

SUMMARY OF ACTIONS TAKEN

June 2, 2026 – Wexner Medical Center Board Meeting

Members Present:

Gary R. Heminger
Tomislav B. Mitevski
Juan Jose Perez
George A. Skestos
Kara J. Trott

Kendall C. Buchan
Robert H. Schottenstein
Cindy Hilsheimer
Amy Chronis
Hiroyuki Fujita

John W. Zeiger (ex officio)
Ravi V. Bellamkonda (ex officio)
Trevor Brown (ex officio)
Michael Papadakis (ex officio)
John J. Warner (ex officio)

Members Present via Zoom: N/A**Members Absent:**

Leslie H. Wexner

Stephen D. Steinour

PUBLIC SESSION

The Wexner Medical Center Board convened for its 58th meeting on Tuesday, March 3, 2026, at Longaberger Alumni House on Ohio State's Columbus campus. Board Secretary Jessica A. Eveland called the meeting to order at 2:37 p.m.

Item for Action:

1. Approval of Minutes: No changes were requested to the March 3, 2026, 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 of the Wexner Medical Center and executive vice president at Ohio State, began his remarks by celebrating the 100th day of operations for the new University Hospital. Already, patient experience scores for services within the facility are approaching the top decile in the nation. Patient volumes are also strong, a primary driver of which is an increasing number of transfers from partner hospitals across the state. He highlighted the cardiac care partnership with Blanchard Valley Health System in Findlay, Ohio. In just the first year of the relationship, the number of non-emergent cardiac visits to Blanchard has increased by 26%.

Construction of Outpatient Care Powell is more than 90% complete. The facility is targeted to open in early August. Notably, two floors of the building will be dedicated to multidisciplinary oncology care. This is the latest example of the medical center's commitment to expanding direct access to care in communities throughout central Ohio and its broader land-grant mission of partnership and service in every corner of the state.

(See Attachment X for background information, page XX)



3. James Cancer Hospital Report: Chief Executive Officer Kimryn Rathmell began her report by discussing the hospital's increasing bed capacity, patient volumes and treatments delivered. She then offered a close look at the internationally known lung cancer program at The James. Recent data collected by The James and the Ohio Department of Health demonstrated significant progress on lung cancer rates in the state over the last decade-plus, which can be attributed to focused attention on prevention, detection and treatment. The team at The James, through its multi-faceted approach to these issues, is leading these efforts through unique and innovative research in both biology and public policy, cutting-edge treatments and targeted outreach throughout Ohio.

(See Attachment X for background information, page XX)

4. Wexner Medical Center Financial Report: Chief Financial Officer Richard Silveria shared that operating results for the health system through the first nine months of FY26 were strong, driven by continued volume growth. This was enhanced by the successful opening of the new University Hospital, strong performance in cancer and pharmacy, and effective expense management. Operating revenue totaled \$4.2 billion, exceeding budget by \$154 million, or 3.8%, and prior year by \$496.8 million, or 13.3%.

Outpatient volumes continued to be the primary driver of revenue growth, exceeding budget and prior-year figures. Inpatient discharges and surgeries were slightly below budget while outpatient surgeries and surgeries overall were slightly ahead of budget. Total expenses were \$73.5 million or 1.9% above budget, primarily driven by strong volume performance and infusion activity.

Total margin for the health system was \$228.7 million, exceeding budget by \$83.6 million and prior year by \$39.6 million, or 20.9%. Total margin percentage was 5.4%, compared to a budget of 3.6%. EBIDA margin was 11.3%, compared to the budgeted 9.6%.

(See Attachment X for background information, page XX)

Items for Action:

5. Recommend for Approval Wexner Medical Center FY2027 Budget: Mr. Silveria is seeking the board's endorsement of the medical center's FY27 budget. It will also be 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 FY27 budget for the combined Wexner Medical Center, which forecasts an 7.7% increase in total operating revenue and a 9.7% increase in expenses. This is due to an anticipated decline in 340B revenues and state-directed payments while staffing, benchmarked physician compensation, medical benefits and overhead costs rise at a greater pace — influenced heavily by site-of-care expansions and associated workforce growth.

(See Attachment X for background information, page XX)

6. Resolution No. 2026-115, Recommend Approval to Enter Into Professional Services and Enter Into Construction Contracts:

APPROVAL TO ENTER INTO PROFESSIONAL SERVICES CONTRACTS
EAST HOSPITAL – CATH LAB

APPROVAL TO ENTER INTO CONSTRUCTION CONTRACTS
DOAN – REPLACE PET/CT WITH BIOGRAPH

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	
East Hospital – Cath Lab	\$0.6M	\$0.6M	Auxiliary funds

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

	Construction Approval Requested	Total Requested	
Doan – Replace PET/CT with Biograph	\$6.4M	\$6.4M	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)

7. Resolution No. 2026-116, Recommend for Approval for Acquisition of Real Property – University Boulevard, Dublin:

16+/- ACRES AT UNIVERSITY BOULEVARD,
DUBLIN, FRANKLIN COUNTY, OHIO

Synopsis: Authorization to purchase real property located at 6515 Pullman Drive, Lewis Center, Ohio, is proposed.

Synopsis: Authorization to acquire unimproved real property located at University Boulevard, Dublin, Franklin County, Ohio, is proposed.

WHEREAS The Ohio State University seeks to acquire approximately 16 acres of unimproved real property located at University Boulevard, adjacent to the Outpatient Care Dublin facility, identified as Franklin County parcel number 274-012327 at an acquisition price of \$2,934,000; and

WHEREAS the City of Dublin (“Dublin”) has agreed to transfer and convey ownership of the additional adjacent acreage to the University pursuant to a Real Estate Purchase and Sale Agreement (the “Agreement”). Under the Agreement, Dublin retains the option to require the University to reconvey the property to Dublin if the University fails to satisfy specified terms and conditions, as set forth in a property reconveyance escrow agreement or a similar agreement to be executed contemporaneously with the Agreement; and

WHEREAS the acquisition of this property supports the Wexner Medical Center’s long term strategic plan:

NOW THEREFORE



THE OHIO STATE UNIVERSITY

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 and potential reconveyance to Dublin of the aforementioned property upon terms and conditions deemed to be in the best interest of the university and, at an acquisition price at or below the appraised value. If a reconveyance becomes necessary, the reconveyance price will equal the university's acquisition price.

(See Attachment X for background information, page XX)

8. Resolution No. 2026-117, Recommend for Approval for Acquisition of Real Property – 10190 Blacklick-Easter Road NW, Violet Township:

17.1 +/- ACRES AND 12.4 +/- ACRES AT 10190 BLACKCLICK-EASTERN ROAD NW,
VIOLET TOWNSHIP, FAIRFIELD COUNTY, OHIO

Synopsis: Authorization to acquire unimproved real property located at 10190 Blacklick-Eastern Road NW, Violet Township, Fairfield County, Ohio.

WHEREAS The Ohio State University seeks to acquire 17.1 +/- acres of unimproved real property located at 10190 Blacklick-Eastern Road NW in Violet Township, Fairfield County, identified as a portion of Fairfield County parcel number 036-00734-00 and referred to as Phase I Parcel; and

WHEREAS The Ohio State University seeks to acquire 12.4 +/- acres of unimproved real property located at 10190 Blacklick-Eastern Road NW in Violet Township, Fairfield County, identified as a portion of Fairfield County parcel number 036-00734-00 and referred to as Phase II Parcel; and

WHEREAS the acquisition price of both tracts is \$8,750,000, as may be adjusted per the contract; and

WHEREAS the acquisition of the Phase I Parcel and Phase II Parcel properties is strategically important to supporting the objectives of the Wexner Medical Center ambulatory care strategy; and

WHEREAS Violet Township will be responsible for the installation and construction of certain public infrastructure improvements:

NOW THEREFORE

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

BE IT FURTHER 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 properties upon the terms and conditions deemed to be in the best interest of the university.

(See Attachment X for background information, page XX)

9. Resolution No. 2026-118, Recommend for Approval for Execution of an Economic Development Agreement Amendment:

50+/- ACRES AT 6700 UNIVERSITY BOULEVARD,
DUBLIN, FRANKLIN COUNTY, OHIO

Synopsis: Authorization to enter into an amendment of an Economic Development Agreement related to property located at 6700 University Boulevard, Dublin, Franklin County, Ohio, is proposed.

WHEREAS The Ohio State University entered into an Economic Development Agreement (EDA) with the City of Dublin, Ohio (Dublin) in May 2019 as approved in Resolution 2019-63 encompassing +/- 34 acres of unimproved land upon which the Outpatient Care Dublin facility was constructed: and

WHEREAS the EDA outlined agreement between the parties as to development of the original site; and

WHEREAS the university intends to acquire an additional adjacent +/- 16 acres of unimproved land from Dublin and wishes to amend the EDA to add the acreage to the EDA and document, among other items, public infrastructure work to be performed by Dublin:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves and proposes that the amendment of said EDA 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 amendment to the Economic Development Agreement upon terms and conditions deemed to be in the best interest of the university.

10. Resolution No. 2026-119, Ratification of Committee Appointments FY2026-27:

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves that the ratification of appointments to the Quality and Professional Affairs Committee for FY2026-27 are as follows:

Quality and Professional Affairs Committee

Juan Jose Perez, Chair
George A. Skestos
Trevor Brown
Michael Papadakis
John J. Warner
Eric Bourekas
Stacy A. Brethauer
David E. Cohn
Scott A. Holliday
Kami Maddocks
Traci Mignery
Elizabeth Seely
Corrin Steinhauer
Andrew M. Thomas

Action: Upon the motion of Mr. Perez, seconded by Dr. Warner, the Wexner Medical Center Board recommended these items for approval by voice vote with the following members present and voting: Mr. Heminger, Mr. Mitevski, Mr. Perez, Mr. Skestos, Ms. Trott, Dr. Buchan, Mr. Schottenstein, Ms. Hilsheimer, Ms. Chronis, Dr. Fujita, Mr. Zeiger, President Bellamkonda, Dr. Brown, Mr. Papadakis and Dr. Warner.

EXECUTIVE SESSION

It was moved by Dr. Warner and seconded by Mr. Heminger that the Wexner Medical Center Board recess into executive session to consider business-sensitive trade secrets and quality matters required to be kept confidential.

A roll-call vote was taken, and the board voted to go into executive session with the following members present and voting: Mr. Heminger, Mr. Mitevski, Mr. Perez, Mr. Skestos, Ms. Trott, Dr. Buchan, Mr. Schottenstein, Ms. Hilsheimer, Ms. Chronis, Dr. Fujita, Mr. Zeiger, President Bellamkonda, Dr. Brown, Mr. Papadakis and Dr. Warner.

The Wexner Medical Center Board entered executive session at 3:05 p.m. and adjourned at 5:19 p.m.



OSUCCC – James Wexner Medical Center Board Presentation

September 2026

W. Kimryn Rathmell, MD, PhD

Chief Executive Officer/Director

The James



THE OHIO STATE UNIVERSITY
COMPREHENSIVE CANCER CENTER

Framework for a Cancer-Free World

VISION

Creating a cancer-free world, **every person, every discovery, every time.**

5-YEAR GOALS

- **ACCESS:** Bring world-class cancer care to every patient
- **INNOVATION:** Redefine cancer care
- **SCALE:** Rapidly translate discoveries into standard practice
- **OUTCOMES:** Measurably expand meaningful knowledge, create innovations and improve life



MISSION

Personalizing cures, discoveries and care across the cancer continuum.

PRIORITIES

- Leaning into our **CULTURE OF CURIOSITY**
- **DELIVERING IMPACT** across the board
- **EXPANDING OUR REACH** in all domains
- Recognizing **LEARNING AS A CORE VALUE**

Taking cancer personally

DELIVER OPERATIONAL EXCELLENCE

Advance best-in-class processes, break down unnecessary bureaucratic barriers and enable responsible AI integration to improve performance, access and quality across the enterprise.

SUSTAIN FINANCIAL STRENGTH

Support disciplined stewardship, modern funds-flow models, expanded Pelotonia participation, transformational philanthropy and new major partnerships.

ELEVATE NATIONAL DISTINCTION

Strengthen The James brand and position our leaders as visible, influential voices in oncology, expanding our reach to more people who need us.

Pelotonia: Record Momentum

Record fundraising year:

\$29.2M raised

1,000+ cancer survivors participating (record)

8,000 riders, 3,000 volunteers, 15,000+ attendees

\$339M+ invested in cancer research since 2009

New 17-mile route expands access to even more riders –

like all of Team Rathmell!



community + industry + Ohio State = scale, speed





Cancer care is changing faster than our delivery model

The opportunity is not only to do **more** cancer care.

It is to **build** the intelligence, access model and restorative capability that anticipate where the field is going.

2.1M+

projected new
U.S. cancer
cases in 2026

70%

5-year relative
survival for all
cancers combined

3 shifts

earlier detection,
aging population,
higher survival rates

At The James, we identify where cancer care is moving, provide data-driven evidence, and scale personalized access.

The field is moving from “more treatment” to smarter, more personal treatment

1 Detect earlier

Screening, imaging and biomarkers shift demand upstream.



2 Personalize

Genomics, AI and clinical expertise guide the care path.



3 Treat less invasively

When appropriate, use targeted, robotic, image-guided or organ-sparing approaches.



4 Restore function

Reconstruction, rehab and survivorship become core to excellence.

**The whole field will change.
Our care model has to change with it.**

Restorative medicine is the next frontier of comprehensive cancer care.



The James

The James is ready to lead the next era of cancer care.

First in the nation

Multidisciplinary sarcoma recovery and prehabilitation program

Best in the world

Supermicrosurgery for lymphedema prevention and restorative care

Only in the nation

Center performing HIPEC for complex intra-abdominal cancers





Wexner Medical Center Board Financial Report Public Session

September 1, 2026



Preliminary FY26 Year-End Financials

The Ohio State University Health System

Consolidated Statement of Operations

For the YTD ended: June 30, 2026

(in thousands)

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	5,726,673	5,444,261	282,412	5.2%	5,035,963	13.7%
Operating Expenses						
Salaries and Benefits	2,184,775	2,177,654	(7,121)	-0.3%	2,003,957	-9.0%
Resident/Purchased Physician Services	298,991	297,929	(1,062)	-0.4%	259,697	-15.1%
Supplies/Pharmaceuticals/Other	2,286,969	2,211,986	(74,983)	-3.4%	2,046,177	-11.8%
Depreciation	282,014	291,132	9,118	3.1%	259,959	-8.5%
Interest	47,328	47,328	-	0.0%	50,719	6.7%
Total Expense	5,100,077	5,026,029	(74,048)	-1.5%	4,620,509	-10.4%
Gain (Loss) from Operations (pre MCI)	626,596	418,232	208,364	49.8%	415,454	50.8%
Medical Center Investments	(353,827)	(311,052)	(42,775)	-13.8%	(270,547)	-30.8%
Income from Investments	130,733	50,984	79,749	156.4%	108,314	20.7%
Other Gains (Losses)	83,011	58,011	25,000	43.1%	56,523	46.9%
Excess of Revenue over Expense	\$ 486,513	\$ 216,175	\$ 270,338	125.1%	\$ 309,744	57.1%
EBIDA	\$ 815,855	\$ 554,635	\$ 261,220	47.1%	\$ 620,422	31.5%
Financial Metrics						
Operating EBIDA Margin	16.7%	13.9%	2.8%	20.0%	14.4%	2.3%
EBIDA Margin	14.2%	10.2%	4.0%	39.8%	12.3%	1.9%
Total Margin	8.5%	4.0%	4.5%	114.0%	6.2%	2.3%
Total Liquidity (DCOH)	128.5	111.2	17.3	15.6%	137.8	(9.3)

The Ohio State University Wexner Medical Center

Combined Statement of Operations

For the YTD ended: June 30, 2026

(in thousands)

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	7,272,646	7,012,050	260,596	3.7%	6,571,981	10.7%
Operating Expenses						
Salaries and Benefits	3,890,297	3,884,529	(5,768)	-0.1%	3,550,181	-9.6%
Resident/Purchased Physician Services	78,740	82,972	4,232	5.1%	74,529	-5.7%
Supplies/Pharmaceuticals/Other	2,717,279	2,624,416	(92,863)	-3.5%	2,516,467	-8.0%
Depreciation	286,410	295,521	9,111	3.1%	281,036	-1.9%
Interest	47,517	47,553	36	0.1%	58,009	18.1%
Total Expense	7,020,243	6,934,990	(85,252)	-1.2%	6,480,221	-8.3%
Gain (Loss) from Operations	252,404	77,060	175,344	227.5%	91,760	175.1%
Income from Investments	137,729	61,171	76,558	125.2%	118,367	16.4%
Other Gains (Losses)	73,915	62,759	11,157	17.8%	51,614	43.2%
Excess of Revenue over Expense	\$ 464,048	\$ 200,990	\$ 263,058	130.9%	\$ 261,740	77.3%
EBIDA	\$ 797,975	\$ 544,064	\$ 253,911	46.7%	\$ 600,785	32.8%
Financial Metrics						
Operating EBIDA Margin	8.1%	6.0%	2.1%	34.6%	6.6%	1.5%
EBIDA Margin	11.0%	7.8%	3.2%	41.4%	9.1%	1.9%
Total Margin	6.4%	2.9%	3.5%	122.6%	4.0%	2.4%
Total Liquidity (DCOH)	134.1	115.1	19.0	16.5%	143.1	(9.0)

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

The Ohio State University Wexner Medical Center

Combined Balance Sheet

As of: June 30, 2026

(in thousands)

	June 2026	June 2025	Change
<u>Assets</u>			
Cash	\$ 1,549,230	\$ 1,592,347	\$ (43,117)
Net Patient Receivables	886,344	839,574	46,770
Other Current Assets	353,213	244,749	108,464
Assets Limited as to Use	929,959	843,906	86,053
Property, Plant & Equipment - Net	4,244,677	4,049,573	195,104
Other Assets	680,636	628,564	52,073
Total Assets	\$ 8,644,059	\$ 8,198,713	\$ 445,346
<u>Liabilities & Net Position</u>			
Current Liabilities	\$ 725,283	\$ 709,651	\$ 15,632
Other Liabilities	456,333	420,478	35,855
Total Debt	1,264,380	1,348,084	(83,705)
Net Position	6,198,063	5,720,499	477,564
Liabilities and Net Position	\$ 8,644,059	\$ 8,198,713	\$ 445,346
Total Liquidity (DCOH)	134.1	143.1	(9.0)
Net Days in Accounts Receivable	50.4	52.7	2.3
Debt to Capital	16.9%	19.1%	2.1%

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



Thank You

Wexnermedical.osu.edu

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

APPROVAL TO ENTER INTO/INCREASE PROFESSIONAL SERVICES CONTRACTS

EAST HOSPITAL – ENDOSCOPY EXPANSION AND CATH LAB
WEXNER MEDICAL CENTER – COMMUNITY FACILITIES

APPROVAL TO INCREASE PROFESSIONAL SERVICES AND CONSTRUCTION CONTRACTS

OUTPATIENT CARE EAST – CLINIC RENOVATIONS AND RELOCATIONS

APPROVAL TO ENTER INTO CONSTRUCTION CONTRACTS

UNIVERSITY HOSPITAL PAVILION AHU REVIEW/REPAIR

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/increase professional services contracts for the following project; and

	Prof. Serv. Approval Requested	Total Requested	
East Hospital – Endoscopy Expansion and Cath Lab	\$3.6M	\$3.6M	Auxiliary funds
Wexner Medical Center – Community Facilities	\$20.0M	\$20.0M	Auxiliary funds

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

	Prof. Serv. Approval Requested	Construction Approval Requested	Total Requested	
Outpatient Care East – Clinic Renovations and Relocations	\$0.6M	\$13.6M	\$14.2M	Auxiliary funds

WHEREAS in accordance with the attached materials, the university desires to enter into construction contracts for the following project; and

	Construction Approval Requested	Total Requested	
University Hospital Pavilion AHU Review/Repair	\$37.8M	\$37.8M	Auxiliary funds

**RECOMMEND APPROVAL TO ENTER INTO PROFESSIONAL SERVICES
AND ENTER INTO CONSTRUCTION CONTRACTS (cont.)**

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

East Hospital – Endoscopy Expansion and Cath Lab

OSU-255807 (REQ ID# WMC240004)

Project Location: OSU East Hospital

- **Approval Requested and Amount**

Professional services	\$3.6M
Total requested	\$3.6M
- **Project Budget**

Professional services	\$4.2M
Construction w/contingency	TBD
Total project budget	TBD
- **Project Funding**

Auxiliary funds
- **Project Schedule**

BoT professional services approval	09/26
Design	10/26 – 05/27
BoT construction approval	TBD
Construction	TBD
Facility opening	TBD



- **Project Delivery Method**

Construction Manager at Risk
- **Planning Framework**
 - o This project is included in the FY27 Capital Investment Plan.
 - o Scope is based on a 2026 study.
- **Project Scope**
 - o This project now includes improvements for both Cath Lab and Endoscopy to achieve cost, operational and schedule efficiency.
 - o New scope includes relocated and enlarged endoscopy procedure rooms and related support space to accommodate increasing capacity, relocation of physical and occupational therapy services to space vacated by endoscopy, and modernization of adjacent impacted entry level spaces to enhance patient services and safety and to improve flow.
 - o This project also includes the renovation of the Cath Lab (procedure room to treat heart conditions) located on the fifth floor of Ohio State East Hospital.
- **Approval Requested**
 - o Approval is requested to increase professional services contracts.

-
- **project team**

University project manager: Vetrano, Christina
AE/design architect: Gensler
CM at Risk or Design Builder: CMR

Project Data Sheet for Board of Trustees Approval

Wexner Medical Center – Community Facilities

OSU-265987 (REQ ID# WMC270004)

Project Location: Central Ohio

- **Approval Requested and Amount**

Professional services	\$20.0M
Total requested	\$20.0M

- **Project Budget**

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

- **Project Funding**

Auxiliary funds

- **Project Schedule**

BoT professional services approval	09/26
Design	10/26 – TBD
BoT construction approval	TBD
Construction	TBD
Facility opening	TBD

- **Project Delivery Method**

Construction Manager at Risk

- **Planning Framework**

- o This project is included in the FY27 Capital Investment Plan.

- **Project Scope**

- o This project will advance planning and design for Wexner Medical Center community facilities, creating a standardized model for future care sites.
- o This initial request will evaluate site feasibility, desired program and optimal design approach to ensure future adaptability and scalability. A contractor will also be engaged to provide pre-construction services including phasing strategies and cost estimating.

- **Approval Requested**

- o Approval is requested to enter into professional services contracts.

- **project team**

University project manager: Fallang, Ragan
AE/design architect: TBD
CM at Risk or Design Builder: TBD

Project Data Sheet for Board of Trustees Approval

Outpatient Care East – Clinic Renovations and Relocations

OSU-255996 (REQ ID# WMC240003)

Project Location: Outpatient Care East (0837)

- **Approval Requested and Amount**

Professional services	\$0.6M
Construction w/contingency	\$13.6M
Total requested	\$14.2M

- **Project Budget**

Professional services	\$1.7M
Construction w/contingency	\$17.5M
Total project budget	\$19.2M

- **Project Funding**

Auxilliary funds

- **Project Schedule**

BoT professional services approval	08/25
Design	09/25 – 09/26
BoT construction approval	03/26
Construction (Optometry)	07/26 – 11/26
BoT construction approval	09/26
Construction (balance of scope)	10/26 – 06/28
Facility opening (Optometry)	01/27
Facility opening	07/28

- **Project Delivery Method**

Construction Manager at Risk

- **Planning Framework**

- o This project is included in the FY26 and FY27 Capital Investment Plan.

- **Project Scope**

- o Renovates and relocates primary care, urgent care, lab services, non-oncology infusion, and provides new optometry services.
- o Additional funding supports a new retail pharmacy, centralized patient registration, a new patient drop-off canopy, and MEP infrastructure modernization.

- **Approval Requested**

- o Approval is requested to increase professional services and construction contracts.



- **project team**

University project manager: Radabaugh, Alexandra
AE/design architect: NAC
CM at Risk or Design Builder: Barton Malow

Project Data Sheet for Board of Trustees Approval

University Hospital Pavilion AHU Review/Repair

OSU-200524 (REQ ID# WMC240002)

Project Location: UH - Pavilion

- **Approval Requested and Amount**

Construction w/contingency	\$37.8M
Total requested	\$37.8M

- **Project Budget**

Professional services	\$5.2M
Construction w/contingency	\$37.8M
Total project budget	\$43.0M

- **Project Funding**

Auxiliary Funds

- **Project Schedule**

BoT professional services approval	02/25
Design	03/25 – 08/26
BoT construction approval	09/26
Construction	10/26 – 04/29
Facility opening	05/29

- **Project Delivery Method**

Construction Manager at Risk

- **Planning Framework**

- o This project is included in the FY25 Capital Investment Plan.

- **Project Scope**

- o This project will replace the existing air-handling units serving the University Hospital Pavilion with new units to improve system reliability, performance, and long-term maintainability.
- o Replacement of these units will prepare the Pavilion for reliable performance throughout another cycle of useful life supporting WMC patient services, including James radiation oncology, theranostics, Same Day Surgery and miscellaneous high acuity outpatient clinics that need to remain close to our inpatient facilities.
- o Work phased to maintain hospital operations and minimize disruptions to patient care.

- **Approval Requested**

- o Approval is requested to enter into construction contracts.



- **project team**

University project manager: Radabaugh, Alexandra
AE/design architect: Design Group / Osborn Engineering
CM at Risk or Design Builder: Barton Malow

RATIFICATION OF COMMITTEE APPOINTMENTS FY2027

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves that the ratification of appointments to the Quality and Professional Affairs Committee for FY2027 are as follows:

Quality and Professional Affairs Committee

Kara J. Trott, Chair

George A. Skestos, **Vice Chair**

Suzanne R. Kiggin

Trevor Brown

Michael Papadakis

John J. Warner

Eric Bourekas

Stacy A. Brethauer

David E. Cohn

Scott A. Holliday

Daniel Like

Kami Maddocks

Traci Mignery

W. Kimryn Rathmell

Elizabeth Seely

Corrin Steinhauer

Andrew M. Thomas

Crystal Tubbs

Nicole Williams

**RECOMMEND APPROVAL OF AMENDMENTS TO THE
BYLAWS OF THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER BOARD**

Synopsis: Recommended approval of the attached amendments to the *Bylaws of The Ohio State University Wexner Medical Center Board* is proposed.

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

WHEREAS a periodic review of the board's bylaws is a governance best practice; and

WHEREAS the last revisions to the *Bylaws of The Ohio State University Wexner Medical Center Board* took place in November 2023:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby recommends approval by the University Board of Trustees of the attached amendments to the *Bylaws of The Ohio State University Wexner Medical Center Board*.

Rule 3335-93-01 | The Ohio state university Wexner medical center board.

(A) The Ohio state university Wexner medical center board ("University Wexner Medical Center Board") shall be the governing body responsible to the Ohio state university board of trustees ("University Board of Trustees") for operation, oversight, and coordination of the Ohio state university Wexner medical center consisting of the Ohio state university hospitals, (Ohio state university hospital, Ohio state university hospital east, Ohio state Richard M. Ross heart hospital, Ohio state Harding hospital, Ohio state brain and spine hospital, and Ohio state university rehabilitation services at Dodd hall) and the Ohio state James cancer hospital and Solove research institute ("The James") and other such clinical health care enterprises, including without limitation to ambulatory services and outpatient health care facilities, clinics, the faculty group practice, primary and specialty practices, university Wexner medical center signature programs, and clinical laboratories.

Although the Ohio state university board of trustees has the fiduciary and legal responsibility for the Wexner medical center, the Ohio ~~Statestate~~ university board of trustees acknowledges the important contributions and role of the Wexner medical center board. The complexity and scope of the Wexner medical center makes the focused oversight of the Wexner medical center board particularly helpful to the Ohio state university board of trustees. To assure clarity of roles and maximize the benefit of this structure, the Wexner medical center board shall be responsible for providing input and recommendations regarding the development and strategic allocation of resources, planning and delivery of medical services, and such other powers and duties as detailed in rule 3335-93-02 of the Administrative Code, subject to the ultimate authority of the university board of trustees.

(B) The university Wexner medical center board shall be composed of up to twenty-two voting members:

(1) Up to six members of the university board of trustees, including one student trustee, appointed annually by the chair of the university board of trustees and ratified by the university board of trustees;

(2) Up to eleven public members appointed annually by the chair of the university board of trustees in consultation with the university president, the chair of the Wexner medical center board, the executive vice president and chief executive officer, and the chair of the university board of trustees' governance committee and ratified by the university board of trustees; and

(3) Five ex-officio voting members consisting of:

(a) The chair of the university board of trustees;

(b) The university president;

(c) The executive vice president and chief executive officer;

(d) The university senior vice president and chief financial officer; and

(e) The university executive vice president and provost.

(C) The selection criteria for public members shall ensure that the university Wexner medical center board membership will include persons with a broad array of skill sets, perspectives, backgrounds, including knowledge in health care delivery, sophisticated business expertise, prior board service, and/or persons who can assist the university Wexner medical center in its outreach to and relationships with the public, communities, and patients served, and governmental entities to ensure optimal operations and advancement of the university Wexner medical center's strategic mission, vision, and goals. Membership shall be national in scope and the selection processes shall incorporate the diversity policies of the university.

Rule 3335-93-02 | Powers and duties.

The university board of trustees retains its ultimate sovereign power and authority over and fiduciary responsibility for all aspects of the mission and operations of the university Wexner medical center, health sciences colleges, and clinical health care enterprises.

Under the ultimate authority of the university board of trustees and consistent with Ohio law, the university board of trustees authorizes and designates the university Wexner medical center board to act as a governing body on behalf of the university for certain quality and patient care matters, for all of the hospitals and clinics of the university. In accordance with that responsibility, as authorized by the university board of trustees, the university Wexner medical center board will be responsible for the following:

(A) Assuring the quality of patient care throughout the university Wexner medical center, including the planning and delivery of patient services and formation of quality assessments, improvement mechanisms and monitoring the achievement of quality standards and patient safety goals;

(B) Oversight for the purposes of accreditation and licensure; and

(C) Approval of clinical privileging forms, medical and dental staff appointments, clinical privileges, medical staff operations, including the approval, adoption, and amendment of medical staff bylaws and rules and regulations, and the conducting of peer review and professional review actions for medical staff and credentialed providers within university board of trustees-defined and approved parameters.

Any action taken by the board pursuant to the powers and duties as defined in paragraphs (A) to (C) of this rule shall be taken only by the voting, non-public members and approved by majority vote thereof.

(D) In addition, in accordance with that authority and responsibility authorized by the university board of trustees, and consistent with Ohio law, the university Wexner medical center board shall serve in a consultative role and shall be responsible for, subject to the review and approval of the university board of trustees, the following:

(1) Making recommendations to the university board of trustees, university president, and executive vice president and chief executive officer for the Wexner medical center regarding the development and strategic allocations of resources of the university Wexner medical center, including operations, fiscal health, space and facilities management and utilization, personnel, safety and security, and technology;

(2) Oversight of extramural affiliations, partnerships, operating agreements, and strategic business opportunities as approved by the university board of trustees, with regard to the university Wexner medical center and its affiliated entities;

(3) Upon recommendation by the medical staff of university hospitals or the medical staff of the James, approval of medical staff bylaws amendments and recommendation thereof to the university board of trustees;

(4) Making recommendations for approval to the university board of trustees of the purpose and governance documents of any organization established as an auxiliary service organization to the university Wexner medical center;

(5) Monitoring and assisting the university Wexner medical center in its relationship with the public, affected communities, governmental entities, and public and private organizations;

(6) Monitoring the university Wexner medical center integrity and compliance programs as adopted by the university board of trustees; ~~and~~

(7) Reviewing strategic plans, capital and operating budgets of the university Wexner medical center, and making recommendations for approval to the university board of trustees, university president, and executive vice president and chief executive officer for the Wexner medical center;

(8) Providing general advice and guidance to the university board of trustees, university president, and executive vice president and chief executive officer for the Wexner medical center regarding extramural affiliations, operating agreements and other strategic business opportunities of the university Wexner medical center; and

(9) Advising the university board of trustees, university president, and executive vice president and chief executive officer for the Wexner medical center regarding strategic aspects the university's education and research programs in the health sciences colleges.

Rule 3335-93-03 | Relationship of the university Wexner medical center board to the health sciences academic programs.

The health sciences schools and colleges of the university carry out a significant portion of their educational and research activity in facilities of the university Wexner medical center. The university board of trustees shall have exclusive governing authority over the academic and research programs of the university Wexner medical center, including the college of medicine, the planning, administration, and operations of the health sciences schools and colleges and all other educational and research institutes, centers, and programs. The university Wexner medical center board shall lend its best efforts to assure that the programs of the health sciences colleges are effectively supported in collaboration with the university Wexner medical center's patient care programs. The executive vice president and chief executive officer shall be charged with maintaining an effective liaison between the health sciences colleges and the university Wexner medical center board to assure excellence in both academic and patient care programs.

Rule 3335-93-04 | Scope of role, accountability and reporting.

(A) To ensure that the university board of trustees meets its governance obligations under all applicable laws and regulations, the university Wexner medical center board shall be accountable to the university board of trustees.

(1) The chair of the Wexner medical center board or his/her designee shall, at the request of the university board of trustees, present a comprehensive report annually to the university board of trustees at its fall meeting on the state of the Wexner medical center, including an assessment of quality of care, overall operations and finance, compliance, and strategic plans, as well as opportunities for the future.

Rule 3335-93-05 | Meetings and notice.

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

(B) Regular meetings. Regular meetings of the university Wexner medical center board shall be held at least four times per year on a schedule established by the university board of trustees. The regular meetings shall be set and publicallypublicly announced and/or at such other time or place as may be announced by the chair.

(C) Special meetings. Special meetings may be called at the discretion of the chair of the university Wexner medical center board, the university president, the executive vice president and chief executive

officer for the Wexner medical center, or the chair of the university board of trustees, and shall be called by the chair at the request of three members of the university Wexner medical center board, provided that notice of any special meeting shall be given in accordance with Ohio law.

(D) Meetings of the university Wexner medical center board shall be conducted in accordance with the state laws of Ohio and open meetings laws, including, but not limited to, the production and maintenance of minutes for all proceedings of the university Wexner medical center board.

(E) Except as otherwise specified in these bylaws, all meetings of the university Wexner medical center board and its committees shall be conducted in accordance with the latest revision of "Robert's Rules of Order."

(F) All trustees are encouraged to attend meetings of the Wexner medical center board, whether they are members or not, to maximize effective and knowledgeable oversight by the university board of trustees. Trustees who are members of the Wexner medical center board shall represent the interests of both boards during their service.

Rule 3335-93-06 | Quorum.

A majority of voting members, including at least three university trustees, shall constitute a quorum for the conducting of business at any meeting of the university Wexner medical center board. If quorum is present, a majority vote of those members present and voting, subject to these bylaws, shall be required for approval of actions by the university Wexner medical center board. If there is a vacancy in an ex-officio voting position of the university Wexner medical center board, that position shall not be included for the purposes of determining quorum for a meeting.

Rule 3335-93-07 | Vacancies.

Whenever a vacancy occurs on the university Wexner medical center board, the chair of the university Wexner medical center board shall immediately notify the chair of the university board of trustees, the university president, and the executive vice president and ~~chancellor for health affairs~~chief executive officer, so that the university board of trustees or the appropriate appointing authority identified in paragraph (B) of rule 3335-93-01 of the Administrative Code may appoint a new member as soon as possible to fill the unexpired term.

Rule 3335-93-08 | Removal.

The university Wexner medical center board chair, in consultation with the chair of the university board of trustees, the chair of the university board of trustees talent, compensation and governance committee, the university president, and the executive vice president and ~~chancellor for health affairs~~chief executive officer may recommend to the university board of trustees that a public member of the university Wexner medical center board be removed or suspended. The university board of trustees has sole authority to appoint and remove public members of the university Wexner medical center board.

Rule 3335-93-09 | Indemnification of university Wexner medical center board members.

Members of the university Wexner medical center board shall be entitled to legal defense and indemnification against any claims or liabilities which might arise from the performance of their duties on behalf of the university Wexner medical center board to the full extent permitted by Ohio law.

Rule 3335-93-10 | Compensation of university Wexner medical center board and board committee members.

No university Wexner medical center board member shall receive compensation for services rendered in the capacity as a board member. However, nothing herein shall be construed to preclude any board member or committee member from receiving reimbursement for actual expenses incurred in the course of such service.

Rule 3335-93-11 | Confidentiality and conflicts of interest.

In addition to any applicable restrictions or obligations set forth in Chapter 102, section 2921.42 of the Revised Code and section 2921.43 of the Revised Code, which may apply to university trustees and ex-officio members of the university Wexner medical center board as employees of the university, all members of the university Wexner medical center board, including public members and the appointed members of any and all board committees have a duty of loyalty and fidelity to the university, and they must govern their affairs honestly, exercising their best care, skill and judgment for the benefit of the university so as to avoid conflicts of interest and the appearance of impropriety.

Members of the university Wexner medical center board and its committees shall disclose to the chair of the university Wexner medical center board and the university general counsel any situation wherein such member has a potential conflict of interest that could possibly cause that member to act in other than the best interest of the university. In any such situation deemed as a conflict of interest the member shall abstain from acquiring any information developed by the university Wexner medical center board and from participating in any discussions or voting related to such situation.

All members of the university Wexner medical center board and its committees shall keep confidential all sensitive information of every kind including the strategic goals of groups, practices, entities or subdivisions within the university Wexner medical center to the extent permitted by law. Members of the board and its committees also shall abide by all confidentiality and conflict of interest policies and programs adopted by the university board of trustees from time to time.

The university Wexner medical center board shall adopt and periodically review the university board of trustees' statement of expectations, which shall address comportment among board members, with the university president and other internal constituents, and with external constituents.

Rule 3335-95-01 | Officers of the board.

The officers of the university Wexner medical center board shall consist of a chair and such other officers appointed by the university board of trustees.

Rule 3335-95-02 | Chair.

The chair shall be selected among the voting members of the university Wexner medical center board and shall be appointed by the chair of the university board of trustees, in consultation with the university president and the executive vice president and ~~chancellor for health affairs~~chief executive officer, and ratified by the university board of trustees. The chair shall be appointed annually and have specific skills and qualifications including, but not limited to, prior experience leading a board and demonstrated experience in business management. The chair of the university Wexner medical center board shall preside at all meetings of the board.

Rule 3335-97-01 | University Wexner medical center board standing committees.

The university Wexner medical center board shall approve the appointment of a finance committee and a quality and professional affairs committee. The chair of the university Wexner medical center board shall appoint the members of the board's committees. The chair of each committee of the university Wexner medical center board shall be selected from the voting members of the university Wexner medical center board. The board or the chair of the board may designate guidelines for the selection and participation of non-trustee members of committees.

Rule 3335-97-02 | Finance committee.

(A) Responsibilities. The finance committee shall, upon call of the chair of the committee, meet to review and evaluate the financial results, plans, and audits of the university Wexner medical center and its component entities for the purpose of assessing the overall financial risks and capacities of the university Wexner medical center and the congruity of the financial management, plans and objectives of the university Wexner medical center. The committee shall be responsible for: reviewing financial performance including achievement of financial goals and targets approved by the university Wexner medical center board and university board of trustees; reviewing and making recommendations regarding the operating and capital budgets to the university Wexner medical center board and the university board of trustees; advising on the acquisition or sale of property; advising on current and future strategic business opportunities, including, but not limited to, affiliations, partnerships, mergers, acquisitions, and other business ventures; and other responsibilities as assigned by the chair of the university Wexner medical center board.

(B) Composition. The finance committee shall be composed of no fewer than five voting members of the university Wexner medical center board, with at least three members being university trustees; the university chief financial officer; and such other members as determined by the chair of the university Wexner medical center board.

(C) Meetings. The committee shall meet at the call of the chair of the committee. A majority of the voting members of the committee shall constitute a quorum. Meetings shall be conducted in accordance with the state laws of Ohio and open meetings laws.

Rule 3335-97-03 | Quality and professional affairs committee.

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

(1) Reviewing and evaluating the patient safety and quality improvement programs of the university Wexner medical center, including, but not limited to, the hospitals, clinics, ambulatory care facilities, and physician office facilities;

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

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

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

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

- (6) Reviewing and approving clinical privilege forms;
- (7) Reviewing and approving membership and granting appropriate clinical privileges for the credentialing of practitioners recommended for membership and clinical privileges by the university hospitals medical staff administrative committee and the James medical staff administrative committee;
- (8) Reviewing and approving membership and granting appropriate clinical privileges for the expedited credentialing of such practitioners that are eligible by satisfying minimum approved criteria as determined by the university Wexner medical center board and are recommended for membership and clinical privileges by the university hospitals medical staff administrative committee and the James medical staff administrative committee;
- (9) Reviewing and approving 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 university Wexner medical center board;
- (11) Reviewing and resolving any petitions by the medical staffs for amendments to any rule, regulation or policy presented by the chief of staff on behalf of the medical staff pursuant to the medical staff bylaws and communicating such resolutions to the university hospitals medical staff administrative committee and the James medical staff administrative committee for further dissemination to the medical staffs; and
- (12) Such other responsibilities as assigned by the chair of the university Wexner medical center board.

(B) Composition. The committee shall consist of: no fewer than four voting members of the university Wexner medical center board, appointed annually by the chair of the university Wexner medical center board, one of whom shall be appointed as chair of the committee. The executive vice president and chief executive officer; ~~the chief executive officer for the James;~~ the chief ~~executive operating~~ officer of the ~~Ohio state university health system medical center;~~ the chief clinical officer of the medical center; ~~the chief operating officer of the James;~~ the chief administrative officer of the Ohio state university health system hospital division; ~~the chief administrative officer of the Ohio state university health system ambulatory services division;~~ 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 ~~of the medical center;~~ ~~the associate vice president for quality and safety of the medical center;~~ the chief nursing officer for university hospital ~~and Ross heart hospital;~~ and the chief nursing officer for the James ~~or their equivalent positions~~ shall serve as ex-officio, voting members. Such other members ~~may be~~ appointed by the chair of the university Wexner medical center board, in consultation with the chair of the quality and professional affairs committee.

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

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

| defined in ~~section 3335-97-03~~paragraphs (A)(7) and (A)(10) of rule 3335-97-03 of the Administrative Code.

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

Rule 3335-97-04 | University Wexner medical center board special or ad-hoc committees.

The university Wexner medical center board may establish special or ad-hoc committees as needed upon the approval of the university board of trustees.

**APPROVAL OF FY2027 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 FY27 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 FY27 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 FY27 was approved by the Quality Leadership Council on June 22, 2026; and

WHEREAS the annual review of the Clinical Quality Management, Patient Safety, and Patient Experience Plan for FY27 was approved by the University Hospitals Medical Staff Administrative Committee on July 8, 2026; and

WHEREAS on July 28, 2026, 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 FY27:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board and Board of Trustees hereby approve the Clinical Quality Management, Patient Safety, and Patient Experience Plan for FY27 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 2027

July 1, 2026 - June 30, 2027

The Ohio State University Wexner Medical Center

Clinical Quality Management, Patient Safety, & Patient Experience Plan

Table of Contents

- I. Ambition, Mission, Vision & Values
- II. Definition
- III. Consistent Level of Care
- IV. Performance Transparency
- V. Confidentiality
- VI. Scope/Purpose
- VII. Objectives
- VIII. Structure for Quality Oversight
- IX. Committees
- X. Roles & Responsibilities
- XI. Approach to Clinical Quality, Patient Safety and Patient Experience Management
- XII. Determining Priorities
- XIII. Data Measurement and Assessment
- XIV. Communication of Data/Performance
- XV. Performance Based Physician Quality & Credentialing
- XVI. Conflict of Interest
- XVII. Annual Approval and Continuous Evaluation

Ambition, Mission, Vision and Values

Ambition: To be a top tier (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, online 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 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

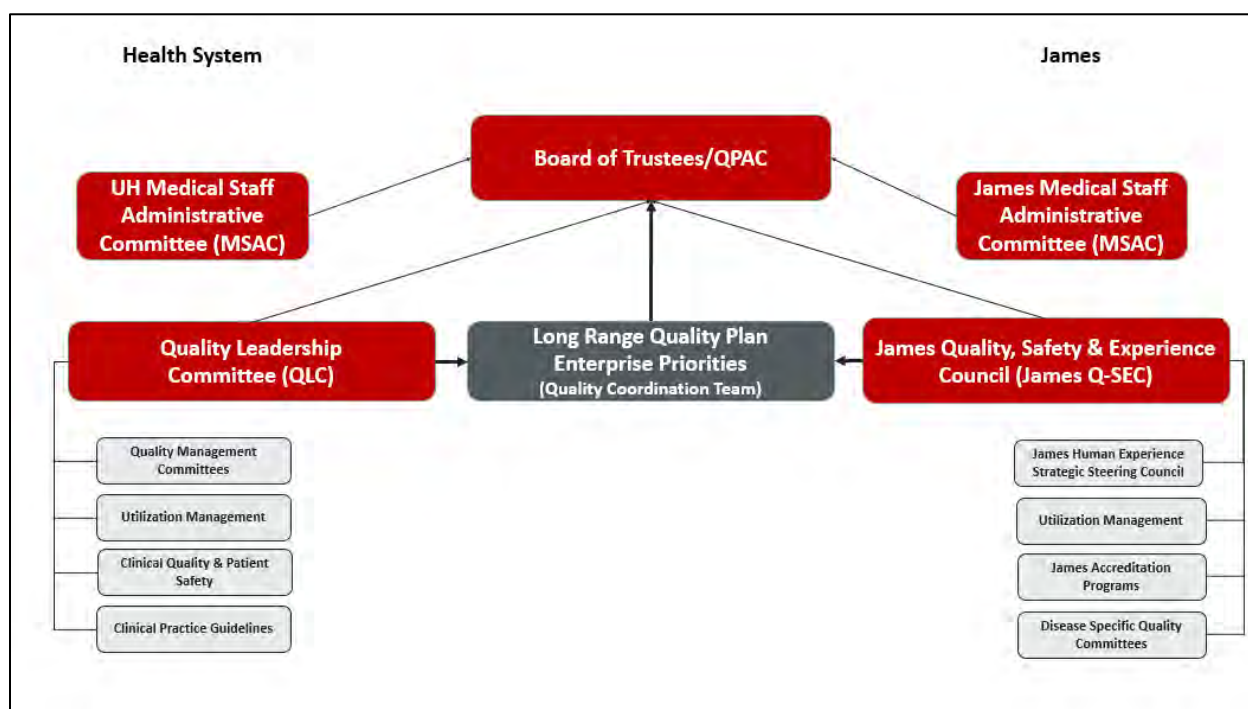
The Clinical Quality Management, Patient Safety & Patient Experience Plan includes all inpatient and outpatient facilities in The OSU Wexner Medical Center (OSUWMC) and appropriate entities across the continuum of care and in any clinical setting. The execution of the Clinical Quality Management, Patient 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 unwarranted 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 ensure processes involve an interdisciplinary teamwork approach.
- Improve processes to prevent patient and employee harm.
- Improve clinical documentation to accurately reflect the risk factors and 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 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 Improvement Teams and Quality Management Committees 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 consistently meets Joint Commission and CMS requirements for Conditions of Participation while advancing a high reliability culture focused on zero harm, continuous learning, and system-level improvement.

Function:

- Fosters a culture of safety which promotes organizational learning and minimizes individual blame or retribution associated with reporting or involvement in a healthcare errors
- Assures optimal compliance with patient quality and 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
- Directs education and risk-reduction strategies as they relate to Sentinel Event Alerts from TJC
- Provides oversight and guidance for quality management committees
- Evaluates clinical practices and, when indicated, recommends improvements to enhance care delivery and patient outcomes
- Ensures timely actions are taken to improve performance whenever an undesirable pattern or trend is identified
- Receives reports from committees that have a potential impact on the quality and safety of patient care delivery

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 Hospital & Ross Heart Hospital's Council is co-chaired by the Chief Nursing Officer for University Hospital & Ross Heart Hospital, the Executive Director for University Hospital / Ross Heart Hospital, and the University Hospital & Ross Heart Hospital Medical Directors. It occurs as part of the Hospital's Monthly Performance Review. The committee reports to the QLC by way of an annual report by the Director of Patient Experience 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. The OSU East Patient Experience Council is co-chaired by the Chief Nursing Officer for OSU East Hospital and the Director of Patient Experience. The committee reports to the QLC by way of an annual report by the Director of Patient Experience and reports out to additional committees as applicable.

Function:

- Create a culture and environment that delivers an exceptional experience through world class care for every person, every time 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.

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.
- 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 ensuring they are actionable, sustainable, and designed to mitigate recurrence and drive system-level improvement.

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.

Quality Management Committees

Composition: For the purposes of this plan, Quality Committees will refer to any standing service line committees or sub-committees 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 multidisciplinary work group(s) for the continuous process of monitoring, evaluating, and improving the quality of care services provided throughout a hospital, clinical department, and/or a group of similar clinical departments (e.g., service lines).

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, and other leaders as appropriate, across the system to establish a clear level of accountability for quality improvement activities. The QI teams use data provided by the Analytics Center of Excellence (ACE) to identify and prioritize processes and tactics to improve a specific outcome or priority metric. 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 Chairperson 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, patient safety, and quality improvement 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 and Improvement
3. Quality Program Reporting
4. Provider Engagement / Peer Review

Patient Experience

The primary responsibility of the Patient Experience team is to coordinate and facilitate the operationalization of patient centered compassionate care designed to ensure patients and their loved ones leave with a trusting perception of The Ohio State University Wexner Medical Center. 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.

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.

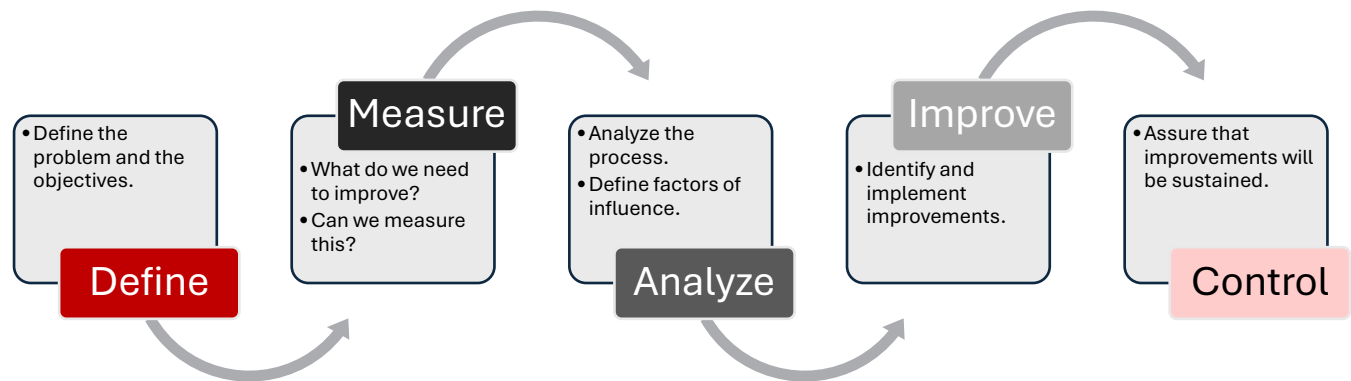
Approach to Clinical Quality, Patient Safety & Patient Experience Management Systematic Approach/Model to Process Improvement

The OSUWMC embraces continuous improvement 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.
3. A data-driven and patient-centered approach to continuous improvement.

With 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 with iterative improvement cycles is an instrumental to help focus our process improvement efforts.

DMAIC Roadmap



High Reliability Organization (HRO) and Commitment to Zero Harm

The Ohio State University Wexner Medical Center (OSUWMC) is committed to advancing a culture of safety through the principles of a High Reliability Organization (HRO), with the ultimate goal of achieving zero preventable harm. This commitment reflects a system-wide expectation that safety is a core value, embedded in daily operations, leadership behaviors, and clinical practice.

OSUWMC operationalizes HRO principles by promoting:

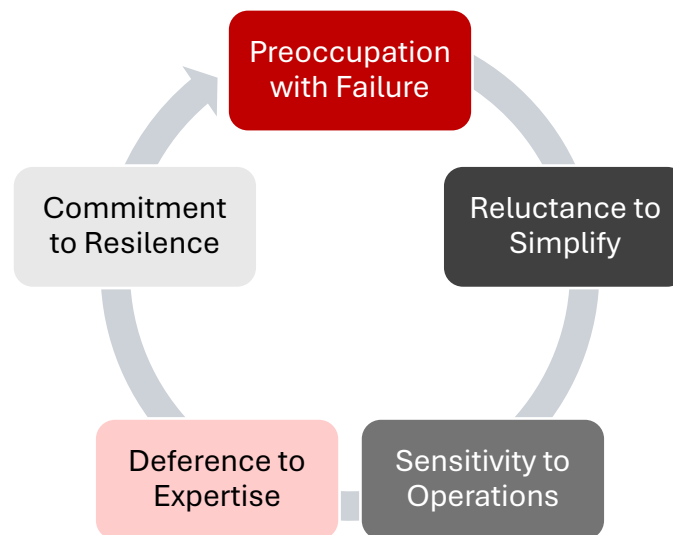
- **Preoccupation with Failure** – Proactively identifying risks, near misses, and system vulnerabilities through event reporting, safety surveillance, and continuous monitoring.
- **Reluctance to Simplify** – Encouraging thorough analysis of events and conditions to understand underlying system drivers rather than attributing issues to individual performance.
- **Sensitivity to Operations** – Maintaining situational awareness through leadership rounding, multidisciplinary communication, and frontline engagement.
- **Commitment to Resilience** – Strengthening the organization's ability to respond, recover, and learn from adverse events and operational disruptions.
- **Deference to Expertise** – Empowering frontline staff and subject matter experts to speak up and influence decision-making regardless of hierarchy.

To support these principles, OSUWMC integrates Every Person Every Time (EPET) skills and standardized tools (e.g., just culture, escalation pathways, and tiered safety huddles) across clinical and operational settings. Leaders at all levels are expected to model HRO behaviors, reinforce psychological safety, and promote accountability through consistent use of these tools.

OSUWMC fosters a Just Culture environment in which individuals are treated fairly, and accountability is balanced with system improvement. This approach supports open reporting, encourages learning from failure, and drives continuous improvement.

Through these efforts, OSUWMC seeks to create a highly reliable system in which safe, high-quality care is consistently delivered, variation is minimized, and every team member is accountable for preventing harm and improving patient outcomes.

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

OSUWMC systematically collects and measures healthcare quality data to monitor performance, identify opportunities for improvement, tracks impact of improvement initiatives, and support regulatory and organizational priorities. Data collection occurs through multiple sources to ensure a comprehensive and reliable view of patient care and outcomes.

Primary data sources include:

- **Administrative and clinical data systems and registries** (e.g., EHR, Vizient, specialty registries) capturing patient demographics, clinical conditions, treatments, and outcomes
- **Retrospective and concurrent medical record review**, including targeted surveillance activities (e.g., infection prevention, mortality review, and clinical quality audits)

- **Event and safety reporting systems**, including patient safety reports, near misses, and serious safety events
- **Surveys and feedback mechanisms**, including patient experience (e.g., HCAHPS), family input, and workforce engagement surveys

Data collection processes are standardized where possible to ensure consistency, validity, and reliability. Key measures are defined using internal specifications and external benchmarks (e.g., CMS, Joint Commission, Vizient), and data are collected at the unit, service line, and organizational levels.

Collected data are regularly validated, trended, and stratified (e.g., by population, location, and provider) to support actionable insights and performance improvement initiatives.

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 are 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: Compares performance across units overtime to evaluate improvement efforts and identify best practices.

External Benchmarking: Uses national databases and clinical registries (e.g., Vizient, The US News & World Report, National Database of Nursing Quality Indicators, and The Society of Thoracic Surgery) to measure performance against peer organizations and inform goal setting.

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.

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 IHS 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, and Readmission data over time. The data can be displayed at the health system, business unit, clinical service, and unit 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, care coordination, discharge, restfulness, and environment. It also measures process indicators, such as joint physician-nurse 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 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 promotes the delivery of safe, high-quality care by physicians and advanced practice providers. This process includes both **Focused Professional Practice Evaluation (FPPE)** and **Ongoing Professional Practice Evaluation (OPPE)**.

FPPE is conducted in three situations: at initial appointment, when new privileges are requested, and when concerns arise regarding a practitioner's ability to provide safe, high-quality care.

OPPE is performed on a continuous basis, with formal review at least every six months, to monitor ongoing performance and support the maintenance of clinical competence.

Profiling Process



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

Long-Range Quality Plan

World-class care for every person, every time



Exceptional Care

Safe

Industry-leading safety performance

As evidenced by a reduction in preventable harm as measured by the serious safety event rate

Patient-Centered

Exceptional experience for patients and families

As evidenced by Likelihood to Recommend scores in the top decile

Effective

Excellence in clinical outcomes

As evidenced by Vizient Q&A performance in the top decile

High reliability is the foundation of everything we do



Performance-improvement program rooted in standardized methodology



Leverage Analytics Center of Excellence to drive performance improvement around targets and outcomes



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: FY27 Priorities/Metrics

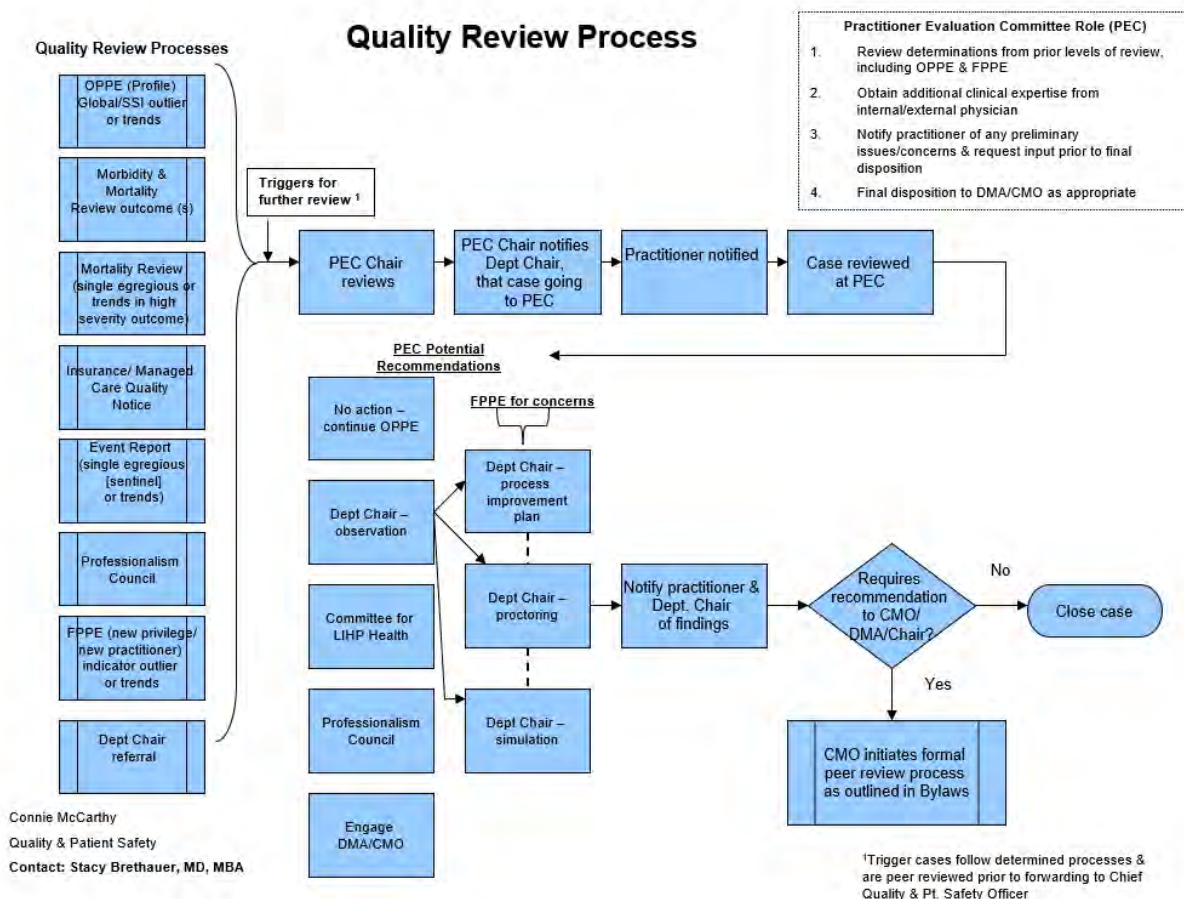
Board Endorsed FY27 Quality & Safety Priorities

- Update process for safety event review, classification & action
- Mortality
- Patient Experience (Likelihood to Recommend)
- Central Line Associated Blood Stream Infection (CLABSI)
- Catheter Associated Urinary Tract Infections (CAUTI)
- Falls with Injury

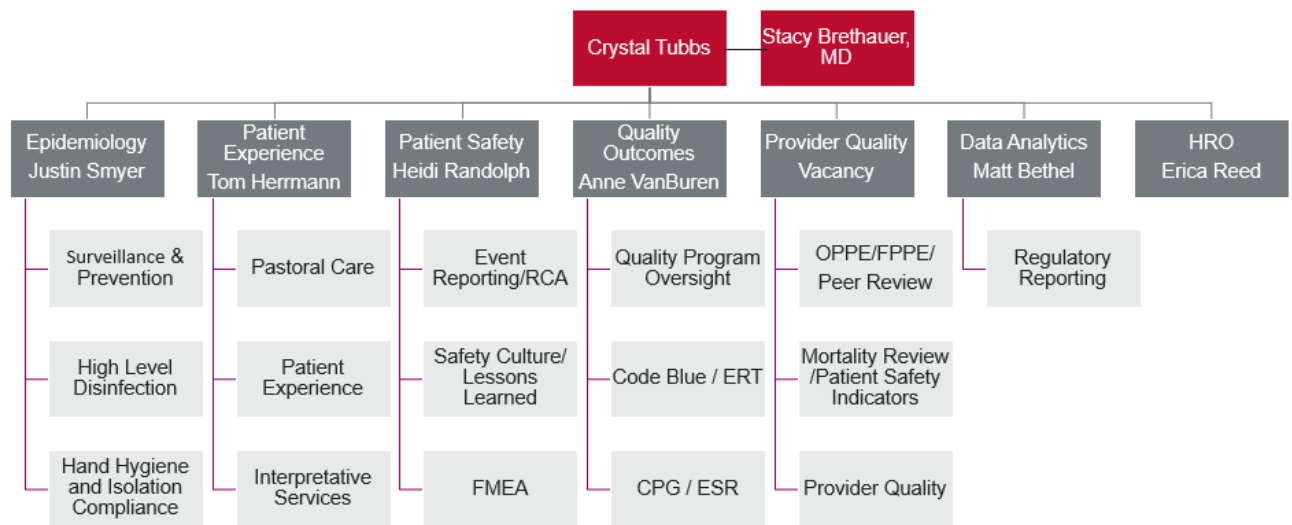
Appendix D: Quality Structure for The James Cancer Hospital & Solove Research Institute



Appendix E: Quality Review Process & Physician Performance Based Profile



Appendix F: Quality & Operations Improvement Organizational Chart



APPROVAL OF FY2027 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 FY2027 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 FY27 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 FY27 was approved by The James Quality, Patient Safety, and Reliability Committee on May 27, 2026; and

WHEREAS the annual review of The James Quality, Safety, and Experience Council Plan for FY27 was approved by The James Medical Staff Administration Committee on June 12, 2026; and

WHEREAS on July 28, 2026, the Quality and Professional Affairs Committee recommended that the Wexner Center Board approve the annual review of The James Quality, Safety and Experience Council Plan for FY2027:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board and Board of Trustees hereby approve The James Quality, Safety and Experience Council Plan for FY2027 as outlined in the attached document.

Approvals

QSEC: 05/27/2026

MSAC: 06/12/2026

QPAC:

OSUWMC Board of Trustees:

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 2027
July 1, 2026, through June 30, 2027

The James



The James Cancer Hospital Quality, Safety and Experience Council Plan

Table of Contents

Mission, Vision, and Values.....	3
Definition.....	3
Scope.....	3
Purpose.....	4
Objectives	4
Structure for Quality Oversight.....	4
Governance and Committees.....	4
Roles and Responsibilities.....	9
Philosophy of Patient Care Services.....	11
Consistent Level of Care.....	13
Performance Transparency	13
Confidentiality.....	14
Determining Priorities	14
Data Measurement and Assessment.....	14
Performance Based Provider Quality and Credentialing	16
Annual Quality Plan Evaluation.....	17
Enterprise-Wide Alignment and Strategic Plan.....	18
Attachment A: James Quality, Safety, and Experience Council Structure.....	18
Attachment B: Impact 2035.....	18
Attachment C: Long-Range Quality Plan.....	19

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, every person, every discovery, every 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 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 designed to enrich patient outcomes, reduce harm, and improve value-added care and service utilizing High Reliability Organization (HRO) Principles 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 Plan establishes an effective, ongoing framework for identifying problematic events, policies, and practices, implementing corrective actions, and following up to ensure improvements in performance, quality, and safety are both effective and sustained over time. 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 patient experience by providing safe and high-quality care at the best value.
7. Prioritize identifying health care disparities by assessing trends in the data; developing and implementing action plans and communicating progress to key stakeholders.
8. Provide education to the governance, faculty and staff regarding quality management principles and processes for improving systems.
9. Provide appropriate levels of data transparency.
10. Assure quality and patient safety processes developed involve trans-disciplinary teamwork.
11. Provide process improvement initiatives to clinical systems to prevent or eliminate patient harm.
12. Monitor and evaluate integration and sustained HRO principles.

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, Accreditation, 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 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:

- Adhere to HRO principles to promote Just Culture.
- 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 identifies risks to patient safety and creates a call-to-action to reduce risk with a focus on process and system improvement.
- Evaluate and monitor the National Performance Goals (NPG) 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.
- Acquire and review 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, Patient Experience, Grievance Committee, and Utilization Management Committee.
- Provide direct oversight for the James Quality, Safety and Experience Council QAPI Sub-Committee (QAPI).
- Receive annual quality reports from James Accreditation programs, such as the Commission on Cancer (CoC), Geriatric Surgery Verification Program (GSV), National Accreditation Program for Breast Centers (NAPBC) and National Accreditation Program for Rectal Cancers (NAPRC).

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

Composition:

The James Quality, Safety and Experience QAPI Sub-Committee (QAPI) 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 (Q-SEC). 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, Patient Family Advisory Council (PFAC), 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.
- Advises and supports 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 Team (SET) and Sentinel Event Determination Group (SEDG):

Composition:

The Sentinel Event Team (SET) includes membership from both The James and the OSUWMC. Membership from The James includes: the Executive Director Medical Affairs/Chief Medical Officer, Chief Nursing Officer, the Quality Medical Director for The James, the Quality Medical Director for Perioperative services, and the Director of Quality & Patient Safety. Members from the Medical Center include: an Administrator, Chief Quality and Patient Safety Officer, 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.

The Sentinel Event Determination Group (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 is comprised of quality leaders from The James and OSUWMC and chaired by the Health System Chief Quality Officer. The SEDG meets weekly to review sentinel events and significant events.

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.

Conflict of Interest:

A person is considered 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. A person professionally involved is to refrain from participation in the care under review, except as requested by the appropriate administrative or medical leader. During peer review evaluations, deliberations, or voting, the committee chairperson will take steps to avoid the presence of any person professionally involved, including committee members, and should resolve all questions. 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 related to any action under peer review.

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.

Chief Operating Officer (COO)

The Chief Operating Officer (COO) reports to the CEO of The James and is responsible for planning, executing and leading a broad range of operational functions including leading and partnering with teams to ensure highly reliable, high quality and safe care at The James. The COO executes strategies to expand patient access, and leads efforts to continuously improve patient experience, manage patient flow and care coordination and develop strategic partnerships to ensure consistent delivery of world-class cancer care.

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 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.

Chief Nursing Officer (CNO)

The James Chief Nursing Officer (CNO) reports to the James CEO 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 James Q-SEC and OSUWMC- QLC Committee. Nursing directors and managers are responsible for patient quality and safety initiatives within their respective areas. 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 are responsible for providing the highest standard of care and services within their scope of practice.

Quality and Patient Safety Leadership

The Director of Quality and Patient Safety and the Director of Clinical Outcomes collaborate directly with executive leaders as well as with directors and managers of all areas to evaluate, plan, and improve 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 and James Clinical Outcomes Teams

The primary responsibilities of The James Quality and Patient Safety Team and James Clinical Outcomes teams are:

- Track and trend quality events, including Sentinel Events.
- Coordinate and facilitate clinical quality improvement to achieve desired 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.
- Teach and influence utilizing HRO principles.
- Support operational areas with efforts to achieve highest level of patient safety.

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 team serve as internal consultants for the development, evaluation, and on-going monitoring of those activities. The James Quality and Patient Safety, James Quality and Clinical Outcomes teams, including The James Operations Improvement team, and the Analytics Center of Excellence (ACE), and James Accreditation maintain human and technical resources for team facilitation, use of performance improvement tools, data collection, statistical analysis, and reporting.

Hospital Management Team

All members of The James management teams are responsible for ensuring 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-centered care.
- 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 information available to patients and their families 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 a patient's 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.

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.

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).

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 indicates 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 team and Analytics Center of Excellence collect and report data for monitoring important processes and outcomes related to patient care. In addition, each team is responsible for identifying quality

indicators specific to their area of service. Areas are 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 patient experience. These include regulatory, governmental, payer, and specialty certification organizations.

Data Collection

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, NQF, 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 The Quality and Professional Affairs Committee (QPAC) at the Wexner Medical Board. The indicators to be included in The Scorecard represent the priorities of The James Quality, Safety and Experience Council(Q-SEC). The Council evaluates opportunities each month as well as monthly at the Medical Staff Administrative Committee (MSAC). Safety goals are reviewed annually and adjusted as necessary by event trending, regulatory changes, and other opportunities as 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 Likelihood to

Recommend, physician communication, nursing responsiveness, admitting, and discharging efficiencies and quality in addition to other service categories. The information from this dashboard is shared in multiple forums with staff, clinicians, administration, and the Board of Trustees. Performance on these indicators serve as annual goals for leaders and members of clinical and patient experience teams.

Quality and Patient Safety Education

Education is identified as a key principle for providing safe, high-quality care, and excellent service for our patients. There are 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
- Virtual Reality
- 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 benchmarking projects to compare performance with that of other cancer hospitals/peer institutions. The James Cancer Hospital joins other comprehensive cancer centers for benchmarking such as C4QI (Comprehensive Cancer Center Consortium for Quality Improvement), ADCC (Alliance of Dedicated Cancer Centers), and National Cancer Institute (NCI). Additionally, The James participates in national benchmarking efforts through 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 (ACS) and others.

Performance Based Provider Quality and 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.

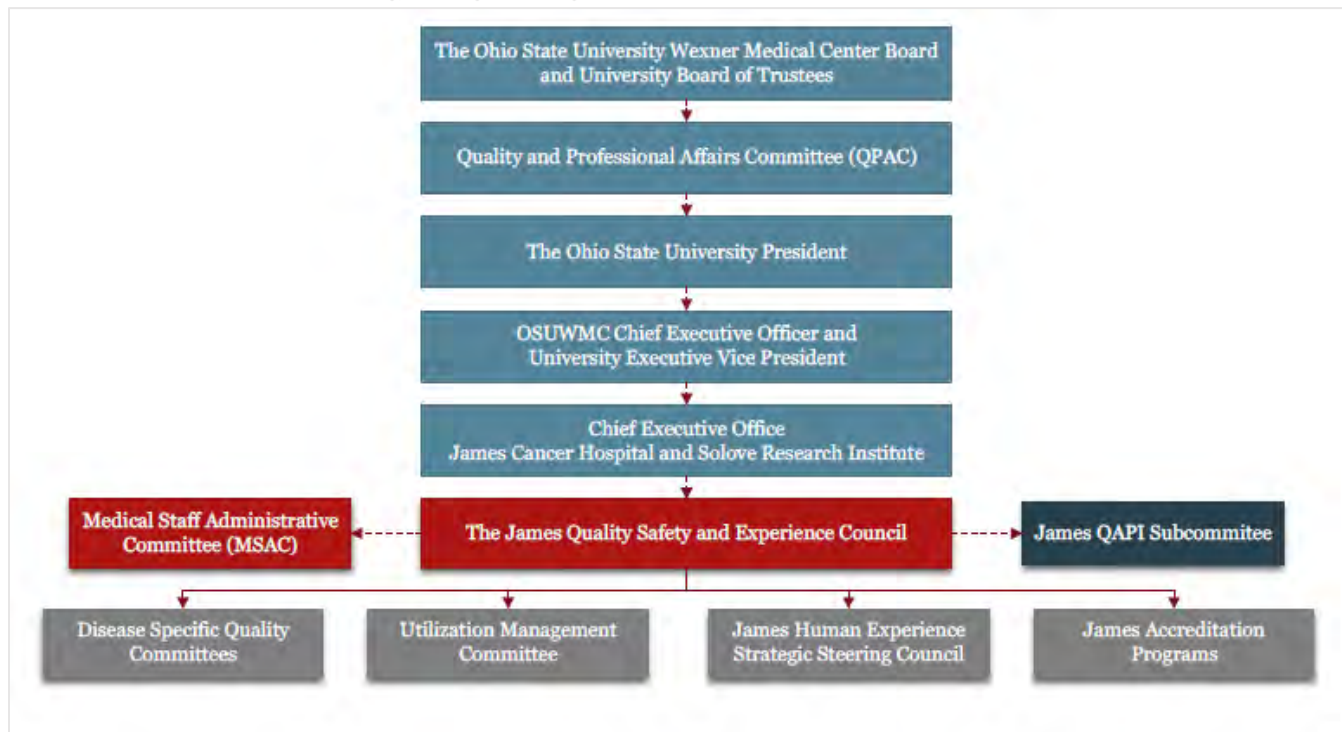
Annual Quality Plan Evaluation

The 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 Impact 2035 Strategic Plan (Attachment B) and the Long-Range Quality Plan (Attachment C). The plan for Impact 2035 includes our shared purpose for these three components: world-class care for every person, every time; relentless innovation to improve lives; and the best place to work and learn. 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: Impact 2035



Long-Range Quality Plan

World-class care for every person, every time



Exceptional Care

Safe

Industry-leading safety performance

As evidenced by a reduction in preventable harm as measured by the serious safety event rate

Patient-Centered

Exceptional experience for patients and families

As evidenced by Likelihood to Recommend scores in the top decile

Effective

Excellence in clinical outcomes

As evidenced by Vizient Q&A performance in the top decile

High reliability is the foundation of everything we do



Performance-improvement program rooted in standardized methodology



Leverage Analytics Center of Excellence to drive performance improvement around targets and outcomes



THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

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 13, 2026; and

WHEREAS on July 28, 2026, 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 and Board of Trustees hereby approve 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.



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 UNIVERSITY 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
ACCREDITATION AND POLICY	Accreditation provides support and guidance to the organization to monitor compliance with regulatory bodies. Develops and implements processes and policies for the organization to improve efficiencies and to help report findings to leadership and outside entities.
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.

DEPARTMENT	SERVICE
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.
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 system.
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.

DEPARTMENT	SERVICE
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.
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.

DEPARTMENT	SERVICE
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 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.

APPROVAL OF THE 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 May 15, 2026; and

WHEREAS on July 28, 2026, 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 and Board of Trustees hereby approve the plan for patient care services for The James as outlined in the attached Plan for Patient Care Services.



Approvals:
MSAC: 05/15/2026
QPAC:
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, every person, every discovery, every 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 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 Richard J. 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 the planning 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. This leadership team is responsible for establishing a framework for planning health care services provided by the organization, guided by the hospital's mission and strategic planning. These responsibilities include developing and implementing a planning process that defines clear, timely, and measurable goals.

The planning process also includes an assessment of our customer and community needs. This process 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 collaborates closely with all operational leaders to ensure integration of planning, evaluation, and communication processes within and between departments, to enhance patient care services and support. Collaboration occurs on an informal, daily basis, as well as formally through 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, and 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 efficiency and care from a patient's viewpoint.
- Ensuring consistent patient care standards across the continuum of care in alignment with professional practices and organizational policies and procedures. Providing job enrichment, professional development, and continuing education opportunities that support staff retention and excellence in care and service delivery. 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 improvement initiatives and establishing mechanisms to provide appropriate follow-up actions or reprioritizing in response to anticipated events.
- Implementing effective and continuously monitored programs to 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 Chief Nursing Officer

The Chief Nursing Officer is a member of the Executive Leadership Team and possesses the authority and responsibility for direct activities related to the provision of care, treatment and services within departments designated as providing care to patients.

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 to quality, safety, and innovation initiatives in partnership with the Chief Executive Officer.
- 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 throughput 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:

- 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.
- Discharge decisions, 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 ([James Medical Staff Bylaws](#)). Registered Nurses support the medical aspect of care by assessing, directing, coordinating, providing nursing care consistent with statutory requirements, according to the organization's Nursing Standards of Practice and hospital-wide policies and procedures. Allied health professionals provide patient care and services 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 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/7 days 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.

The James adheres to the Ohio Revised Code 3727.53 regarding written nursing services staffing plans, the American Nurses Association Principles for Nurse Staffing (3rd Edition, 2020), and The Joint Commission National Performance Goal 12 (2026). Additionally, we incorporate staffing recommendations from a range of specialty nursing organizations, including but not limited to the Emergency Nurses Association (ENA), American Nurses Credentialing Center (ANCC), American Association of Critical-Care Nurses (AACN), Association of perioperative Registered Nurses (AORN), American Society of Pediatric Nurses (ASPN), American Organization for Nursing Leadership (AONL), and Oncology Nursing Society (ONS).

Nursing units are staffed based on projected average daily census and patient acuity. A nurse leader evaluates both census and acuity multiple times within a 24-hour period. Staffing levels are adjusted as needed to meet patient care demands. During periods of increased patient volume or identified staffing needs within a unit, leadership may deploy appropriately trained staff through the nursing float pool and/or offer additional hours to unit nurses. When staffing shortages are anticipated due to vacancies or leaves of absence, the unit manager and director may request temporary agency nurses. Use of agency staff is a short-term measure and requires approval by the Chief Nursing Officer.

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.

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 the 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 that 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 Arthur G. James Cancer Hospital and Richard J. 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 consistent 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 each individual patient and their support system are determined through ongoing assessments conducted by qualified health professionals. Each patient care service within the organization has a defined scope of assessment responsibility. Assessment and reassessment of patient care needs occur continuously throughout the continuum of care and for the duration of the patient's contact with the organization.

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 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 the 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 the 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 can impact patient care by ensuring timeliness of services, utilizing staff resources appropriately, and maximizing 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 the quality of patient care and patient satisfaction.
- Primary nursing characteristics, such as relationship-based care, the conceptual frameworks 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 a 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 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 define the organization's responsibilities to patients, staff, physicians, and communities it serves. General guiding principles include:

- Services and capabilities offered meet 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 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 in achieving the desired patient outcomes and serve 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 12) 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, 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 appropriate 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 needs.

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 include:

- Ensuring the integrity and security of the hospital's information resources and protecting patient confidentiality.
- Developing and maintaining 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 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	Provides routine equipment evaluation, maintenance, and repair of electronic equipment, and 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 telephone triage department receives and manages telephone calls for established The James patients outside normal business hours. The call center operates 24 hours a day and seven days of the week including 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 target internal and external audiences. Manage 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. 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's records.
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 care 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 (Epidemiology Plan)
Facilities Operations	Provide oversight, maintenance and repair of the building's life, fire, 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 establishes equity for payroll.

Immediate Care Center (ICC)	Evaluate patients 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's records.
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 for 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's records.
James Patient Access Services (JPAS)	Coordinate patient registration and admissions.
Patient Care Resource Management (PCRM) and Social Services	Provide personalized care coordination and resource management for 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 requests of physician, nurse or the patient or patient support system. and utilization review.
Patient Education	Provide educational resources that facilitate patient learning and encourage the patient to take an active role in their care. 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/caregiver understanding and to reinforce the learning provided during their hospital stay or clinic visit.

Patient Experience	Develop and manage programs that support patient relations, customer service, and information desk operations. Coordinates volunteer services with volunteers providing wayfinding assistance, hosting visitors in waiting areas, serving as patient/family advisors and advocates, and assisting 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 through specialty practice pharmacists and clinical generalists. Practitioners promote optimal medication use and assist 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. Projects are intended to develop, implement, and monitor more efficient, cost-effective business processes and strategies.
Observation Unit	Provide additional bed capacity and 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. (James Quality Plan)
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, theragnostic, and brachytherapy.
Radiology Services	Provide state-of-the-art radiological diagnostic and therapeutic 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 plan of care.
Respiratory Therapy (RT)	Provide respiratory therapeutic interventions and diagnostic testing, by physician order including ventilator support, bronchodilator therapy, and pulmonary hygiene.

Environmental Health and Safety	Hospital safety personnel handle issues associated with regulations, such as EPA, OSHA, and fire safety. (Emergency Operations Plan and James Supplemental Emergency Operations Plan)
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 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, provide clinical orientation, and continued 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) activities. Timely and accurate patient placement based on level of care and service line is expedited through a capacity management system.
Transportation	Supply patients with secure and proficient transport within the 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 include but are not limited to the diagnosis and management of skin impairments, on-going wound management, treatment, and prevention measures.

APPROVAL OF THE 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 July 28, 2026, 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 and Board of Trustees hereby approve 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

Dr. J. Heard, MD, MBA
Medical Director, Ambulatory Peri-Operative Services

X Sheryl Burtch

Sheryl Burtch, DNP, MA, RN, NEA-BC
Associate Chief Nursing Officer, Surgical 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.

Approved: May 24, 2021

Date Last Reviewed: 3/8/2023, 5.23.25, 4.22.26

Date Last Reviewed: 6/24/24, 5.23.25, 4.22.26

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.

Approved: May 24, 2021

Date Last Reviewed: 3/8/2023, 5.23.25, 3.27.26, 4.22.26

Date Last Reviewed: 6/24/24, 5.23.25, 3.27.26, 4.22.26

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.

Approved: May 24, 2021

Date Last Reviewed: 3/8/2023, 5.23.25, 3.27.26, 4.22.26

Date Last Reviewed: 6/24/24, 5.23.25, 3.27.26, 4.22.26

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.

Approved: May 24, 2021

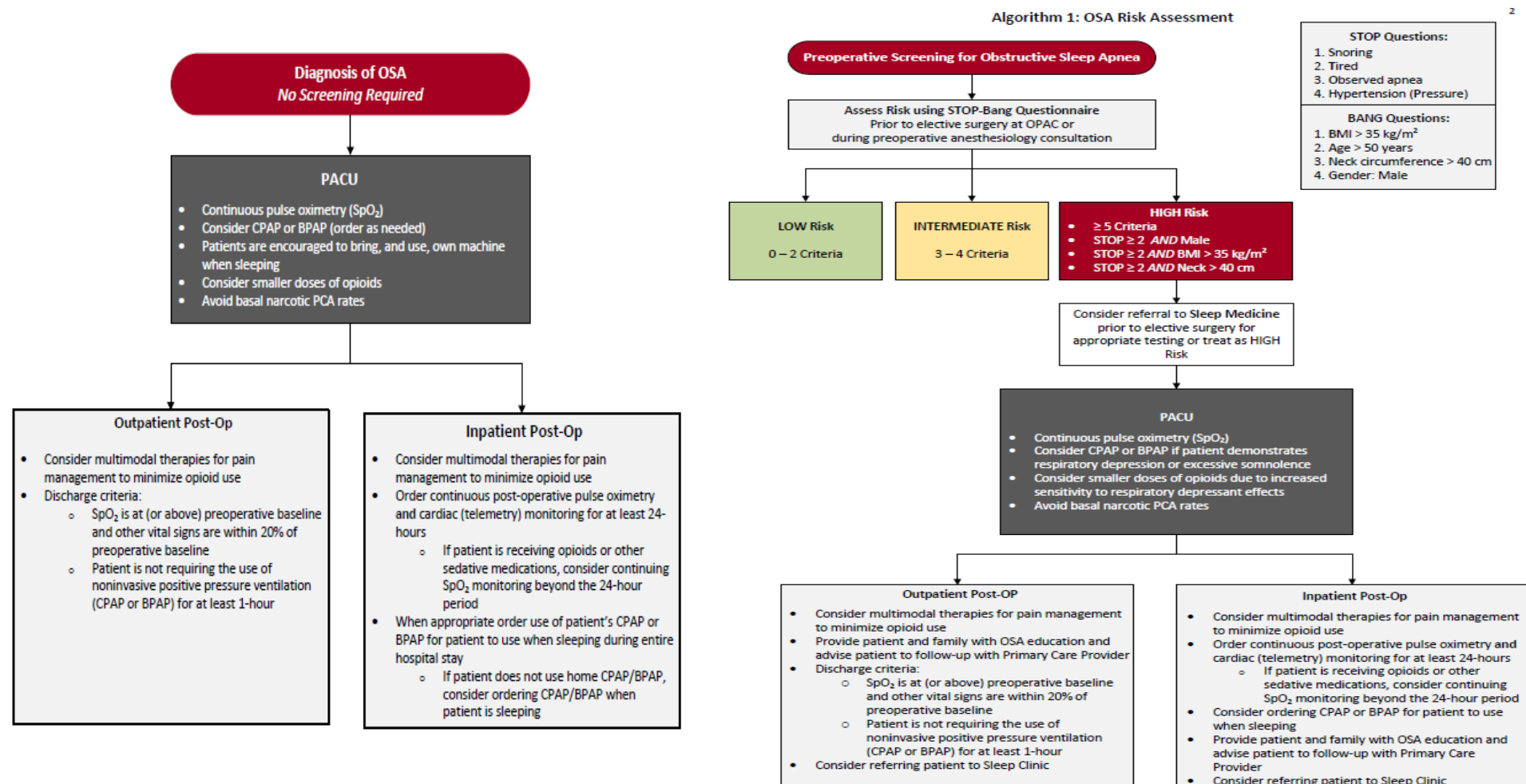
Date Last Reviewed: 3/8/2023, 5.23.25, 3.27.26, 4.22.26

Date Last Reviewed: 6/24/24, 5.23.25, 3.27.26, 4.22.26

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: May 24, 2021

Date Last Reviewed: 3/8/2023, 5.23.25, 3.27.26, 4.22.26

Date Last Reviewed: 6/24/24, 5.23.25, 3.27.26, 4.22.26

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%20282%29/Pages/61.aspx](http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/Jun7%20282%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.

Approved: May 24, 2021

Date Last Reviewed: 3/8/2023, 5.23.25, 3.27.26, 4.22.26

Date Last Reviewed: 6/24/24, 5.23.25, 3.27.26, 4.22.26

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, Robotics, Ophthalmology, Otolaryngology, 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.

Approved: May 24, 2021

Date Last Reviewed: 3/8/2023, 5.23.25, 3.27.26, 4.22.26

Date Last Reviewed: 6/24/24, 5.23.25, 3.27.26, 4.22.26

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, Robotics, Ophthalmology, Otolaryngology, Plastic Surgery, and Urology 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, Associate Chief Nursing Officer, 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.

Approved: May 24, 2021

Date Last Reviewed: 3/8/2023, 5.23.25, 3.27.26, 4.22.26

Date Last Reviewed: 6/24/24, 5.23.25, 3.27.26, 4.22.26

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.

Approved: May 24, 2021

Date Last Reviewed: 3/8/2023, 5.23.25, 3.27.26, 4.22.26

Date Last Reviewed: 6/24/24, 5.23.25, 3.27.26, 4.22.26

APPROVAL OF THE 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 July 28, 2026, 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 and Board of Trustees hereby approve 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 Garrett A. Heard

Dr. J. Heard, MD, MBA
Medical Director, Ambulatory Peri-Operative Services

X Sheryl Burtch

Sheryl Burtch, DNP, MA, RN, NEA-BC
Associate Chief Nursing Officer, Surgical 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.

Approved: July 2022

Date Last Revised: 3/8/2023

Date Last Reviewed: 6/24/2024, 5.23.25, 3.26.26

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.

Approved: July 2022

Date Last Revised: 3/8/2023

Date Last Reviewed: 6/24/2024, 5.23.25, 3.26.26

- 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.

Approved: July 2022

Date Last Revised: 3/8/2023

Date Last Reviewed: 6/24/2024, 5.23.25, 3.26.26

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.

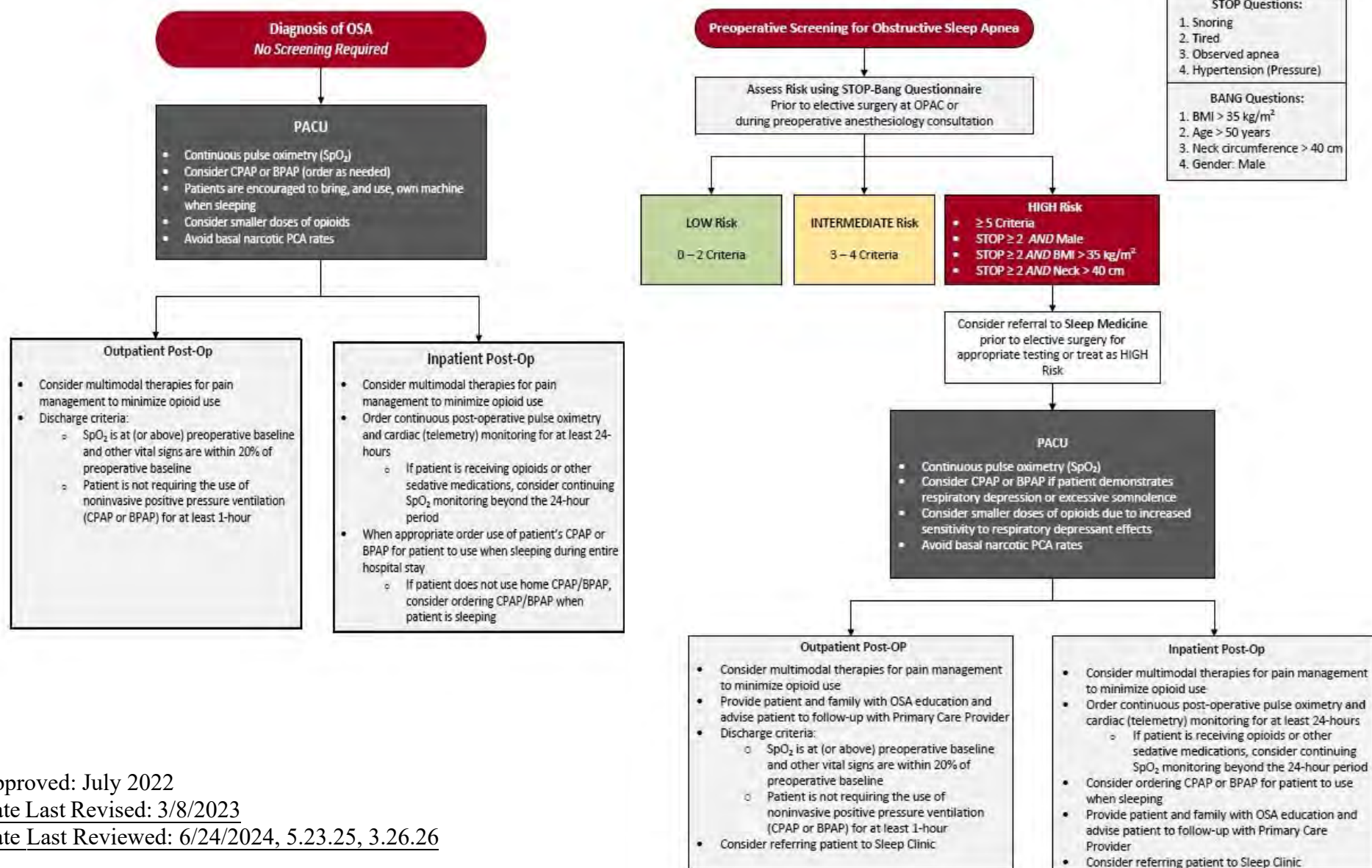
- Patients with known diagnosis of OSA that have optimized co-morbid medical conditions will be considered.
- Patients with a presumed diagnosis of OSA based on screening (STOP Bang) questionnaire, and with optimized co-morbid conditions, will be considered for the OSC if postoperative pain can be managed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

Algorithm 1: OSA Risk Assessment



Approved: July 2022

Date Last Revised: 3/8/2023

Date Last Reviewed: 6/24/2024, 5.23.25, 3.26.26

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](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.

Approved: July 2022

Date Last Revised: 3/8/2023

Date Last Reviewed: 6/24/2024, 5.23.25, 3.27.26

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.

Approved: July 2022

Date Last Revised: 3/8/2023

Date Last Reviewed: 6/24/2024, 5.23.25, 3.27.26

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, Associate Chief Nursing Officer, 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

Approved: July 2022

Date Last Revised: 3/8/2023

Date Last Reviewed: 6/24/2024, 5.23.25, 3.27.26

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.

Approved: July 2022

Date Last Revised: 3/8/2023

Date Last Reviewed: 6/24/2024, 5.23.25, 3.27.26

APPROVAL OF THE SCOPE OF CARE

**THE OHIO STATE UNIVERSITY AMBULATORY SURGERY CENTER
OUTPATIENT CARE POWELL**

Synopsis: Approval of the annual review of the scope of patient care services for The Ohio State University Ambulatory Surgery Center — Outpatient Care Powell, 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 Powell; and

WHEREAS ON July 28, 2026, 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 Powell:

NOW THEREFORE

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

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

Approved By:

X Garrett A. Heard

Dr. J. Heard, MD, MBA
Medical Director, Ambulatory Peri-Operative Services

X Sheryl Burtch

Sheryl Burtch, DNP, MA, RN, NEA-BC
Associate Chief Nursing Officer, Surgical Services

Department/ Patient Care Unit Name: The Ohio State University Ambulatory Surgery Center – Outpatient Care Powell. 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.

First Established: 4.22.26

Date Last Reviewed: 4.22.26

Date Last Reviewed: 4.22.26

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.

First Established: 4.22.26

Date Last Reviewed: 4.22.26

Date Last Reviewed: 4.22.26



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.

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.

First Established: 4.22.26

Date Last Reviewed: 4.22.26

Date Last Reviewed: 4.22.26

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 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 ASC if postoperative pain can be managed predominantly with non-opioid analgesia.

First Established: 4.22.26

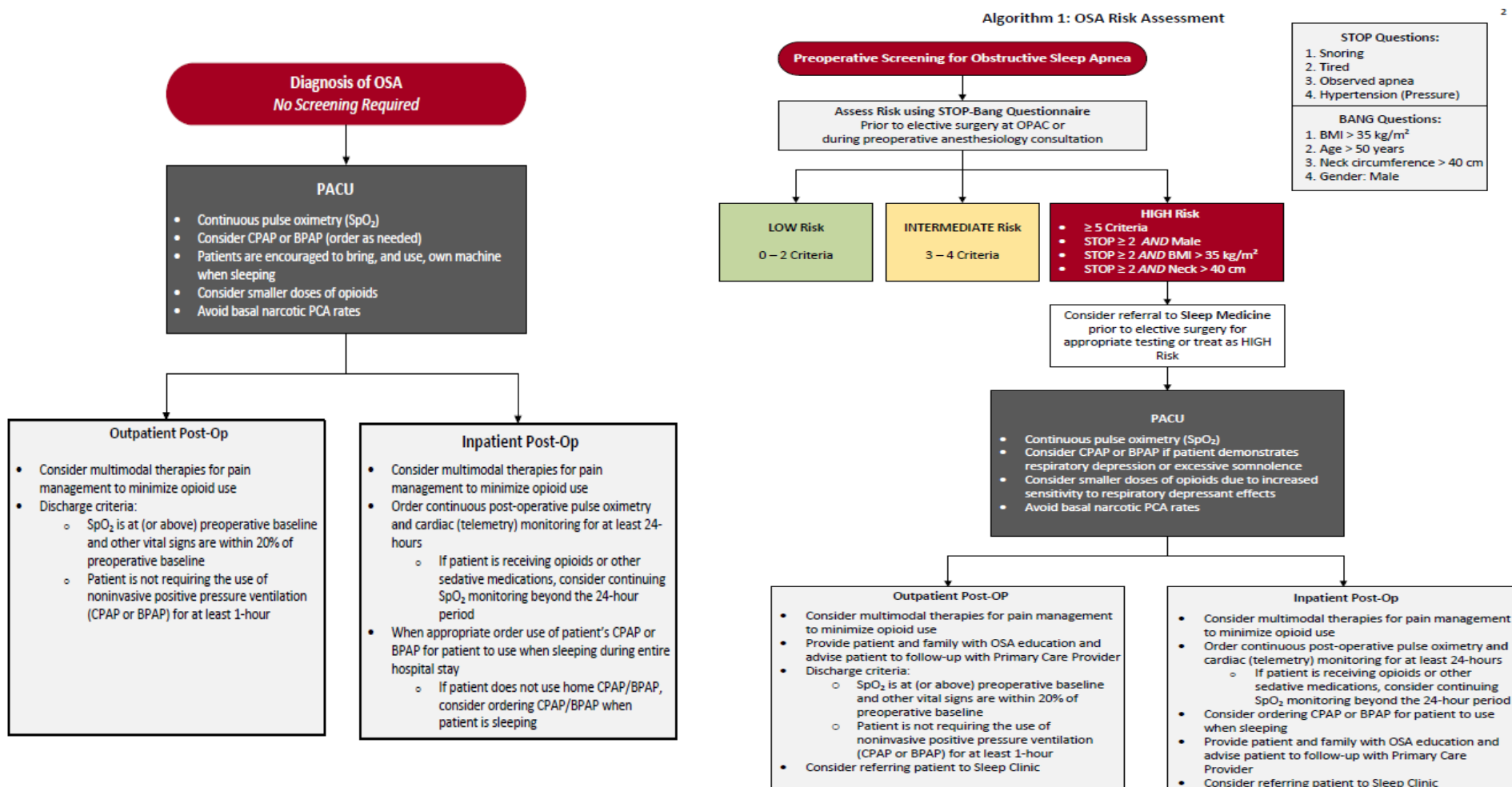
Date Last Reviewed: 4.22.26

Date Last Reviewed: 4.22.26

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>



First Established: 4.22.26
Date Last Reviewed: 4.22.26
Date Last Reviewed: 4.22.26

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%20282%29/Pages/61.aspx](http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/Jun7%20282%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.

First Established: 4.22.26

Date Last Reviewed: 4.22.26

Date Last Reviewed: 4.22.26

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:

Five Endoscopy suites and Two Procedure rooms located on the second floor of The Ohio State University Outpatient Care Powell servicing the following specialties: 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, or regional 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.

First Established: 4.22.26

Date Last Reviewed: 4.22.26

Date Last Reviewed: 4.22.26

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 servicing from Gastroenterology, Hepatology and Nutrition (GHN), General Surgery and open access referrals at 7171 Sawmill Parkway, Powell, OH 43065. The OSUWMC Board of Directors, the OSUWMC Medical Staff, in conjunction with the Ambulatory Executive Director, Ambulatory Medical Director, Associate Chief Nursing Officer, Sr. 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.

First Established: 4.22.26

Date Last Reviewed: 4.22.26

Date Last Reviewed: 4.22.26

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.

APPROVAL OF THE SCOPE OF CARE

**THE OHIO STATE UNIVERSITY AMBULATORY SURGERY CENTER
EXTENDED RECOVERY UNIT FOR OUTPATIENT CARE DUBLIN AND NEW ALBANY CLINICAL
DEPARTMENTS**

Synopsis: Approval of the annual review of the scope of patient care services for The Ohio State University Ambulatory Surgery Center — Extended Recovery Unit for Outpatient Care Dublin and New Albany Clinical Departments, 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 — Extended Recovery Unit for Outpatient Care Dublin and New Albany Clinical Departments; and

WHEREAS ON July 28, 2026, 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 — Extended Recovery Unit for Outpatient Care Dublin and New Albany Clinical Departments:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board and Board of Trustees hereby approve the scope of care for The Ohio State University Ambulatory Surgery Center — Extended Recovery Unit for Outpatient Care Dublin and New Albany Clinical Departments.

OSU AMBULATORY SURGERY CENTER
Scope of Care – Extended Recovery Unit for Outpatient Care Dublin and New Albany
Clinical Departments

Approved By:

X Garrett A. Heard

Dr. J. Heard, MD, MBA
Medical Director, Ambulatory Peri-Operative Services

X Sheryl Burtch 3.27.26

Sheryl Burtch, DNP, MA, RN, NEA-BC
Associate Chief Nursing Officer, Surgical Services

Department/ Patient Care Unit Name: The Extended PACU at The Ohio State University Outpatient Care New Albany and Outpatient Care Dublin - Ambulatory Surgery Centers.

CMS Appendix L -Ambulatory Surgical Centers

- (1) The ASC must have an effective procedure for the immediate transfer, to a hospital, of patients requiring emergency medical care beyond the capabilities of the ASC.**
- (2) This hospital must be a local, Medicare participating hospital or a local, nonparticipating hospital that meets the requirements for payment for emergency services.**
- (3) The ASC must periodically provide the local hospital with written notice of its operations and patient population served**

Approved: July 2022

Date Last Revised: 6.10.25

Date Last Reviewed: 6.10.25, 3.27.26

Definitions:

Extended Recovery: Recovery after a procedure or surgery that is prolonged by 2 hours or longer after surgery.

Non-emergent/Urgent Transfer: Transfer to OSU hospital to provide further testing and diagnosis.

Emergent Transfer: Emergent care is needed to sustain life and is transported by squad to closest facility.

Scheduled ERU Stay: Anticipated extended recovery without complications that would require remaining in the facility for up to 23hrs, 59 minutes.

Unscheduled ERU Stay: Unanticipated extended recovery without complications that would otherwise require a non-emergent/urgent transfer or an emergent transfer.

Extended Recovery Unit Length of Stay:

- Extended amount of recovery prolonged for 2 hours or longer but no more than 23 hours and 59 minutes from the “in pre-op” timestamp.

Types of patients served

- Extended Recovery Unit Patient will meet the following the medical requirements:
 1. Pain Management
 2. Oxygen Saturation (Obstructive Sleep Apnea Management)
 3. Blood Pressure Management
 4. Urinary Retention Management
 5. Non-symptomatic Blood Loss Management
 6. Nausea and vomiting

Accompanying Adult:

One person must always stay with patient (if visitors must switch out: one stays until relieved by the next visitor).

Patient Nutrition:

- Prepared turkey sandwiches will be sent OH Bistro at ASC site.

- o OCNA will pick up on Monday for all sandwiches for the week
- o OCD will pick up on Monday and Wednesday for all sandwiches for the week
- Microwavable soups will be available via shelf stock for each center.
- Frozen foods will be available for special Diets- Kosher, Gluten Free, Vegan.
- Expiration dates on all refrigerated food will be checked Monday, Wednesday, and Friday of each week.
- Expirations dates on all shelf food and snacks, vegan and gluten free patient snacks and diabetic frozen food will be checked pm Friday of each week.

Pharmacy Guidelines:

- Providers will be instructed to educate all patients to bring home medications that cannot be missed in a 23-hour period (exception is pain medication, which the facility will provide).
- Home medications will only be used when not stocked or available by pharmacy.
- All meds will be locked and only be witnessed and documented by nurse.
- If patient has planned extended recovery or if known prior to 2:30pm then the pharmacist will identify the medications, after 2:30pm home medications will be identified by 2 RNs and verified utilizing the reference guide:
<https://online.lexi.com/lco/action/home?siteid=67309>

Lab Guidelines: *After hours waive testing capability:*

- | | |
|-------------|--------------|
| * Glucose | * APL |
| * Potassium | * ALT |
| * Sodoi, | * AST |
| * Co2 | * TBili |
| * Chloride | * ALB |
| * Calcium | * TP |
| * BUN | * Hemoglobin |
| * Creatine | |

Approved: July 2022

Date Last Revised: 6.10.25

Date Last Reviewed: 6.10.25, 3.27.26

Security: Will be provided for both campuses after hours.

Escalation Process for Advanced Practice Professional: The attending Physician will provide contact information (for 1 to 3 persons to be called/paged/texted) on the Surgeon/Physician Pre-operative Checklist Form. for after-hours/ERU questions and concerns. The attending surgeon/physician would be required to list a pager number, cell phone or some contact information on the Surgeon Pre-operative Checklist sheet which would be verified by the Pre-op and PACU nurses.

References:

Gabriel, Rodney A. MD*†; Waterman, Ruth S. MD†; Kim, Jihoon MS*; Ohno-Machado, Lucila MD, PhD* A Predictive Model for Extended Postanesthesia Care Unit Length of Stay in Outpatient Surgeries, Anesthesia & Analgesia: May 2017 - Volume 124 - Issue 5 - p 1529-1536 doi: 10.1213/ANE.0000000000001827

https://journals.lww.com/anesthesia-analgesia/Fulltext/2017/05000/A_Predictive_Model_for_Extended_Postanesthesia.28.aspx

<https://osumc.policytech.com/dotNet/documents/?docid=92753>

Approved: July 2022

Date Last Revised: 6.10.25

Date Last Reviewed: 6.10.25, 3.27.26

**APPROVAL OF THE 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 10, 2026; and

WHEREAS on July 28, 2026, 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 and Board of Trustees hereby 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 as outlined in the attached University Hospitals Contracted Services Annual Evaluation Report.

**APPROVAL OF THE 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 July 17, 2026; and

WHEREAS on July 28, 2026, 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 and Board of Trustees hereby approve 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.



CONTRACTED SERVICES EVALUATION

COMPLETED: CALENDAR YEAR 2025

CONTENTS

OVERVIEW	2
CONTRACTS BY CATEGORY	2
REGULATION OF CONTRACTED SERVICES.....	3
COMPLIANCE ACTIVITIES	4
DATA COLLECTION	4
IMPROVEMENTS MADE WITHIN THE PAST YEAR.....	5
FOLLOW UP NEEDED.....	5
BETWEEN PROVIDER NUMBERS.....	6
CONCLUSION	6
APPENDIX A– LIST OF EXTERNAL CONTRACTS.....	7
APPENDIX B– SERVICES SUPPLIED TO THE JAMES FROM UNIVERSITY HOSPITAL	14
APPENDIX C – SERVICES SUPPLIED TO UNIVERSITY HOSPITAL FROM THE JAMES.....	15
APPENDIX D- DEPARTMENTS REQUESTING FOLLOW UP	16
APPENDIX E – VENDOR IMPROVEMENTS FROM 2024 EVALUATIONS.....	17

OVERVIEW

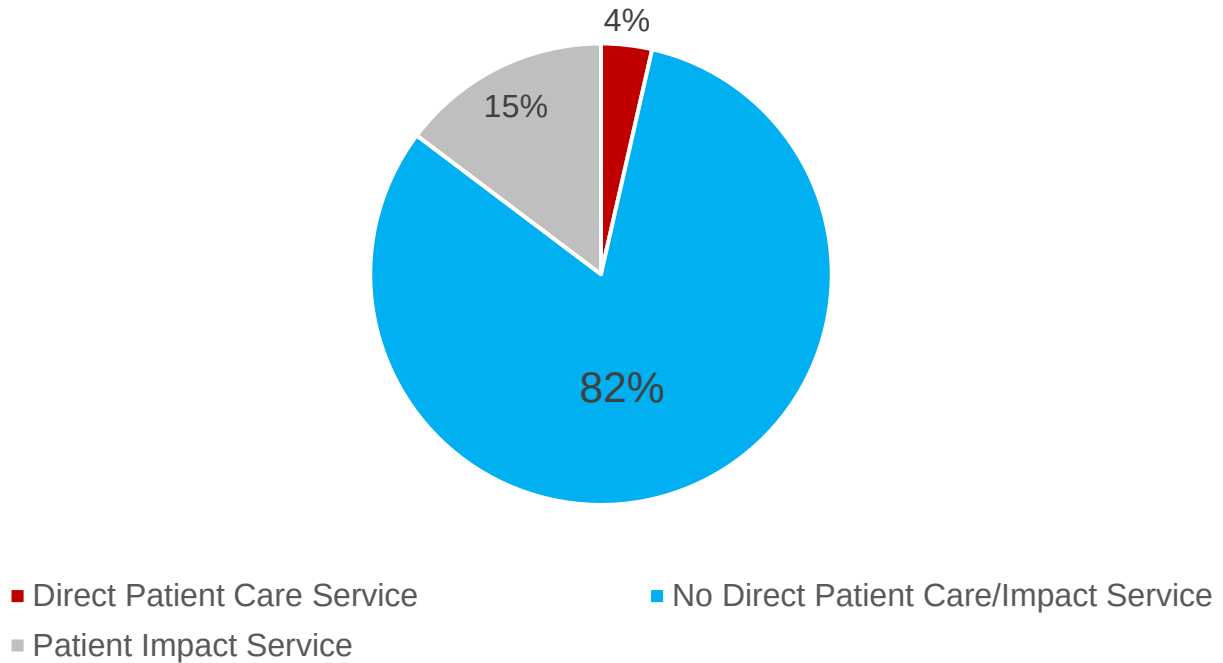
Annually, The Ohio State University Wexner Medical Center (OSUWMC) and Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (The James) complete an evaluation for contracted services. Evaluations are completed for compliance with the Joint Commission's (TJC) Leadership standard – LD.13.03.03 – 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 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 'Healthcare 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

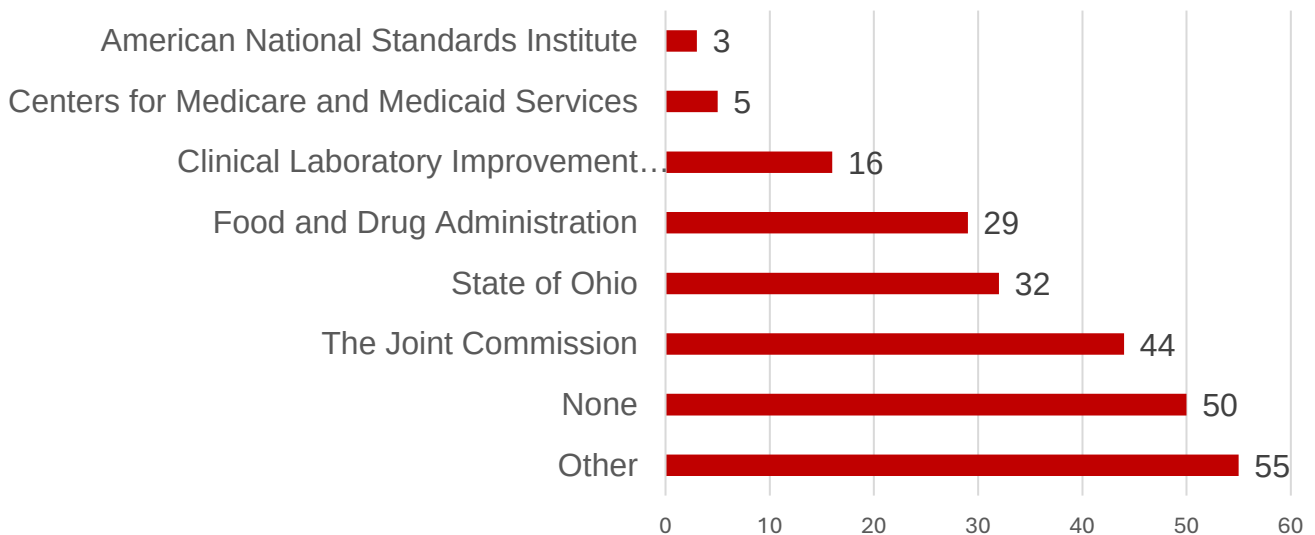
Direct Patient Care Service	Health care that involves the examination of patients, treatment of patients (e.g. nurses, dialysis providers, radiologists) and/or preparation for diagnostic tests and procedures, including services (e.g. remote monitoring) used in the clinical management/diagnoses of the patient.
Patient Impact Service	Suppliers of services that effect a patient's environment, typically in the hospital room (e.g. environmental services, florists, linen, pest control, preventative maintenance)
No Direct Patient Care/Impact	Suppliers of business services that the hospital and/or clinic uses to help manage a specific part of their business but do not have a direct impact on the patient (e.g. outside window washer, auditor, copy machine service contract).



For calendar year 2025, completed evaluations totaled 147. See Appendix A. The overall evaluation completion rate (71%) is a 15% increase from 2024 (56%). The remaining incomplete evaluations have been escalated to leadership for follow-up.

REGULATION OF CONTRACTED SERVICES

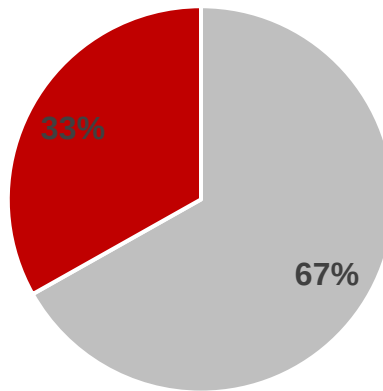
WHAT REGULATORY BODY IS THE CONTRACTOR/VENDOR ACCREDITED, LICENSED, OR CERTIFIED BY?



Other regulatory bodies included the City of Columbus, the Drug Enforcement Agency, Accreditation Council for Graduate Medical Education, and Association of Air Medical Services.

COMPLIANCE ACTIVITIES

ARE PERFORMANCE/QUALITY METRICS BEING COLLECTED?

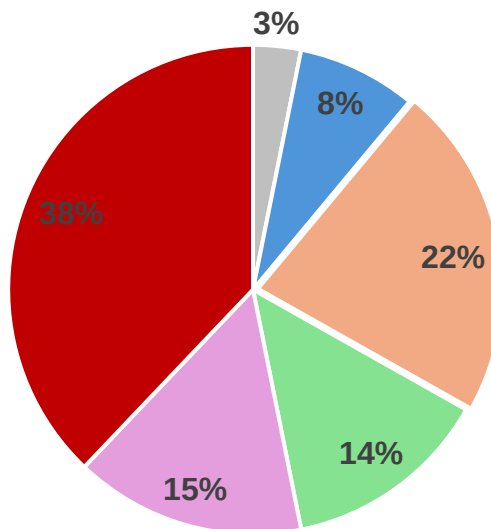


■ Yes ■ No

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.

DATA COLLECTION

ARE PERFORMANCE/EFFICIENCY/QUALITY METRICS BEING COLLECTED?

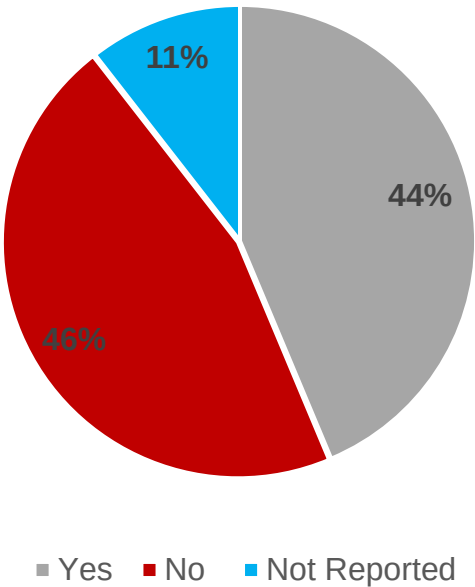


■ Annually ■ Quarterly ■ Monthly ■ As Requested ■ Other ■ Not Reported

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. 13.03.03, element of performance 2 requirement that 'The governing body is responsible for all services provided in the hospital, including contracted services. The governing body assesses that services are provided in a safe and effective manner and takes action to address issues pertaining to quality and performance.'

IMPROVEMENTS MADE WITHIN THE PAST YEAR

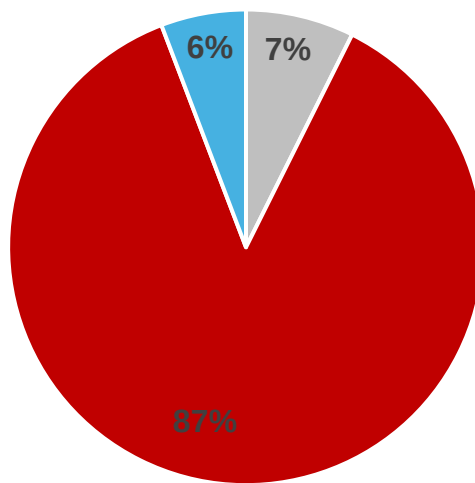
DID THE CONTRACTOR/VENDOR MAKE ANY IMPROVEMENTS IN THE PAST YEAR?



Overall, 44% of respondents reported improvements within the past year, which remains consistent from CY2024. Improvements included additional report capability, upgraded ambulances, promptly addressing issues, implementation of reporting dashboards, return to in-person training, and reduced wait times.

FOLLOW UP NEEDED

WOULD YOU LIKE SUPPLY CHAIN TO FOLLOW UP WITH YOU TO ADDRESS CONCERNS ABOUT THIS CONTRACTOR/VENDOR?



■ Yes ■ No ■ No Response

A list of the departments that requested follow-up is listed in [Appendix D](#).

BETWEEN PROVIDER NUMBERS

SERVICES PROVIDED BETWEEN PROVIDER NUMBERS

OSUWMC purchases and evaluated twenty-one (21) services from The James. Those services include but are not limited to Infusion, Pastoral Care, Interventional Radiology, and Chemotherapy Nurse Float Pool. [See Appendix C](#).

The James purchases and evaluated twenty-seven (27) services from OSUWMC. Those services include but are not limited to Medical Information Management, Nutrition, Legal, and Registration. [See Appendix B](#).

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.

APPENDIX A – LIST OF EXTERNAL CONTRACTS

Contract Name	Description
3M COMPANY	MedSurg Commit 3M Housekeeping and Laundry Chemicals
A&R Pest Solutions, LLC.	Pest Control Services - OSUWMC Ambulatory
ABBOTT LABORATORIES INC	M2000 Equipment Service
Abigail D Merriam	Abigail D. Merriam contract for James Care for Life
ACELIS CONNECTED HEALTH SUPPLIES	VADWatch Data Access & Patient Remote Monitoring Services
ADAIR,JEFFREY ROBERT	Chaplaincy Services
ADVANCED STERILIZATION PRODUCTS	Service Agreement Amendment Schedule A
AGILITI HEALTH INC	Specialty Bed Rental Service (Not including Vertical Beds) amendment added 2020 to add services of preventative maintenance and repair / bed shop
AIR FORCE ONE INC	HVAC, Preventative Maintenance and Repair, Services, Parts and Equipment
Alliance Healthcare Solutions LLC	Staffing Services
AMER NAT RED CROSS & ITS CONST CHAP & BR	Therapeutic Apheresis
AMERICAN KIDNEY STONE MANAGEMENT LTD	Extracorporeal Shockwave Lithotripsy Equipment and Technician Rental
AMERICAN MESSAGING SERVICES LLC	Pagers
AMERICAN ORTHOPEDICS INC	American Orthopedics Inpatient Bracing and Orthotics
ARJO INC	bed and support surfaces for rental... rotoprone specific
ARUP LABORATORIES	ARUP Commercial Reference Lab Testing and Services
ASIST TRANSLATION SERVICES INC	Interpretation Services
AYA HEALTHCARE INC	HR AYA MSA Agreement
Barclay Water Management, Inc.	water treatment
BARTON MALOW CO	General Trades for Repair and Maintenance and Painting
BOILER TECH INC	Boiler PM & Repair Supplier - Building Assignments in contract
BRAINLAB INC	Curve Navigation Service Agreement - UH Main - Attached To Airo CT - 7 year agreement
BROCON CONSTRUCTION INC	General Trades for Repair and Maintenance and Painting
BUTTERFLY NETWORK INC	Ultrasound Probes
Care.AI	Care.AI license agreement
CARL ZEISS MEDITEC INC	Forum Licenses
CATHOLIC DIOCESE OF COLUMBUS	Chaplaincy service contract 2024
CBORD GROUP INC	The CBORD Group Food Service Software

Contract Name	Description
CEMS OF OHIO INC	MedCare Transportation Contract
CHAMPA,LANE	Lane Champa contract for James Care for Life
Chanl Health	Master agreement for Chanl Health Connect Software platform
Chapel Electric Co LLC	Low Voltage under 600 amp Electrical Services
Chapter Advisory LLC	Chapter Partner For Medicare Service agreement
CHEM AQUA INC	Chem-Aqua Water Treatment
CISCO SYSTEMS INC	Cisco Call Manager EA
CITY APPAREL INC	Operating Room Scrub Rental Distribution and Dispensers
Claypool Electric	Low Voltage Electric PM and Service
CLINICAL COMPUTER SYSTEMS INC	Software and Service
Collective Medical Technologies Inc	This agreement is a pilot program for care management of patients transitioning from inpatient to post-acute stays.
COLLEGE OF AMERICAN PATHOLOGISTS	EPIC Document Templates
COMMERCIAL PARTS & SERVICE OF OHIO INC	Ice Machine PM and Repairs
CONNEXALL USA INC	IT Alarm Management System Software
CONSENSUS MEDICAL SYSTEMS INC	VascuPro Support
CRA HEALTH LLC	breast cancer risk assessment Software
CRNA LOCUM LLC	HR Temp Staffing - CRNA
CRYSTAL CLEAN POWER WASH &PAINT SERVICE	General Trades for Repair and Maintenance and Painting
DASCO CAPITAL OHIO LLC	DME
DAY FUNERAL SERVICE	Morgue Services
DEAF SERVICES CENTER INC	Interpretation Services
DEBRA-KUEMPEL INC	HVAC, Preventative Maintenance and Repair, Services, Parts and Equipment Assignments for PM Brain and Spine Doan Hall Harding Rhodes Hall NO CHILLERS
EC2 SOFTWARE SOLUTIONS LLC	Radiation Oncology Software
EDM XPRESS CLEANING SOLUTIONS LLC	Housekeeping and flushing services
Elevate PFS Holdings Inc	Medicaid Eligibility Service RFP Contract
ELFORD INC	General Trades for Repair and Maintenance and Painting
ELITE CONSTRUCTION DESIGN MANAGMENT LLC	General Trades for Repair and Maintenance and Painting
EMORY UNIV	Emory Medical Laboratories Service Agreement 2016
EPIC SYSTEMS CORPORATION	EMR Software
EUROFINS VIRACOR	At home CMV testing

Contract Name	Description
FB Olentangy Suite LLC	Hotel Service for Patient Lodging Program - Fairfield Inn & Suites Columbus
FERGUSON CONSTRUCTION COMPANY	General Trades for Repair and Maintenance and Painting
Floyd Lee Locums Inc	HR OSUP - Locums + Advanced Practice Staffing
FOLLETT LLC	Follett Ice Makers, Water, and Ice Dispensers
FORTEC MEDICAL INC	Laser Rental and Technician Labor Services
FRED HUTCHINSON CANCER CENTER	Reference lab agreement - Seattle Cancer Care Alliance
FRESCO FOOD GROUP LLC	Nutrition Services GUEST RESTAURANT
FRESENIUS USA MARKETING INC	Fresenius Dialysis Machine Service Agreement
FUJITEC AMERICA INC	Elevator PMs and Repairs
GE HEALTHCARE	GE Healthcare Echo Pacs
GE HEALTHCARE IITS USA CORP	GE Centricity CVIS Cath Lab
GEBHART, JENNIFER KAY	Jamescare for Life (JENNIFER KAY GEBHART)
GEIGER BROTHERS INC	HVAC PM AND REPAIR CONTRACT. 2025-IND-254-RFP
GENEDX INC	Reference Lab Agreement
Georgia-Pacific Consumer Products LP	MedSurg Commit Georgia Pacific Sanitary Paper
GILBANE BUILDING COMPANY	General Trades for Repair and Maintenance and Painting
GLOBUS MEDICAL INC	Globus EHUB E3D Spine Navigation
Heartistic Transformations Art Therapy	Jamescare for Life (HEARTISTIC TRANSFORMATIONS ART THERAPY)
HILSCHER-CLARKE ELECTRIC COMPANY	Low Voltage Electrical Service
Histotrac - One lambda - Thermo Fisher Scientific	Lab Software
HMPC A JOINT VENTURE	The James, IPH, Rhodes Hall, Doan Hall, Brain and Spine, Ross Hall HVAC Preventative Maintenance and Repair - enterprise wide if needed.
HRS	Fisher Healthcare Lab Distribution Acute
HUDMED LLC	Supplier provides OR deep cleaning services
ICON Exchange LLC	HR OSUP - Locums + Advanced Practice Staffing
IMPEDIMED INC	License for three Sozo Systems
INSPIRATA INC	Digital Pathology Outsourcing Hardware, Software and Services
Integra Testing	HVAC Air Balance Services
INTOUCH TECHNOLOGIES INC	Telemedicine Software and Hardware
INTUITIVE SURGICAL INC	Agreement 408906 - Xi Surgeon Console and a SimNow Skills Simulator Loaner Agreement Amendment to extend
iThink	CliniThink MLA, EULA, SOW, and Order Form
J & J COATINGS LLC	General Trades for Repair and Maintenance and Painting

Contract Name	Description
Jackson & Coker Locum Tenens LLC	HR OSUP - Locums + Advanced Practice Staffing
Janet Wiltjer	Jamescare for Life (JANET WILTJER)
Jeff Adair	Chaplaincy Services
Jimmy McFadden	Chaplaincy Service Contract
Joanna Samuelson	Chaplaincy Services
JOHNSON & FISCHER INC	General Trades for Repair and Maintenance and Painting
JOHNSON & JOHNSON HEALTH CARE SYSTEMS	Biosense Webster Carto SmartAblate PSA
JOHNSON CONTROLS INC	Fire suppression enterprise wide OSUMC. managed by OSUMC FOD
KAHOE	Air Balance Supplier
KARL STORZ ENDOSCOPY-AMERICA INC	KARL STORZ ON-SITE ENDOSCOPIC SPECIALIST SERVICES AGREEMENT (not temporary services)
KCI USA INC	Wound VAC Agreement Final
Kelly Vaughn	Kelly J. Vaughn contract for James Care for Life
KHINexspan LLC	Patient Rail Supplier
KIDRON ELECTRIC INC	HVAC Services - Wooster company - Joint bid OSUMC lead
KONE INC	Elevator PMs and Repairs
KOUSTIC KLEAN INC	Supplier provides services for air duct cleaning and nutritional services area cleaning of equipment.
KREG THERAPEUTICS INC	verticalization/standing and tilt bed
Kristin Schoeff	Jamescare for Life (SCHOEFF,KRISTIN)
LAB ONE INC	Quest Diagnostics Laboratory
LANGUAGE LINE SERVICES INC	Interpretation Services
LAUREL BRIDGE SOFTWARE INC	Subscription Agreement
Laurel Health Care Company	Skilled nursing facility service contract
LEGACY MAINTENANCE SERVICES LLC	Terminal Cleaning and Maintenance for all phases of IPH until hand off.
Legion Healthcare Partners, LLC	Proton Therapy Billing Consulting Service Contract
LEICA MICROSYSTEMS INC	Leica Bond Interface Software
LEPI ENTERPRISES INC	Abestos Abatement Services
Lester, Michael	Music Service for James Care for Life
Living Story Tattoo L.L.C.	Tattoo service for breast cancer patients
Lyft Healthcare Inc	Transportation Services
LYNKARE INC	James Tumor Board Software Solution
MAKO SURGICAL CORP	Stryker Mako Robot PM and Service
MARTIN CARPET CLEANING CO INC	Floor Mat Rental Services
Mason, Donald Asa	Donald Mason Chaplaincy Service Contract
MCG HEALTH LLC	OSUHP MCG Health
MEDICAL GRAPHICS CORPORATION	OSU BreezeConnect MU
MEDLINE INDUSTRIES INC	Medline EBSI Risk Share Agreement

Contract Name	Description
MEDTRONIC USA INC	Touch Surgery DS1 Enterprise Agreement
MERRIAM, ABIGAIL D	Abigail D. Merriam contract for James Care for Life
MESSER LLC	Messer Bulk Medical Gases
MID AMERICAN CLEANING CONTRACTORS INC	Custodial Services for Ambulatory, Rehab, and other clinical spaces Floor cleaning included per amendment
MIDWEST ELEVATOR COMPANY INC	Elevator PMs and Repairs (including ATS)
MORGAN SERVICES INC	Linen and uniform laundry
MRG INC	3rd Party Post Discharge RFP Software solution
MyMobility	MyMobility Agreement
Nationwide Children's Hospital Inc	Nationwide Childrens Hospital Pediatric Echocardiograms
NEUROVIRTUAL USA INC	Sleep Lab Neurovirtual Software
NEXSPAN HEALTHCARE LLC	Patient Rail Supplier
NUVASIVE CLINICAL SVCS MONITORING INC	IONM Service
OHIO HEATING & REFRIGERATION	HVAC, Preventative Maintenance and Repair, Services, Parts and Equipment PM East
OHIO MEDICAL TRANSPORTATION INC	Air and Ground Transport Services
OhioHealth Corporation on behalf of its Riverside Methodist Hospital, Grant Medical Center and Dublin Methodist Hospital	Grant (Ohio Health) Master Affiliation LOA and Extension For Resident Rotation
Olentangy C-Bus Buckeye LLC	Hotel Service for Patient Lodging Program - Fairfield Inn & Suites Columbus
PALADIN HEALTHCARE LLC	Patient Rail Purchase
PATHOLOGISTS ASSISTANT CONSULTING LLC	HR Locums Contract
Patricia Riley	Patricia A. Riley contract for James Care for Life
PAXMAN US INC	Paxman Scalp Cooling Agreement
PBJ CONNECTIONS INC	Jamescare for Life (PBJ CONNECTIONS INC)
PLUNKETTS PEST CONTROL INC	Pest Control Services - Joint Contract
PREMIER GENERAL CONSTRUCTION LLC	General Trades for Repair and Maintenance and Painting
PREVENTATIVE MAINTENANCE SERVICE OF OHIO	Max spend \$75k
PRINGLES INC	Air Duct Cleaning Joint commission requirement
PROCEPT BioRobotics Corporation	PROCEPT HYDROS Robotic System
PRO-FLOW PLUMBING AND DRAIN CLEANING	Drain Cleaning
Proprio INC	Proprio Evaluation Agreement
PROVATION MEDICAL INC	Imaging Software License
Quest laboratory Diagnostic (Lab One)	Quest Diagnostics Care360 Data Exchange Technology Software
RENTOKIL NORTH AMERICA INC	Pest Control Services - University

Contract Name	Description
REZOD LLC	General Trades for Repair and Maintenance and Painting
RHOADS CONSTRUCTION INC	General Trades for Repair and Maintenance and Painting
Robert Daron Larson	Independent contract for services for Jamescare for Life
ROBERTS SERVICE GROUP INC	Electrical Services
ROCKWOOD BUILDERS LTD	General Trades for Repair and Maintenance and Painting
RUSCILLI CONSTRUCTION CO	General Trades for Repair and Maintenance and Painting
SCHOEFF,KRISTIN	Jamescare for Life (SCHOEFF,KRISTIN)
SDG PARTNERS LLC	Nutrition Services GUEST RESTAURANT
SENTRY IMAGING SERVICES LLC	MRI/CT CLEANING SERVICES
SETTERLIN BUILDING COMPANY	General Trades for Repair and Maintenance and Painting
SIEMENS MEDICAL SOLUTIONS USA INC	Share360 Master Service Agreement + Service Schedule
SMITHS MEDICAL ASD INC	Pump Software for Pharmacy
STAFF CARE INC	HR OSUP - Locums + Advanced Practice Staffing
STERICYCLE INC	Comprehensive Proactive Sharps Disposal Service with Reusable Containers and regulated waste
Sweet Cleaning Solutions LLC	Pharmacy terminal cleaning services
SYSTEMLINK INC	SystemLink Tissue Typing Software
Tamar Sorin	Independent Contractor for James for Life
TEDESCO AND AFFILIATES LLC	DonorSearch - A grateful patient screening SW to provide wealth capacity ratings for our patient population
TEEMOK CONSTRUCTION INC	General Trades for Repair and Maintenance and Painting
TELEFLEX LLC	Preventative Maintenance Autocat 2 Wave, 9 units
THAI PALACE INC	Nutrition Services Guest Restaurant
THE KINGS CLEAN LLC	Custodial Services for Ambulatory, Rehab, and other clinical spaces
The Laser Institute	
THINK Surgical Inc	TMINI Miniature Robotic System Sales Agreement
THYSSENKRUPP ELEVATOR CORP	Elevator PMs and Repairs (including AGVs)
Tony Cornett	Tony Cornett Chaplaincy Contract
TOWER EQUIPMENT CO INC	Ameriwater Service Agreement- Main Campus Central and Portable ROs
TOWNE PARK HOLDINGS	Valet Service
TP MECHANICAL CONTRACTORS INC	HVAC, Preventative Maintenance and Repair, Services, Parts and Equipment
Translogic Corporation d/b/a Swisslog Healthcare and affiliates	Pneumatic Tube System Support and Maintenance

Contract Name	Description
TRANSPARENTLY LLC	Loyal Health - Transparently SW for Marketing
TRIMBLE CONSTRUCTION COMPANY LLC	General Trades for Repair and Maintenance and Painting
TRINITY GUARDION LLC	Pricing agreement and SOW for bed and stretcher mattress inspection
UNIVERSAL PROTECTION SERVICE	Security Staffing weapons detection
UPMC PRESBYTERIAN SHADYSIDE INC	UPMC Reference Lab Agreement
US TOGETHER INC	Interpretation Services
VANCE,RAY A	Chaplaincy Services
VAUGHN,KELLY J	Kelly J. Vaughn contract for James Care for Life
VERNON INC	Curtain Cleaning Services 2025-IND-235-RFP
VERSITI INDIANA INC	Master with Addenda
VIDATAK LLC	Patient Communication App, Picture Board
VISTA Staffing Solutions, Inc	HR LOCUMS SEARCH AND PLACEMENT
VITAL IMAGES INC	Medical Imaging Products Licenses
VITAL IMAGES INC - 4017.11844C	Medical Imaging Products Licenses
VIZ AI INC	CT Angiogram and CTP AI Software
WELLSENSE INC	Three year service and pad replacement agreement for Wellsense VU system.
Wellsky	Wellsky Master agreement for Careport
WILSON,DAVID A	Chaplaincy Services
WILTJER,JANET	Jamescare for Life (JANET WILTJER)
WISER TRANSFORMATION	General Trades for Repair and Maintenance and Painting
ZIMMER US INC	MyMobility Agreement

APPENDIX B – SERVICES SUPPLIED TO THE JAMES FROM UNIVERSITY HOSPITAL

Service
Ancillary Float Pool Services
Behavioral Emergency Response Team Services
Care Management Services
Central Sterile Processing
Clinical Engineering Services
Credentialing Services
Dialysis and Apheresis Nurse Services
Fetal and Uterine Nurse Monitoring Services
Heart and Vascular Services
Interventional Radiology Call Services
Interventional Radiology Technician Services
Laboratory Services
Legal Services
Medical Information Management
Nursing Float Pool Services
Nutrition Services
Occupational Health and Wellness
Ohio Department of Rehabilitation and Corrections Nursing Services
Pastoral Care Services
Pharmacy Services
Physician Advisor Services
Radiologic Services
Registration Services
Rehabilitation Services
Respiratory and Pulmonary Services
Security
Solid Organ Transplant Nursing Services

APPENDIX C – SERVICES SUPPLIED TO UNIVERSITY HOSPITAL FROM THE JAMES

Service
Ancillary Float Pool Services
Apheresis and Dialysis Nurse Services
Chemotherapy Nurse Float Pool Services
Emergency Oncology Pod Services
Environmental Management Services
Equipment Distribution
High-Level Disinfection and Ambulatory Sterilization
Infusion Nurse Services
Interventional Radiology
Interventional Radiology Call and Patient Clinic Services
Interventional Radiology Technician Services
Laboratory Services
Management Of Perioperative Services
Materials Management
Nursing Float Pool Services
Nutrition Services
Pastoral Care Services
Perioperative Policy and Procedure Support Services
Pharmacy Services
Radiologic Services
Wound Ostomy Services

APPENDIX D– DEPARTMENTS REQUESTING FOLLOW UP

Department	Vendor	Reason for Request
Perioperative Services	City Apparel	Equipment reliability
Laboratory	Histotrac	Software validation
Facilities	Midwest Elevator	Invoice timeliness
Women and Infants	Nationwide Children's Hospital	Agreement needs updated.
Neurosurgery	Proprio	Trial period ending

*Follow up requests have been sent to Supply Chain for resolution.

APPENDIX E– VENDOR IMPROVEMENTS FROM 2024 EVALUATIONS

Vendor	Improvement(s) Made
Abigail D Merriam	Assisted in developing new Gentle Yoga programming.
Advanced Sterilization Products Services Inc.	Resolved equipment issues with reader by issuing replacement equipment.
Agiliti	Moved to onsite storage space for quicker deliveries at Ackerman
Air Force One	Standardized and documented review of performance and quality metrics.
American Red Cross	Arrival to unit
Aya	KPI improvements in contractual areas.
Boiler Tech Inc	The contractor improved performance by addressing prior issues promptly, improving communication, and delivering more consistent, higher-quality work.
Carl Zeiss	System upgrades completed at least yearly with additional patching throughout the year.
Catholic Diocese of Columbus	We increased our priest coverage to ensure 7 day a week coverage.
CBORD Group Inc	Upgrade to cloud-based service
CEMS of Ohio Inc.	Upgrade of actual ambulances (fixed asset) to replace significantly aged vehicles.
City Apparel	More on site support
Clinical Computer Systems	System upgrades at least yearly with regular patching throughout the year.
College of American Pathologists	Preventative maintenance updates as required by accreditation agencies
Connexal USA INC	Standard bug fixes and patching
DASCO Home Medical Equipment	Improvements were made to the following: respiratory referral process; spinal bracing offerings; pulmonary device supply replenishment process
Day Funeral Services	Day Funeral Service has improved its process for providing decedent documentation for private autopsy pick-ups by ensuring that a copy of the decedent's state ID is obtained to confirm proper identification prior to transport.
Deaf Services Center INC	They have switched to using a dashboard instead of just emails so that we can now easily look up interpreter coverage by date and time.
Debra-Kuempel INC	The contractor improved performance by addressing issues promptly, improving communication, and delivering consistent, quality work.
Donnie Mason	Donnie has improved on taking more shifts and flexibility of schedule
EC2 Software solutions	updated drivers and reports as well as new version installed across our organization
Elevate	This is a new vendor, so improvements are made consistently
Epic Systems Corporation	Quarter releases with hundreds of enhancements, fixes and changes.

Vendor	Improvement(s) Made
Fortec Medical Services	Per agreement and added to the contract, they are providing service documentation for the lasers they bring into OSUWMC facilities.
Fujitec	Fujitec has made some improvement on the punch list items for the University Hospital.
GE Healthcare	Enhancements, bug fixes/patches
GE Healthcare	Major upgrade to MUSE NX which has many enhancements and abilities to work with new machines
Geiger Brothers INC	The contractor improved performance by addressing prior issues promptly, improving communication, and delivering more consistent, higher-quality work.
Heartistic Transformations Art Therapy	Assisted in developing a Healing Through Art program specific to caregivers for National Caregivers Month.
Hilscher-Clarke Electric Company	Vendor had an issue with performing work without notifying site stakeholders. After sharing the expectation of communication, vendor began contacting stakeholders prior to taking equipment offline.
Hisstotrac	Helping us undergo windows 11 validation and upgrading the software version.
HMPC (Joint Venture)	The contractor improved performance by addressing prior issues promptly, improving communication, and delivering more consistent, higher-quality work.
HRS	Standard preventive maintenance and bug fixes and patches.
Integra Testing	The contractor improved performance by addressing prior issues promptly, improving communication, and delivering more consistent, higher-quality work.
Intuitive Surgical	Many of the updates include software, new instrumentation, and telepresence capabilities.
Jeff Adair	Jeff has improved at being on time and requesting time off or exchanges in advance
Jennifer Gebhart	Assisted in the development of new Gentle Yoga programming.
Jimmy McFadden	Jimmy has improved his timesheet and schedule submission. He is also improving his communication hand offs.
Joanna Samuelson	Joanna asked more questions and followed up with concerns.
Johnson Controls Inc	The contractor improved performance by addressing prior issues promptly, improving communication, and delivering more consistent work.
KAHOE	Performance improved by addressing prior issues promptly, improving communication, and delivering consistent, higher-quality work.
Language Line Services	they have lowered the wait times for several languages including Haitian creole, which has become one of our top languages.
Laurel Bridge	Enhancements, bug fixes/patches
Laurel Health Care Company	On-site review by consultant to determine areas for improved communications between the SNF facility staff and the Ohio State clinical teams.

Vendor	Improvement(s) Made
Lyft Inc/Lyft Healthcare Inc	the addition of Lyft Assist
Midwest Elevator	They have been improving response time.
Nexxspan Healthcare LLC	Input was provided regarding product that was delivered that didn't work as well as it could have. The vendor voluntarily came to our site and made modifications to the product to achieve the desired results
Ohio Heating & Refrigeration	improved addressing issues promptly, improved communication, and consistent, high-quality work.
Ohio Medical Transportation Inc.	Refined certain transport base operations to be more efficient and sold one helicopter that was not necessary.
Patient Experience	Meeting with Endo and OR to help improve customer service
Paxman Scalp Cooling	Temporary codes were replaced with permanent charge codes
Plunkett Pest Control	Decreased bug problem
Preventative Maintenance Service of Ohio	The contractor improved by addressing issues promptly, improved communication, and delivering consistent, high-quality work.
Pringles Inc	The contractor improved performance by addressing prior issues promptly, improving communication, and delivering more consistent, higher-quality work.
Proprio INC	Improved registration
Provation Medical Inc	Quarter Updates to system including bug fixes and patches.
Roberts Service Group	This Vendor became more reliable by increasing their communication overall.
Siemens Medical Solutions	Enhancements, standard bug fixes/patches
Smith's Medical	System upgrade to allow multiple users to access/edit drug libraries. System upgrade for FDA recall compliance.
Stericycle	We have been meeting weekly to fix accounting and invoicing errors to ensure that service is not disrupted
Teladoc (formerly InTouch Technologies)	Continued platform advancements with some items we currently do not use or need. Enhanced carts with lower price point.
Teleflex	They had stopped in person training during COVID and started that back up in the past year.
The Laser Institute	Vendor provides access to training materials via a website as well as access to staff training completions
Tony Cornett	Tony is one of the newer contractors and has continued to improve on understanding, policies, and procedures.
Towne Park/Health	Staffing levels have improved, based on productivity. Top management levels have been provided, standardization of parking, movement and lane controls.
Translogic	much tighter controls have been added to the PM schedules and emergency response to system issues.
Trinity Guardian	For bed barriers, they have been working on an easier identification process for front line staff that correlates with the physical bed.

Vendor	Improvement(s) Made
University Hospital Radiology	improvements in dashboard, TAT metrics for some modalities, staffing at each site
US Together Inc	While the proportion of appointments they are able to fill has not increased, the number of appointments they are able to fill has increased this year.
Versiti Indiana Inc	Review and update of standing order and bought out Community Blood Center of Dayton.
Vital Images	Enhancements, bug fixes, patches
Viz AI	Added modalities, enhancements, bug fixes/patches

APPROVAL OF THE CONTRACTED SERVICES EVALUATION

**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 July 28, 2026, 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 and Board of Trustees hereby approve the annual review of the contracted services for The Ohio State University Ambulatory Surgery Center — Outpatient Care New Albany.

APPROVAL OF THE CONTRACTED SERVICES EVALUATION

**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 July 28, 2026, 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 and Board of Trustees hereby approve the annual review of the contracted services for The Ohio State University Ambulatory Surgery Center — Outpatient Care Dublin.



**CONTRACTED SERVICES EVALUATION
NEW ALBANY AND DUBLIN SURGERY CENTERS
COMPLETED: CALENDAR YEAR 2025**

CONTENTS

OVERVIEW.....2

CONTRACT OVERVIEW.....2

CONCLUSION 3

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.13.03.03 – 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 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 2025, there were 13 services contracted between DASC and OSUWMC.

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

For calendar year 2025, there were 12 services contracted between NAASC and OSUWMC.

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

A security MSA for New Albany is in the process of being developed.

An evaluation of each service 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.

**RECOMMEND APPROVAL OF THE
EMERGENCY GENERAL SURGERY PROGRAM VERIFICATION**

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

Synopsis: Approval of the submission for verification of the Emergency General Surgery Program 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 innovation in research, education, and patient care; and

WHEREAS, the Ohio State University Hospitals continue to provide emergency, specialty, and subspecialty clinical surgical services, as well as professional education, research, and performance improvement programs (collectively, the "Emergency General Surgery or EGS Program"); and

WHEREAS the Ohio State University Hospitals intend to meet all requirements and criteria to obtain Emergency General Surgery verification and support its EGS program; and

WHEREAS the annual review of these contracts was approved by the Ohio State University Hospital Medical Staff Administrative Committee on August 12, 2026; and

WHEREAS on August 25, 2026, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board commit to maintain the high standards needed to provide optimal care of all emergency general surgery patients and support the application for an Emergency General Surgery verification by the American College of Surgeons:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board and Board of Trustees hereby commit to maintain the high standards needed to provide optimal care of all trauma patients and support the application for a Level 1 trauma verification by the American College of Surgeons, Committee on Trauma.

An aerial photograph of the Wexner Medical Center campus. The image shows several large, modern buildings with glass and brick facades. The sky is clear and blue. A white diagonal line cuts across the right side of the image, separating the photograph from a red graphic area at the bottom right.

Emergency General Surgery

Program Verification Support Request



**THE OHIO STATE
UNIVERSITY**

WEXNER MEDICAL CENTER

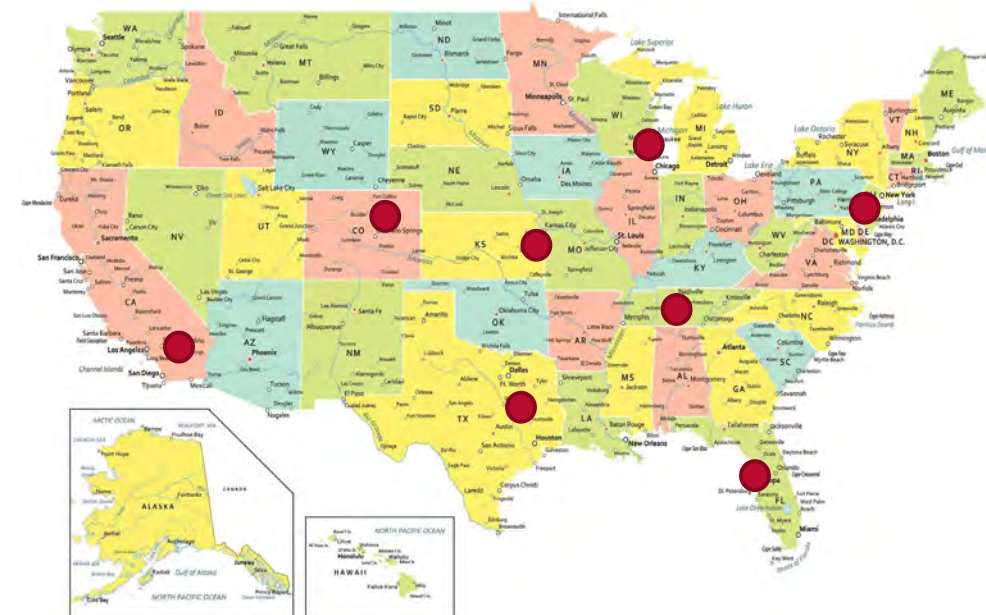
What is EGS and Why Seek Accreditation

- Surgical procedures, if not done emergently, put lives at risk
 - >4 million annual admissions
 - Nearly 50% of operative mortality is due to unplanned emergency surgery
 - 6 times the complication rate compared to elective surgical patients.
 - Approximately 25% of total inpatient costs
- For our patients, this verification means:
 - Access to board-certified emergency general surgeons 24/7
 - Standardized care pathways designed to reduce complications and enhance recovery
 - A dedicated team focused on the highest levels of surgical quality and safety



Value Proposition for OSUWMC

- Clinical,
 - Better patient outcomes
- Operational → Efficiency
 - Better data = better allocation of resources
 - Reducing delays and complications improves throughput.
 - Better care = cheaper care
 - Improved operating room throughput
 - Reduced avoidable delays
 - Enhanced bed utilization
 - Better transfer center performance
- Strategic
 - Differentiation as a regional EGS referral center
 - Alignment with national ACS quality initiatives
 - Competitive advantage in payer and employer discussions
 - Support for institutional quality goals – HRO compatible



Return on Investment

- Decrease LOS
- Improved Quality and Outcomes
 - Lower SSI rates
 - Fewer ICU days
 - Reduced readmissions
 - Lower resource utilization
- OR efficiency
 - Reduced case delays
 - Improved block utilization
 - Faster ED-to-OR throughput
- Referral capture

Verification should be viewed as a health-system transformation initiative rather than simply an accreditation exercise. The framework creates durable infrastructure for quality improvement, operational efficiency, and regional growth.

