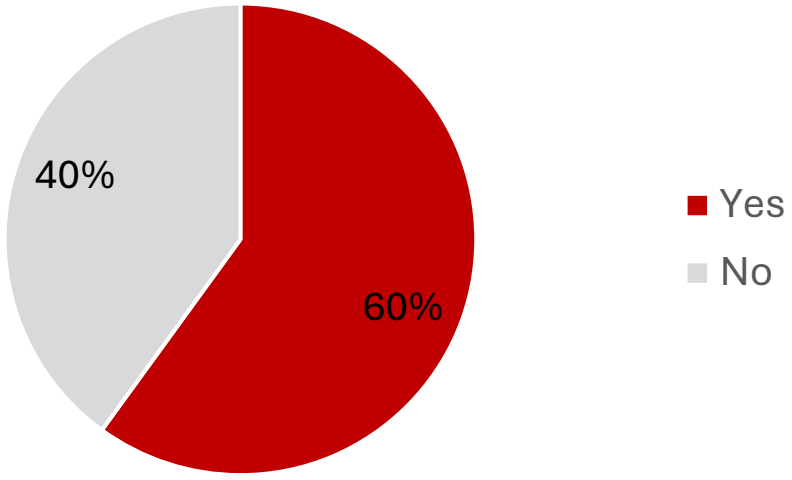
For calendar year 2024, completed evaluations totaled 155. The overall evaluation completion rate (56%) is a 22% increase from 2023 (46%). The remaining incomplete evaluations have been escalated to leadership for follow-up.

REGULATION OF CONTRACTED SERVICES



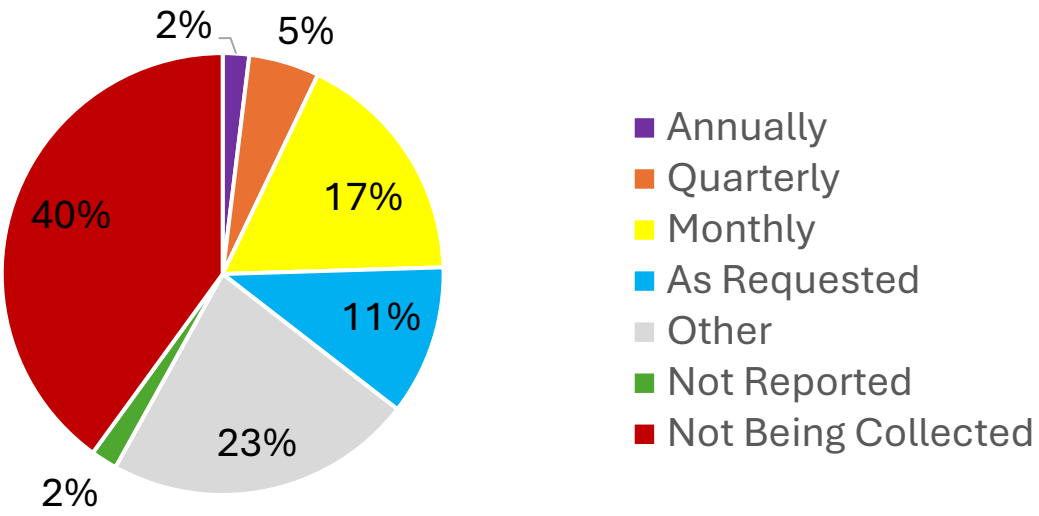
Other regulatory bodies included the Art Therapy Credentials Board, Board of Embalmers and Funeral Directors, Ohio Board of Pharmacy, and local health departments.

COMPLIANCE ACTIVITIES



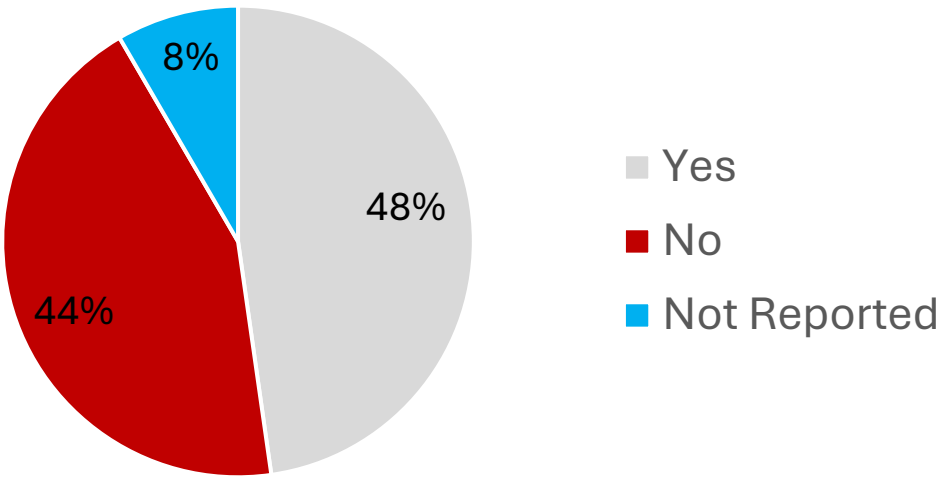
Per the Contract Evaluation policy, operational owners of direct patient care services contracts shall provide and attest to maintain position descriptions, assure licensure, registration, or certification requirements, provide orientation, provide competency assessments, provide and certify on-going education, conduct performance appraisals, and conduct competency evaluations. A secondary review is underway for questions in this section with a "No" response to determine if that answer is appropriate based on the type of service provided (e.g. Otis Elevator).

DATA COLLECTION



Due to the number and variety of contracts, data collection methods and time periods vary across the enterprise. Operational owners are tasked with determining the best method and time period to optimize evaluation of each contract. As shown in the above chart, data collection is largely monthly or another method determined by the operational owner and vendor. Follow up with contract owners will include emphasis on The Joint Commission LD. 04.03.09, element of performance 6 requirement that "Leaders monitor contracted services by evaluating these services in relation to the hospital's expectations."

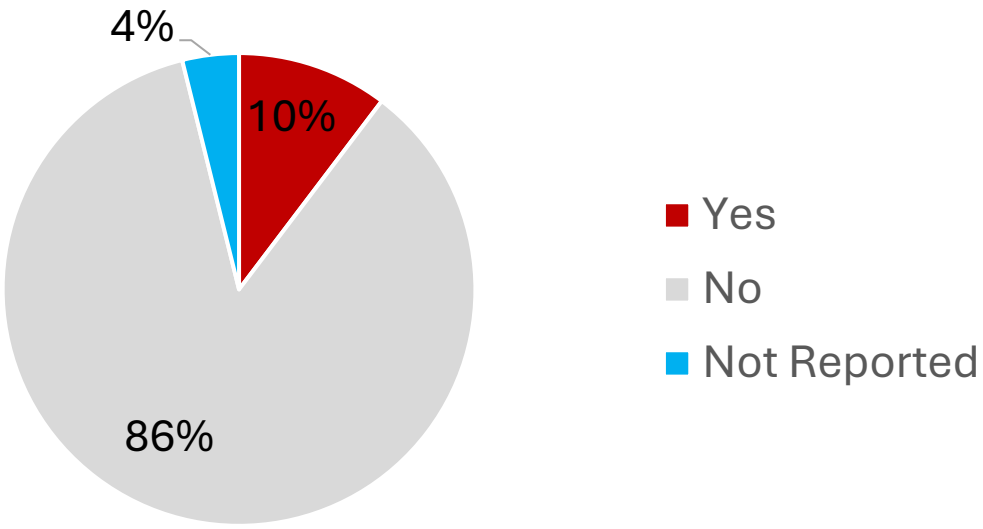
IMPROVEMENTS MADE WITHIN THE PAST YEAR



Overall, 44% of respondents reported improvements within the past year, which is an increase of 6 percentage points from 2023. Improvements included online training modules, forced feedback

technology, increased staffing, improved traffic lane devices, reduced computer crashes, increased coverage rates, and inclusion into a work order database.

FOLLOW UP NEEDED



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SDG Partners, LLC	New flavors for guest satisfaction
Soloinsight	Reduced computer crashes, improved search capability, improved visitor badge picture quality, and decreased CPU spikes
STRYKER SALES CORPORATION	The vendor has adjusted the testing schedule and communicates any issues identified to their research lab. They provide recommendations for repairs, replacements, and upcoming changes as needed.
Teladoc (formerly InTouch)	New devices for use, upgrades to current cart models.
Teleflex	Provide online training modules now for competencies in addition to in person training.
Thai Palace, Inc	Menu upgrades
Towne Park Holdings	Improved lane traffic devices, Podiums at location and key rooms in multiple garages. Staffing increases, along with management level increases.
Us Together	Increased the amount of coverage they can provide. Even though they have the same percentage overall, since our requests have increased by 15%, they have been able to provide more coverage for appointments then they have in previous years in overall numbers. They have also added new languages such as Haitian creole to keep up with our changing patient population and needs.
Veris Health, Inc.	Resolved software bug in thermometer during pilot phase, also improved patient information input fields on web-based portal
Vernon Inc	We have reinvested in the company getting some new vans and we purchased new washers and new buggies. The greatest improvement has been our infrastructure, like the performance installer KPI's mentioned above. We are in the process of transitioning to a new HRIS internal system with onboarding, training and performance tracking programs
Versiti Blood Center	Request to review the standing order and make adjustment to the amount of products received weekly was made. Versiti presented historical ad hoc orders and pitch an increase for each product type for review. Adjustments made 9/1/24.
VIDATAK, LLC	Adding Language Line availability to allow translation services through the app
VIZ AI, Inc	Added modalities

August 19, 2025

CONTRACTED SERVICES
THE OHIO STATE UNIVERSITY AMBULATORY SURGERY CENTER OUTPATIENT CARE NEW ALBANY

Synopsis: Approval of the annual review of the contracted services for The Ohio State University Ambulatory Surgery Center — Outpatient Care New Albany, is proposed.

WHEREAS the mission of the Ohio State University Hospitals is to improve people's lives through the provision of high-quality patient care; and

WHEREAS the contracted services are evaluated annually to review the scope, nature, and quality of services provided to clinical departments and personnel who provide care and services for the mission of The Ohio State University Ambulatory Surgery Center — Outpatient Care New Albany; and

WHEREAS on June 24, 2025, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the contracted services for The Ohio State University Ambulatory Surgery Center — Outpatient Care New Albany:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the annual review of the contracted services for The Ohio State University Ambulatory Surgery Center — Outpatient Care New Albany.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Hospital Administration
Accreditation

168 Doan Hall
410 W 10th Ave
Columbus, OH 43210

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CONTRACTED SERVICES EVALUATION
NEW ALBANY AND DUBLIN SURGERY CENTERS
COMPLETED: CALENDAR YEAR 2023

CONTENTS

OVERVIEW

Annually, The Ohio State University Wexner Medical Center (OSUWMC) Dublin Ambulatory Surgery Center (DASC) and New Albany Ambulatory Surgery Center (NAASC) complete an evaluation for contracted services between the provider numbers. Evaluations are completed for compliance with The Joint Commission's (TJC) Leadership standard – LD.04.03.09 – which states 'Care, treatment, and services provided through contractual agreement are provided safely and effectively' and the Centers for Medicaid and Medicare Services' (CMS) Condition of Participation - 482.12(e) – which states 'The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services.

Evaluations are completed for contracts that fall into direct patient care or patient impact service. Direct Patient Care Service is defined as 'Health care that involves the examination of patients, treatment of patients, and/or preparation for diagnostic tests and procedures, including services used in the clinical management/diagnosis of the patient'. Patient Impact Service is defined as 'Suppliers of services that effect a patient's environment, typically in the hospital room'. Evaluations are not completed for contracts falling into the supply (suppliers of goods) or no direct patient care impact (suppliers of business services that the hospital and/or clinic use to help manage a specific part of their business but do not have a direct impact on the patient) as these are monitored through normal supply chain processes per policy: Contract Evaluation Policy.

Operational owners were identified and asked to complete a Qualtrics survey for each contract under their oversight. Questions on the survey included overall satisfaction, accrediting bodies, metrics being collected, and if follow up was needed by Supply Chain or Legal Services.

CONTRACT OVERVIEW

For calendar year 2024, there were 13 services contracted between each surgery center and (DASC and NAASC) and OSUWMC.

Contracted Services
Management
Laboratory
Radiologic
Central Sterile Processing
Medical Information Management
Nutrition
Registration and Scheduling
Clinical Engineering
Legal
Pharmacy
Epidemiology
Patient Experience
Environmental Management

An evaluation of each services was completed for both DASC and NAASC. All services were reported as improving over the past year and follow up from Supply Chain or Legal services was not requested.

CONCLUSION

Overall, operational owners are monitoring the contracts within their scope.

An area of improvement would be to have performance/efficiency/quality data submitted on a more defined basis rather than as needed.

Efforts will continue to monitor, streamline, and maximize contracts across the enterprise.

August 19, 2025

CONTRACTED SERVICES
THE OHIO STATE UNIVERSITY AMBULATORY SURGERY CENTER
OUTPATIENT CARE DUBLIN

Synopsis: Approval of the annual review of the contracted services for The Ohio State University Ambulatory Surgery Center — Outpatient Care Dublin, is proposed.

WHEREAS the mission of the Ohio State University Hospitals is to improve people's lives through the provision of high-quality patient care; and

WHEREAS the contracted services are evaluated annually to review the scope, nature, and quality of services provided to clinical departments and personnel who provide care and services for the mission of The Ohio State University Ambulatory Surgery Center — Outpatient Care Dublin; and

WHEREAS on June 24, 2025, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the contracted services for The Ohio State University Ambulatory Surgery Center — Outpatient Care Dublin:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the annual review of the contracted services for The Ohio State University Ambulatory Surgery Center — Outpatient Care Dublin.

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