THE OHIO STATE UNIVERSITY

OFFICIAL PROCEEDINGS OF THE

EIGHTEENTH MEETING OF THE

WEXNER MEDICAL CENTER BOARD

Columbus, Ohio, November 2, 2016

The Wexner Medical Center Board met on Wednesday, November 2 at the Richard M. Ross Heart Hospital, Columbus, Ohio, pursuant to adjournment.

** ** **

Minutes of the last meeting were approved.

**

November 2, 2016 meeting, Wexner Medical Center Board

Mr. Wexner called the meeting of the Wexner Medical Center Board to order on Wednesday, November 2, 2016 at 9:10am.

Present: Leslie H. Wexner, Alex Shumate, Janet B. Reid, Cheryl L. Krueger, Abigail S. Wexner, Corbett A. Price, Stephen D. Steinour, Michael V. Drake, Sheldon M. Retchin, Geoffrey S. Chatas, K. Craig Kent, E. Christopher Ellison, David P. McQuaid, Michael A. Caligiuri, Amanda N. Lucas, Elizabeth O. Seely, and Marti C. Taylor. William G. Jurgensen, David B. Fischer, and Robert H. Schottenstein were absent.

Ms. Link:

The minutes of the August meeting of the Wexner Medical Center Board were distributed. If there were no additions or corrections, the minutes are approved. Now, I would like to call on Dr. Retchin for his CEO update.

Dr. Retchin:

Thanks. Let me start this morning, before we review the scorecard, to formally welcome Craig Kent as our new dean. Craig has been with us for a few months and was not able to make it last time, so I want to formally introduce him. We have been blessed to be able to recruit Craig here to be the new Dean of the College of Medicine. Prior to joining us, he served as the Chair of the Department of Surgery at the University of Wisconsin School of Medicine and Public Health where he took that department from number 26 to six in NIH funding, and he also served at that time as the Curreri Professor of Surgery. Dr. Kent has been a funded investigator for more than a quarter of a century. He has authored or co-authored more than 300 articles and peer-reviewed journals, more than 90 abstracts, and more than 60 book chapters and reviews. More than that, Craig is certainly a well-recognized scholar and a mentor and an extraordinary educator. I cannot tell you how many of his former students and mentees contacted me through email and phone calls congratulating us on recruiting Craig Kent here. It is a testament to the great work that happens at the Wexner Medical Center and The Ohio State University. Please join me in welcoming Craig Kent as the new dean.

Dr. Kent:

Sheldon, thank you for those very kind remarks. I am so excited to be here. This is a wonderful institution. I am now on my two-month mark and every day is a new and exciting adventure. What I have enjoyed the most in my first couple of months here is meeting the people. This institution has such absolutely great people. The collaboration with the university I think gives us great advantage and I look forward to a very bright future for the College of Medicine. Thank you so much.

Dr. Retchin:

Thanks Craig. My next item is an announcement of more recognition for the quality of care that is delivered at the medical center. Vizient, formerly known as the University Hospital Consortium, which is the preeminent group of academic health centers that collaborate in a purchasing cooperative and quality initiatives around the delivery of health care. In particular, Vizient works to identify structures and practices associated with high quality and safety across its members. It tries to identify the top hospitals in quality, on patient safety, and as you know, we have been recognized and acknowledged by this organization in the past. This year is no exception. We are the recipient of the Bernard A. Birnbaum Quality Leadership Award. We joined 13 hospitals as a top performer and received five stars. I have a list of the others, including New York University, the University of Utah, the Mayo Clinic, and Cedars Sinai, and behind us in rankings is the University of Michigan. They made the list but just below us in the rankings. Susan do you have any comment on the recognition?

Dr. Moffatt-Bruce:

I think this is an example of the team's effort.

Dr. Retchin:

It is terrific. Leapfrog Group was formed and initiated in 2000. It was a collection of very large employers in the U.S. who came together to form this nonprofit organization, extensively to drive a movement to value purchasing and the like. I do not know if they ever were able to do that but Leapfrog Group has continued to refine its metrics and is widely recognized as one of the prominent gauges of quality and recently they announced that both the Wexner Medical Center and OSU East were recognized with an "A" grade which is the highest grade that they give and puts us in the top 30%, approximately, of hospitals. Both of these recognitions continue to acknowledge the great work that our faculty and staff deliver here at the medical center. Congratulations to everybody but particularly Susan and your leadership, and yours as well, Andy. With that, I am going to move on to the scorecard.

President Drake:

While you are looking at the scorecard, let me say a word about Leapfrog Group because it is actually a profound group. They were founded to really change the paradigm in American medicine. It used to be that in the health care system, a patient would enter the health care system and the patient would leave the health care system and that was pretty much it. The relationship was between the patient and the health care system and the outcome was how the patient felt about how he or she had been treated when they were in the system. Really what Leapfrog Group did was say, as purchasers of health care, people in the business community who are buying health care almost like a commodity for large numbers of people at a time, they wanted to know where you could buy the best health care for the best price. They were really looking at this as something you could go to the market and purchase as a part of their business decision. There they looked for quality outcomes and patient satisfaction, so they were measuring entities to compare them against each other in large scale. That really was a part of the revolution to change us to outcomes based medicine that has taken place over the last couple of decades. Then what they did was they looked for things that were indicators of the best places and tried to have those be a small number of indicators that correlated with quality and outcomes broadly so they could really measure and compare hospitals and say, this is a better place to go than that. Really, it was a profound change in the way that we approach delivering health care nationwide and I want to mention that because then to be at the top of their list means that they really have looked at those things that make a real difference to people who otherwise, as an individual patient do not have much to compare against. It is a great and important seal of approval.

Dr. Retchin:

Michael, you are right, it was the business roundtable I believe that started this and it still holds great promise in terms of a purchasing cooperative.

On the scorecard which is behind the CEO update and there is a glossary behind that, also for your visual acuity there is an accordion, landscape fold out, I believe it is at your seat so you can look at the scorecard. I am going to turn to David McQuaid in a second but let me highlight a few points. We have added a few measures this year, particularly regarding our future direction. Strategically, we are continuing to focus the health system and the delivery of health care in a very disciplined way to meet the needs of the marketplace. You will see some new areas of access and population health management. We have set some ambitious goals on this scorecard. We are trying to raise the bar in terms of our expectations so you will not only see green. We are going to continue to push the bar in a transparent way and I think overall if there is a theme here it is transparency. We have some areas we need to move the battleship, as I

mentioned, one of those is in access and David will go into that in a deeper dive. These are challenges that we feel we are well positioned to meet and push the organization to a higher bar and we have teams of individuals that you will see in the foldout that we call champions so we are disciplined as a team to make sure that we identify those who are charged with taking the lead. There are a lot of metrics on this page, while I want to go through each one of these, in the interest of time, I will ask David McQuaid to highlight a few. David?

Mr. McQuaid:

Thanks Sheldon. To re-emphasize, I think, what is critically important to us here is that if you thought back to the last scorecard there were probably 19 or 20 metrics on the card. We now have 29 metrics on the card and while we want to control the number that we have, I think it is really important that we understand which metrics really drive the business and what behaviors they encourage. That is really important as we have organized, we have thousands of people engaged through these champions, through the structure, behind the scorecard and how we orchestrate tactics to achieve results moving forward so it is really critically important. There was an interesting article, I went back to the *Harvard Business Review* September issue and it was an article, a quick one pager about how to not be tyrannized by old metrics and it is the whole notion that as businesses change, how are we changing the way that we measure. What you see on this card are things that we should really be engaged in monitoring and that is in particular around payment transformation, around bundled payment and that are all things that today, might be five or 10% of the business. We are learning how to live in that world, it is really important that we gauge those things. Other things that we put on here are important to the core of who we are as a university and as a medical center so I thank the team for as spending as much time as they have in moving this forward.

I would tell you that we have about 41% of these metrics, or 12 of 29, that are exceeding or meeting the target. We have about 21%, or six or so, that are ahead of last year but not quite at target, and we have another six that we are below target and really require more intense intervention and we are going to do that. There are about five that were still pending data and we will have that for the next report. Importantly, we have in the people area of the key results, diversity and inclusion, and there is a lot of great work going on. We are in the process of finalizing a diversity plan closely in line with the university's plan. We are working with Dr. Leon McDougle, our Chief Diversity Officer and Mamoon Syed. There is a lot of good work going but looking at things like this whole notion of, for example, implicit bias education training for search committees, and really taking a look at diversity and inclusion from an enterprise point of view. Importantly, a cost of doing business for anyone is employee turnover. We felt that these numbers are pretty high and this includes both faculty and staff turnover and so we put that on the scorecard to shine a bright light on that and we will have a number of interventions and working very closely with Dr. Kent, Dr. Ellison, and Dr. Thomas to work on a physician manpower planning study right now. We are trying to understand areas of turnover and why that is going on in the organization.

We are making good progress on our patient satisfaction scores. HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems), and CG-CAHPS (Clinician and Group Consumer Assessment of Healthcare Providers and Systems). On the HCAHPS, we hover around the 90 percentile and CG-CAHPS around the 56 percentile but we are making progress, not quite at goal but we are doing well.

We put the community health needs assessment and developing plans to implement some actions that we can take around the 2016 health map so more to come on that. One of things that we can do as an enterprise is work with the community and really try to impact things like obesity and infant mortality and access to care. We are doing well in the quality areas. Just to mention, with regard to mortality, we are improving compared to where we ended the year. You can see slightly down to 0.73 would tell you that we are actually at 0.66 on mortality when we add in the James, given the population we rise

a little bit. I think capturing the acuity and severity of illness is a challenge so we have lots going on with coding documentation and education that would tell you that we are ranked in the top ten in the country for really having great numbers on this metric. We are number nine out of 104 academic medical centers as it relates to this mortality statistic so we do a very good job here.

I will tell you that, again, as we go down, in looking at payment transformation, gain from quality based reimbursement programs, recall that these are the combination of readmission rates and value based purchasing and tell you the tremendous improvement the organization has made over the past several years. We tell you that in fiscal year 2014, the value based purchasing, readmission, and hospital readmission numbers, the total impact was a loss of about $2 million. We have improved through fiscal year 2016 to a loss of $191,000 and we hope that moving forward we are going to see positive gain. Again for value based purchasing, there is an upside of about $2 million there; we are leaving money on the table if we do not go after that so we are going to do that.

I would tell you on the bundle care payment improvement initiative, this is Medicare patients. We have been involved in this. We have six areas that we are really spending lots of time on: congestive heart failure, angioplasty or PCI (percutaneous coronary intervention), CABG (Coronary Artery Bypass Graft), hip and knee, spine, and valve. We are doing good in three of those areas on the cost side, I think year to date, our totals are in the area of about $700,000 in reimbursement from Medicare as it relates to our performance. We can do better on readmissions, length of stay, some of the quality parameters but again, we are gaining experience in these areas, it is the first time on the scorecard and I really give kudos to Dr. Susan Moffatt-Bruce and the teams of people, the hundreds of people, the physicians, and everyone who are working so hard in this area.

Finally, and let me close by saying on other access issues that we have, we are really focused on what we are hearing from patients and that is, how can I get an appointment with a primary care physician, how can I get an appointment with a specialist and I want to give kudos to Chris and the team within the College of Medicine. For a number of years, they have been participating with a group that is largely academic medical centers and since 2011 the group was formed and they really focus on these 14 days for specialists and anywhere in the range of two to four weeks for primary care. We need to do better and there is lots of good work going on. About 50% of the departments and practices are doing better than target. We have work to do in the others.

Finally, I will close out with the emergency department. The numbers that you see on the card and the average time patients spend in the emergency department before they were admitted to the hospital as an inpatient is publically recorded Medicare data. This is on the hospital compare website and you can see that for fiscal year 2017, through September, the wait is 408 minutes, that is a very long time. We know that we can do better on that. The national average is about 346 minutes. Our target is 344. We have a number of initiatives going on in Ohio. The state average is about 302 minutes. When we look at some of our competitors they are doing much better than we are. We have capacity issues, some coordination from the time the patient leaves to the inpatient, and some capacity issues that we are working through. Again, what we are hearing from patients, the significant amount of demand that we have at the organization, we are working really hard to improve on these numbers.

Dr. Retchin:

Any questions for anybody on the team regarding the scorecard?

Mrs. Wexner:

I am curious about the access. What would be best in class? I am trying to understand the difference between average and best in class.

Mr. McQuaid:

For the emergency room?

Mrs. Wexner:

Yes.

Mr. McQuaid:

I would say the national average is about 340 minutes or so.

Mrs. Wexner:

And then what would be outstanding? 200?

Mr. McQuaid:

That would be pretty outstanding.

Dr. Retchin:

The only thing about that is there is a reciprocal relationship with occupancy. Someone who gets the 200 minutes, I do not know this to be true, but I would imagine has a lower occupancy since they have so much flexibility on the beds. Is that accurate, Susan? Andy?

Dr. Thomas:

What we tend to find is on days when we have beds open, we do pretty well on those metrics. If you take out the outliers of the people staying in the ER (emergency room) for eight to 12 hours because there are no beds upstairs, you can cut about 50 minutes off that metric if you take out the outliers so that is really one of our goals. There are still some things we can do within the emergency department to make people be seen more quickly by the first provider, time to get some tests done and turned around and there are certainly improvements we can make there. Our big improvement is going to be on the access side, getting patients who we know need to be seen, into a bed more quickly and we think that will really drop the metric down more closer to them.

President Drake:

There are a lot of variables there. Our length of stay is improving so that helps because that frees capacity so good to see that. Also, it is great to see the improvement on the readmission numbers which I know we had a focus on. I think those things together will allow us to be more fluid and a system that works well. I would also say on the access, that we will continue to watch that as we are looking at our compensation strategy. There are ways to fix the access to patient care by adjusting the compensation strategy appropriately. An example that I have had in the past, we were able to get that down to under two weeks routinely because we modified the compensation strategy to be more like the world outside and found that the people could actually see that extra patient almost any time so I think that is something we will be able to arrive to effectively by some of the work that we are doing and I look forward to it.

Dr. Reid:

I have a question about the transferring of patients from the ED to upstairs. Is there some relatively new technology that helps us understand when beds are available? Are we using that?

Mr. McQuaid:

Yes, teletracking. Teletracking has been implemented and the team is making some significant progress in key areas. Bed turnover, we track several statistics in that regard using that technology.

Dr. Reid:

Is it working well? Then another question, this is regarding service and reputation quality and safety. In terms of implicit bias, you had mentioned that that is being utilized as a training mechanism for selection panels, but I am wondering are you also addressing that with regard to patient health disparities.

Mr. McQuaid:

Yes, that is also on the list for the plan as it relates to providing care. Absolutely.

Dr. Reid:

Okay, so Dr. McDougle is recognizing that?

Mr. McQuaid:

Yes, and Mr. Mamoon Syed.

Mr. Steinour:

Sheldon, on the employee turnover, I am used to seeing it bifurcated or even perhaps even further separated. I would assume that faculty turnover would be an area of distinct focus for all of you and from our perspective, shouldn’t we see that broken out instead of staff?

Mr. McQuaid:

Yeah, we can do that. Faculty turnover is about 9.9%.

Mr. Steinour:

How does that compare? Is that good or is it high?

Dr. Ellison:

It is a little higher than the national average. The national average is about 7% and I think four years ago we were about 7% and it has gradually creeped up to about 9.7% or 9.8% and has flattened off there.

Mr. Steinour:

We are 50% worse than the average then. What are we doing then in that regard?

Dr. Ellison:

Well I think many things.

Mr. Steinour:

Well, I am sure you are. I do not know what they are.

Dr. Kent:

I see this as an issue that we need to solve. Part of it is cultural and creating a culture where the faculty feel embraced by the institution and rewarded and I think that is going to be a part of the solution. I think that working through a compensation plan that makes sense and is transparent is another factor that will be really important in turning this around. I think right sizing too. There are access problems but part of is that we may not have right sized our faculty to really create great access and the ones that are there are maybe working a little too hard. Right sizing the group is going to be really important. There are ten other things that I think we have underway that I think are going to help this problem. They will all take time but there is a lot of low hanging fruit and I think we can make some great advancements over the next year.

Mr. Steinour:

If you would not mind I would like to make sure that as we continue to meet, we become aware of the progress and some of us who are not in this area, frankly, would not know what to look for or ask about so I would appreciate the information sharing.

Dr. Kent:

I think we can call that out and I think that is a great idea.

Dr. Reid:

Is there a faculty satisfaction number, like you do the employee satisfaction? You ask all the different questions. Is there something equivalent to that for faculty so we can track?

Mr. McQuaid:

In the engagement score, faculty are included.

Dr. Retchin:

Traditionally, they have been. We did not do one last year but going forward they will be.

Dr. Reid:

Okay, so we will be able to track it year over year.

President Drake:

I think something else that I think to look at, I will mention the same thing again and answer Steve’s question as it strikes me is the inconsistency in the compensation system drives a lot of these numbers. It drives the lack of access because you cannot be sure that extra effort is going to be rewarded in any reasonable way and it drives inconsistency and dissatisfaction for people who thought they were doing the same work were being paid different amounts and people working harder were being paid less. That is a real driver of dissatisfaction. This transparency and clarity will help drive behaviors that make us a better functioning institution and do a lot for faculty satisfaction That is a place where we should see progress over these next several months as we implement these things so I am excited.

Mr. Wexner:

Some things to think about that I think are part of the progress that we are making, is that one, we have a scorecard. That was good and was a simple scorecard and then it got to be a more complex scorecard and so there are signs of improvement. I mean this in a constructive way. I think when we are looking at targets, and mandating it, but thinking about, is measuring improvement. I do not think it is a good idea if that is all we measure. When I was two years old, I was two feet tall and then I was two feet one, but an adult I would say is five foot ten inches or eleven inches or six feet tall. I think in the targets we should know what the best in class goal is, so going from say six hours of wait or seven hours to six and a half if it is going from seven to six and a half that is a big improvement. I would like to know that the best in class is two hours of wait and I think, you think about things differently as operators. I think it is very important at a board level and I think the significance of that it is not unimportant to measure improvement but it is against what is best in class standard. So if we are trying to be a top ten or top 20 hospital or whatever the ambition is, it is like, how do they compare to us and I think be very clear about those goals across everything. The changes in the outlook culture and I think helps the board with insight. If not, we are always measuring in increment, and the increments are likely to be a little bit better, but it does not get you to where you want to be. I do not know if we need to debate that at the moment. I would be happy to park on it and then look at some of these numbers, maybe in executive committee of the board or whatever group we think is important and how do we stack up against what we would consider the best in class that we are competing with, a lot better than ourselves.

Mr. McQuaid:

I think those are really great points. The other point that I will mention with the completion of the strategic plan, moving forward, the notion of having a scorecard that is projected along that timeline as well so that we are having all of those improvements over time. I think it would be a good idea to incorporate that thinking into it.

Dr. Fujita:

Excuse me, I am new to this community so to educate myself, I would like to ask a question regarding the patient satisfaction. When we send an invoice to a patient, is that after the insurance companies have taken care of their part, or do we send the invoice to a patient before anything happens.

Mr. Larmore:

When we send an invoice to a patient, it shows their full cost but it shows the expected payment from the insurance company and then what their portion of it is so they do not feel like they are getting a bill that shows full charges and brings them back to the office because of the bill.

Dr. Fujita:

I see, the reason I said this was in Northeast Ohio, actually, there is this question about how the invoice should be sent. Sometimes if you get an invoice before the insurance companies pay for it, you may pay somehow twice. Then that leads to patient satisfaction and patients say it is so confusing that they should just get the invoice after everything has been taken care of so he or she knows what they owe.

Dr. Retchin:

Any other questions or comments? I do want to note on the scorecard the increase in NIH funding. Craig, you have only been here for two months but I want to congratulate you on excellent results there.

Mr. Chair, I want to move on to the next item. I am going to call on Mark to present on the medical center's financial summary which is behind the tab so labeled.

(See Attachment VIII for background information, page 121)

Mr. Larmore:

I have the first quarter results here. After three months the health system, with all the hospitals, I think are pretty much on budget. The medical center as a whole, when we include the physician practice and the College of Medicine, is ahead of our target, which is good news. A lot of activity in the quarter given that we opened three facilities. We opened the Upper Arlington ambulatory facility, we opened the sports medicine facility, and we also opened three out of the four floors in the Brain and Spine Hospital. You will see when I get to some of the slides that some of the salary numbers are a little high in September but part of that was bringing staff on ahead of time as we expand into that space so that we can hit the ground running when it opens. I think as we go into the rest of this year, a big focus on growth, not cuts and both on the growth in inpatient and hospital ambulatory but also on physician activity. I think we talked a little bit before about a lot of that growth will go with recruiting new physicians here. Our overall feeling is that there is more demand than we can provide right now and so we need to make sure we bring people on to take that demand. Although the focus is on growth and not cutting, I think in this business we never take our eye off the ball on expense levels and so we will be watching that.

On page two, for the first quarter, you can see that admissions were actually 2.4% ahead of budget and prior year. Surgical activity is ahead of both budget and prior year which is a good indicator. Outpatient visits, we are growing year-over-year but slightly behind our target by 3.3%, but we are not worried about that yet because it is early in the year. Our worked hours per adjusted admissions, you can see, we are better than the prior year and then, as I said, this factors in that early staffing for bringing new capacity on, so to budget right now we are slightly over where we had projected.

Page three shows the operating revenue, which is pretty much on budget and showing 5.6% growth over last year and our controllable expenses, we are right on budget and about 8% growth. I will come back to that when I get to the actual P&L (profit and loss) slide, and then our plan for, this is only for the health system, will be about $46 million and we are at $45.5 million so a little bit behind but I am not concerned about that. And then, days cash on hand, you can see the actual is down slightly. I think at the end of the year, we talked about the growth in cash and some of that was deferred capital spending, not intentionally deferred but we had big projects that I spoke about, Upper Arlington and brain and spine, so it is those projects and some of those invoices got paid so we saw a little dip in cash in the first quarter.

On slide four is a quick snapshot of the month of September, I want to focus mostly on the quarter but you can see that most of the volume activity is either on budget or slightly positive to that. A couple highlights would be length of stay, you can see down to 6.1 days which is better than the budget and is a considerable improvement over prior year. A small change in that opens up a lot of capacity and even with that length of stay down, you can see our case mix is at 1.85, which is a measure of the severity of the patients in the house and we are pretty much on budget. Year-over-year you can see the growth from 1.79 to 1.85.

On slide five is the actual income statement for the month. We had a $9.8 million bottom line. The budget was $12.8 million so were about $3 million behind our target. I would attribute that, you can see, the major overspend category is in the salaries and benefits, and I spoke about that already. On the supply side, we are seeing as our business grows in areas that we are targeting, some of them are high cost areas. Our cardiac business is growing and some of our heart valves as an example, we are more ahead of our target

on that and each one of those are $33,000 a pop, so as that business grows we see the extra expense on that front.

Page six is the quarter ending. On the earlier slides I talked about admissions and surgeries so you can see the actual numbers, 363 on admissions and 149 on surgeries. I think the next slide I will go through the ambulatory. We are 14,000 to 15,000 behind on ambulatory visits but over 450,000 it is not a tremendous short fall. You can see it for the quarter we held the same length of stay that we had in the month and case mix is pretty much the same as the month, so we are seeing that increment in case mix through the whole first quarter. Our adjusted admissions, which factors in both admissions and a weighted ambulatory factor, you can see us ahead of the budget about 2.7%, 5.6% compared to last year. Our revenue is slightly behind by 2.3% and we are pretty much right on where we were last year and then the expenses, we are actually running under budget for the quarter and slightly up, only 1.4% growth year over year.

Dr. Retchin:

Mark, when I was reviewing the numbers on the quarter on the expenses, it is remarkable. In an industry, I do not know where the best in class but it is flat really from past year. I do not know if you guys have a comment but that takes discipline. David, do you have a comment on that?

Mr. McQuaid:

Kudos to the teams. We are meeting every two weeks. People are focused on it, we know that side of the equation, and we are going to deliver on that piece. I think the balance with that is the growth we are trying to manage and all the issues we are talking about with access. That is the challenge for us to try to maintain these as good as we can in the face of tremendous demand.

Mr. Retchin:

I think in the industry we are seeing much higher increases on the hospital side. Anyways, I did not mean to interrupt.

Mr. Larmore:

We have a strategic sourcing effort going on for a number of years and initially it was focused on pricing and I think now we have advanced to the stage where we have physicians meeting every other week with the commodity themes, looking at the variability in the usage, and going after that actual piece of the business. I think a lot of great activity there.

Mr. Wexner:

What happens, just the human part, I would relate it to businesses. We press on expenses and have those kinds of meetings. We will get a response and then the unanticipated or unintended consequences is everyone is tense in our businesses, not to get a balanced look. If the focus is on expense, then they focus on expense and then people forget about revenue. I am guessing hospitals and doctors have different behaviors and this is very different, really having an efficiency focus so I am supporting the idea, I am balanced with what happens.

Mr. Larmore:

The bulk of our spending in this business is on labor and, I think, we have been working on putting on a full position control system so we know based on the volume that we expect in the given year, how many bodies we need to deliver the care. The big variable in our business is over time and supplemental staff agency. We spend a lot of time

focusing on that and making sure that we are not seeing those grow, and quite frankly the minute you take your eye off them, they do start to creep up. I would say that is how we manage the bulk of it and then making sure that it is not every time that somebody wants to add a staff member that there is a pause to say, is the volume there to substantiate it?

Dr. Retchin:

I think Les brings up a great point that if the focus is only on cost then as an organization we have missed the mark. Growth cures a lot and if you can grow with just variable cost then your cost per admission is going to go down. I think that is where the discipline is in growing with variable costs and not increasing your fixed.

President Drake:

To the people in the trenches, the length of stay going down and acuity going up, as we saw last month, that is real work. That is real people working every day, all day, the entire team to make those kind of things happen. I mean that is holding the same while the length of stay goes down is great but looking at last month where the acuity where was actually up and the ALOS (average length of stay) was down from last year. That is a lot people doing a lot of hard work on a daily basis. Kudos to Andy and to Susan for helping to make sure that happens.

Mrs. Wexner:

Mark, to Les' earlier point, obviously wonderful that expenses are going down. But I do not have a benchmark to understand at what level we should really be if we were very efficient and operating at the highest level, so that would be helpful. We have improvement, but I do not know yet where we need to go.

Mr. Larmore:

I think we have external benchmarks and as we look across the organization, of course we have a wide range of where people perform based on others and then we try to look at just academics versus the whole industry. I think the answer to your question is that we have opportunity in places to control costs further. We have to continue to go after it. Are you looking for magnitude?

Mrs. Wexner:

Magnitude.

Mr. Larmore:

I would say that we probably have about $25 million to $50 million of opportunity that we can go after and a lot of it, there is reason for why it is there. It is a matter of challenging that to see if we can go after that. I think we do it every year. As we look at the economic model being revenues trends lower than expenses, so if you are not looking at that opportunity every year, it creates a problem for us.

Mr. Wexner:

My reference is my business and we have had a number of businesses, like the businesses we are in. I have a pretty good sense of how many people it takes to replace lightbulbs or do advertising or graphic artists or do display and one of the businesses, I will share this, it is not embarrassing to me, it is what it is, could rationalize why they had 85 display people. We look at display people per store, size of store, and there is some judgement because some display is more complex than others. When you get all done with it the number was about 25 and the increments built up and it was completely logical

to the person that built that expense structure, each increment made sense. I looked at it and said this is complete insanity and whoever the responsible person was said well it is really unfair, you do not understand. The hard discussion was, well, one of us does not and I have the responsibility so the answer is 25 and if I am wrong I am wrong. After a lot of angst and a lot of weeping or that kind of stuff the answer was actually 23. When you go through that kind of thing in an organization and you have outside experience, whether it is a practice or staff then you have targets and I know that it is tough and so I am coming back to the same point, is that when you think you know the answer and you are seeing things that you do not think make sense, you have to be careful to make sure that you do not, or I do not in my case, or you do not, in your cases, are bringing a general knowledge and there really might be a reason for this unique thing to be different. When you all stack hands and say this is out of whack, you get a lot of very funny behaviors because people feel put upon and you do not understand that somebody has to make the tough judgement. That is why I was asking the behavioral part or the cultural part because getting higher performance and being efficient, agreeing with Dr. Drake, is hard. That is what champion-like performance is, or best in class performance.

Mr. Larmore:

We are continually moving resources around so if you look at how the revenue model is changing for us. As we move through value based purchasing, our commercial carriers are actually giving us a piece of our increase only if we achieve these value based goals, which often cost us money to do. The government payers are even worse because they actually cut your rates and say well you have to invest more money to hit metrics to get your same amount of money back. As we are looking at bringing down cost everywhere, often, we are deploying that into different areas.

Mr. Wexner:

But for one, I am enlightened, following this, the opportunity, we are making progress, the opportunity is somewhere between $25 million and $50 million. I would expect that we would find that opportunity in the next day, week, six months, so that I can start benchmarking how we are doing even if it is your estimate is that at this point close enough for government purpose and that is profound because I think that gives us a sense of where we are going.

Mr. Steinour:

Mark, if we could to follow up on that, teletracking was referenced earlier. My recollection of that, little hazy, but it was a major initiative that had components of quality care, accessibility, and expense attached to it. Having, as you think about that $25 million to $50 million, and some of the prior, larger investments that have been made, particularly with the way that reimbursement is going. Having some granularity around the key investments and then achieving objections, where are we on the spectrum, would be helpful and we can do this in committee of full board, whatever you prefer.

Mr. Larmore:

Teletracking, to me, is a means to move people through the house and if we can keep expenses fixed, our cost goes down.

Moving on to page seven, is the ambulatory volume and then on the right side, is the first quarter. I said we are about 15,000 visits and procedures behind but if you look at that really in three categories, ED volume is actually behind our budget but we are seeing that mostly at the East Hospital and there have been a few competitor locations opened up, the freestanding EDs, and we are seeing a little bit of an impact there. Clinic volume off 3000 visits on 111,000. I am not overly concerned about that and then lab again is 1800, which seems like a big number but not over the 67,000. On the physician visits

here, this is the specialty care and primary care network which is within the health system, on a subsequent slide so we can see what the OSUP numbers are.

Slide eight is the quarter ending; we ended the quarter at $45.5 million, budgeted to be at $46.2, about $700,000 behind our budget, at 1.4%. For revenues, $2 million ahead of budgets. I spoke about the supply costs, the implants are about $1 million over budget and we are actually seeing growth in our transplant program so our cost of transplants, with that growth, is about $1.2 million dollars over our budget, and that is $2.2 million of the $4.1 million but that is the biggest variance that is there. Drugs and pharmaceuticals, a lot of focus on that. At our prior meeting, I talked about us getting back into the government 340B program which because of our payer mix allows us to buy drugs at a reduced cost. The health system was out of that program. We reenrolled and it takes some time to ramp up into that so this year we anticipate $2.5 million or $3 million of drug savings and next year, that number should be north of $9 million, so happy to be back in that program.

Mrs. Wexner:

Was there a reason why we were not?

Mr. Larmore:

It is a program that has a lot of compliance components to it and in prior years, apparently we had some issues with that and the decision was made to exit the program. The pharmaceutical lobby is trying to eliminate it because, of course, they do not want to sell drugs at a much reduced price. It is a battle so they have not won at eliminating the program but what they have won is making it more and more difficult to comply with all the rules that are there. We spent a lot of time making sure that we are back in compliance and then of course, it is not just turn it on, it is you got to ramp your way up to it but the savings next year will be nice.

And then on a balance sheet standpoint, you can see that, as I had mentioned before, our cash is up about $6 million, receivables are up a little bit. The last item there, which I normally would not speak about is in other assets because it is a $35 million number at the end of last year, it is down to $14 million. When the Upper Arlington facility opened up, it was $20 million in that category that moved up to the property category so that was the major change there.

Page 10 is the medical center so now we have rolled in the physician practice and the College of Medicine so you can see bottom line, $52 million, budget $47 million so $5 million ahead of our target. Revenue is making up about $3.8 million of that and then the expenses are actually positive by $1.2 in total. This is the slide that has the physician practice or all the LLC business, so you can see that pretty aggressive budget target so we are about 4% behind our budget for 29,000 visits but on a year-over-year basis we are growing physician encounters by 6.6% and that is actually excellent growth.

Slide 11 is breaking out the three components. You can see that I went through the health system and then the third column over was $663,000 off budget, the physician practice is actual $211,000 positive to their budget, and the College of Medicine is about $5.4 million positive to their budget in the first quarter. I would caution you as the college still runs on a cash basis so there are some items, like capital spends and such, that that will come through later in the year. I would not celebrate the $5 million positive, yet.

Ms. Krueger:

When you check with the ambulatory and all the different locations, do we rank the locations like which is our best location or is there any movement as far as one taking over another’s growth. Have we looked at it from those terms?

Mr. Larmore:

Our target is more year over year growth. I would say that this year there is a lot more focus on the new facilities that we are opening. We are monitoring monthly Upper Arlington, as an example. We know what the capacity is and how many visits we are seeing there. We are monitoring how many are moving from other sites that we may have consolidated or are people choosing to go to another site. The thing that we are really focused on is first time visits to OSU. As far as getting down to the primary care we are starting to look at each position and what their patient profile looks like and how big it is and how it compares to the national averages. That is playing into the population health strategic planning group that we have.

Ms. Krueger:

Thank you.

Mr. Larmore:

The last two slides are balance sheets including the college and the practice plans. There are no dramatic changes there.

Mr. Steinour:

Could you talk about the pension increase on the balance sheet, Mark? Just so it is clear.

Mr. Larmore:

The university and the health system are part of the state pension programs and last year they passed a new regulation. GASB (governmental accounting standards board) said that the university had to reflect their percentage for their underfunding of the state pension systems. For the health system, it is called the OPERS (Ohio public employees retirement system). It is the biggest piece for us and for the university the state teachers is a bigger piece and both of those programs are underfunded. One of biggest reasons for the increase this year over last year, was that there was an anticipated 8% return on the money and the fund and the returns were just less than 1%. That delta had the biggest impact on our liability going up. The university has looked at it and Geoff can comment. The university is not liable for the liability but the regulation requires us to actually put it on the financial statements and that is why you are seeing a growth here.

Mr. Chatas:

Just to reiterate that, this is a bizarre accounting requirement by GASB that says that we have to report a liability that is not our legal liability. The state of Ohio has the obligation to pay the pension payments to our retirees. We have an obligation to pay a 14% contribution for each employee up to $260,000 a year of income. The rating agencies completely disregard it because they believe Ohio has taken steps to strengthen pension plans so they do not add anything back. Nowhere in a corporate world will you see anything like this. We have an obligation on our books that has no basis in financial reality that we have an obligation to meet that liability. I have absolutely no concern. This is something we have been following with our board. It is going to get worse next year because GASB will then require us to report post-retirement healthcare benefits. All of our retirees get health insurance based on their years of service. That is being phased out, but it is going to be a huge obligation that the state of Ohio has. This only becomes an issue for Ohio State if the state legislature and governor would sign a law shifting that obligation from STRS (state teachers retirement system) and PERS (public employees retirement system), but we are less than 1% of our medical center is less than 1% PERS and 4.5% of PERS. This would be an issue for the whole state if the state ever tried to shift that obligation.

Mr. Larmore:

The shortfall on the two plans is about $44 billion.

(See Attachment IX for background information, page 122)

Dr. Retchin:

Thank you. Any other questions for Mr. Larmore?

The next item, Mr. Chair is the Clinical Quality Management, Patient Safety and Service Plan. This requires a roll call vote. If it is okay Mr. Chair I will ask for a motion to approve. Is there any discussion? Susan, would you like to make a comment?

Dr. Moffatt-Bruce:

This a document that has been in the system for several years and had been updated. It is a document that with updated metrics that have been changed. (*Inaudible)*

Dr. Retchin:

Any other discussion?

CLINICAL QUALITY MANAGEMENT, PATIENT SAFETY AND SERVICE PLAN

Resolution No. 2017-27

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

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

WHEREAS the Clinical Quality Management, Patient Safety and Service Plan outlines assessment and improvement of processes in order to deliver safe, effective, optimal patient care and services in an environment of minimal risk for inpatients and outpatients of The Ohio State University Hospital, Richard M. Ross Heart Hospital, Harding Hospital, University Hospital East, and the Arthur G. James Cancer Hospital; and

WHEREAS the proposed Clinical Quality Management, Patient Safety and Service Plan was approved by the Quality and Professional Affairs Committee of the Wexner Medical Center Board on October 25, 2016:

NOW THEREFORE

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

(See Attachment X for background information, page 129)

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

Dr. Retchin:

Mr. Chair the next two items are Mr. Kasey's and I will call on Jay.

Mr. Kasey:

Thank you. I have an opportunity for us today to both buy and sell property. I will walk through those for you. Most of you are aware that on the west side of our east hospital was located in Poindexter Village, which was a multifamily housing village controlled and operated by the Columbus Metropolitan Housing Authority. The village was demolished about two years ago under a plan that had mixed housing coming back. At that time, the east hospital approached the metropolitan housing authority and requested the opportunity to purchase approximately 2.7 acres of land located directly to the west of the hospital property, and the 2.7 is North Hawthorne and West Hughes. This property has been agreed to for sale by the housing authority and is here for our review. It would come forward and only be approved by state requirements for how land is purchased which would be at the appraised price. It is here that I can answer questions. Elizabeth Seely is also with us.

Mr. Wexner:

Why are we interested in buying it?

Mr. Kasey:

We would be acquiring this property as a land bank for future development. It does not have a purpose at this time. It is available and we thought we should try to take advantage of it at this time.

Ms. Seely:

In terms of future flexibility and when we look at the geography of where we are and the plans to redevelop, we need to have the ability as we look 10 and more years down the road at facility replacement. In order to have that flexibility of strategic facility, either replacement or growth, we do not want to be in a situation where we become landlocked. This provides that future flexibility.

Mr. Wexner:

Any estimate of the appraised value?

Ms. Seely:

We have appraisals that we have submitted in advance to the Department of Administrative Services at the state. Our purchase price would be in accordance with that appraised value because it has already been approved by DAS.

Mr. Wexner:

What is the number?

Ms. Seely:

$500,000

Mr. Wexner:

For the 2.7 acres?

Mr. Steinhour:

Is that the full site of CMHA (Columbus Metropolitan Housing Authority)?

Ms. Seely:

No, it is a small portion of the site. What the CMHA and the city are actually proposing to do is to connect is two ends of a street that is currently not connected and when that connection is made the property to the east of that is the proposed parcel. It actually is a smaller portion of the total acreage of CMHA, which they are redeveloping with this.

Mr. Kasey:

CMHA is anticipating coming back with 400 units of mixed housing in that area on the remaining land of Poindexter Village.

Mr. Wexer:

I am just wondering why they are selling it to us and why they are not giving it to us. We benefit the community. We are an employer.

Ms. Seely:

One of the things they are doing in order to sell us the property, they have had to purchase additional property, which makes sense in the geography so they can develop the full 400 units of housing.

Mr. Kasey:

They are trying to offset their cost of additional property for their master plan.

Ms. Seely:

Correct.

Mr. Wexner:

I am not going to fall for this trap. I understand that we are doing good for the community and they are doing good in the community and they are trying to reduce their costs, but we are trying to improve the quality of health in the neighborhood. We are going to make some investments in the future capital investments and quality investments and improving health. I understand why they passed through the costs to us and I understand why we should not take the pass through.

Ms. Seely:

Well I would ask, if the situation were reversed, would we want to do the same thing?

Mr. Wexner:

I am saying the same thing to them. I am just a tougher negotiator. I understand the logic of what we are doing and I understand the logic of what they are doing too.

Mr. Kasey:

We will go back and talk to housing authority and see what opportunities we can find to see if we can either find a deal with them or to lower the costs.

Mr. Wexner:

We are buying it for a contingent use.

Mr. Kasey:

Yes.

Mr. Wexner:

I understand that is how they would fund their development, I am not opposed to community good, but I think there should be some reciprocity.

Mr. Kasey:

I think the payment from us allows them to buy other property which builds out their master plan of how they want to bring their 400 units back.

President Drake:

I think the questions is maybe we could pay them less. I think it would be interesting to go back and ask them. Not to say we have not, but often times we look like a source of funding. I had a call yesterday from someone who wanted to know if we wanted to advertise to help them fundraise. I said “we actually are the fundraisers” and that is like most of my conversations.

Mr. Kasey:

We will go back and see what opportunities we have.

President Drake:

Let me say also, to make Elizabeth feel happy. There are likely not to be a lot of suitors for this contended use of purchase on that particular parcel.

Ms. Seely:

I think that was reflected in the appraisal as we got them done as this makes sense.

President Drake:

We can see what happens.

Mr. Kasey:

The next parcel is in fitting with the medical center’s strategic plan for ambulatory care trying to consolidate smaller practices into strategic, larger locations. There was a practice purchased in 1987 at 1727 Bethel Road. This has been operated since that time as the OSU family practice location. It is approximately an acre of ground and 3,400 square feet of space. With the completion of the Kingsdale property and practice moving into the Kingsdale area, and also with Worthington being renovated, the practices located at this site have been moved into those larger locations and this site is deemed to be available in surplus. The university medical center would like to sell the practice and the location and this one will have to go to the legislature for approval of sale. It will be sold at an appraised price.

Mr. Wexner:

What would you guess? Is that corner location, any idea of the relative value?

Mr. Kasey:

I do not think we have an appraisal on it yet. I do not know.

Mr. Steinour:

Would you take it to full exposure to the market?

Mr. Kasey:

We will take it and we will advertise it, as we are required to do by statewide advertising, and have an estimate. Then we will take bids against the estimate not giving anyone what the appraisal is.

President Drake:

How long does that process take and what are our costs now?

Mr. Kasey:

The process take an undetermined period because it has to be linked to a legislative bill and move through the legislature as an attachment to a bill. The appraisal will be done relatively quickly and the advertisement of the site will be done relatively quickly, but then we will have to take it through the final approval. It cannot go through final approval until the offer is within 10% of the appraised value, which is the state's requirement.

Dr. Retchin:

I will say this reflects the strategy of getting away from the multiple small sites that departments have sprouted up over the years and consolidating them, in this case in Upper Arlington. We have about 63 different ambulatory sites in the metropolitan area. Is that right?

Dr. Retchin:

Oh, 68. These onsies really made us uncompetitive.

Ms. Marsh:

This practice consolidates in both Upper Arlington and Worthington.

Mrs. Wexner:

As many of us know there is a newly reestablished facilities and master planning committee that John Wolfe used to chair that was a subcommittee of this board and we discussed reestablishing that and it has its first meeting today in fact. Bob Schottenstein is a member of this board and would chair that, taking John's place, and I think it might be beneficial for this group if these types of decisions regarding acquisitions and dispensations and improvements first come to that group. Then we will have an easier conversation at these meetings. It sounds like it is fine for today, but it would be helpful if we could reestablish this process.

Mr. Wexner:

We can look at all of the things that the university should be doing and have a sense of what their value is because we may be able to fund acquisitions at better sites by selling sites that, for our purposes, are obsolete or may not be obsolete but may have a higher capital value than are necessary for us. The corner of Reed and Bethel Road is a great place for a gas station or a fast food restaurant. If it is, then it is worth several million

dollars. When you inventory them and put values on them so you know in the aggregate what all of these 60 or 70 bits of pieces are come up with a very different view of let's do this one or let's do that one.

Mrs. Wexner:

Also, I think to Sheldon's point of being sure we are being consistent with the strategy and then tying that to the strategic plan in terms of understanding what our footprint looks like and where those investments are made.

Mr. Kasey:

Would you like to table these until we can bring them back with further explanation?

Mr. Wexner:

Yes. I would give them to the committee and give them a whole list of properties. One of the first things I would do is see what we own in bits and pieces and what the commercial value of them are, and then look at the strategy going forward. This is not going to depreciate or appreciate much in 90 days, I do not think.

Mr. Kasey:

Elizabeth, is there any pre-agreement with the housing authority about the time for this one?

Ms. Seely:

I am sure we can accommodate that within the time frame.

Dr. Retchin:

That is tabled. Mr. Chair, for the last session and I know we are a little short on time, is a follow-up from the previous board meeting. Jeff Wadsworth had asked a questions about our research portfolio and some of the elements and in that case it was big data. It led to a discussion about translational science and I suggested at the time that we have Rebecca Jackson, who is the Director for the Center for Clinical and Translational Science address the board. Dr. Kent has come on board and I think you will find this as fascinating and worthwhile to continue to educate the board and ourselves and the value of our clinical research. I will ask Craig to introduce Dr. Jackson.

Dr. Kent:

Thank you, Sheldon. I thought I would start with a couple of slides about the importance of clinical research. The National Institute of Health (NIH) has been thought of to be the best in terms of basic science research. In the mid 2000's there was a sense among congress and many of the constituents that far too much money was being spent on basic science and that there was a need to have earlier translational research. Elias Zerhouni, who at the time was head of the NIH wrote this article in the New England Journal and it was all about reengineering the research enterprise so that there is a focus on clinical research. His idea was that the NIH in fact should be a purveyor of resources for clinical research. At that point in 2005 about a third of the NIH resources were devoted to clinical research. He was actually quite proud of that. The number continues to increase and if you look at 2015, over half of the NIH resources are devoted to clinical research. What that means is that there is a tremendous emphasis on clinical and translational research. Any powerhouse research institution has to have this as a major focus. As part of this initiative, he started the CTSA (Clinical Translational Science Awards) program and the idea was that resources were going to be given to a number of institutions around the country to create an infrastructure to facilitate and grow clinical

research. These are incredibly competitive awards and if you look around the country there are only 62 institutions that compete for these awards. The amount of money is pretty high. It is in the $4 million to $6 million a year range for five years, so a total amount of somewhere between $25 million and $30 million to each institution. The goal of this research is to create provocative and innovative research that in some very direct way is going to change patient care. That is the idea. We happen to be one of those centers and it turns out that in terms of reputation our CTSA is thought to be one of the best in the country and probably the person that is responsible for that is here with us today, Becky Jackson. Becky's background, a Buckeye I hear. She has a bachelor's and a medical degree from Ohio State and had a little sojourn to Johns Hopkins for her internal medicine residency, but then came back for her fellowship in endocrinology at Ohio State. She has been with us for 33 years. Thirty of those 33 years she has been funded by the NIH. Her total research funding over that period of time is an amazing $110 million. Her personal area of research is in osteoporosis and other areas of intricate surgery. She is published widely in the *New England Journal of Medicine*, the *Journal of the American Medical Association*, and *Nature Genetics*. These are just a few of her really fantastic publications. As I mentioned earlier, in the world of translational and clinical research she is a superstar and probably one of the reasons our CTSA is so great. Becky, thanks so much for joining us today and we look forward to your comments.

Dr. Jackson:

Thank you very much for letting me talk about one of my favorite topics. I wanted to put this into the human perspective for you. May 9, 1989 was really one of the happiest days of our lives when our first child Natalie was born. Three weeks later, however, as brand new parents we faced the worst nightmare that parents could have as our child was rushed to Nationwide Children's Hospital in respiratory distress. Over the next ensuing weeks, we underwent countless medical tests to try to understand what happened. Because of the advances of the human genome project, we were able to make a diagnosis of what Natalie had, which is a sporadic genetic disease called Angel Wing Syndrome. We had this really great scientific information of exactly what base pairs were changed, but unfortunately none of the information could be translated to care because there had been no therapies that actually targeted that. As a mother, as a clinician, and as a scientist it became obvious that our system does not work and that we had to have new ways of bringing information together, bringing teams together, and bringing different perspectives together. It actually ultimately does what we want to do in biomedical sciences, which is to ultimately improve the human condition.

As a land grant institution we really have a mission to translate new knowledge as a sacred social compact to the communities locally, nationally, and globally. At Ohio State we have great resources and expertise in those three major disciplines associated with translational science; basic science discovery, clinical research, and then implementation or population types of health. Unfortunately, despite all the resources of expertise that we put into those areas across the university we have really been unable to organize ourselves in ways that actually allows those disciplines to work together to bear on some of the most pressing problems that reach us. There are a lot of challenges associated with really moving forward translational science to that ultimate end game. First of all, it is not a linear process and we have often over the last probably 100 years thought that we could simply march down, but in fact it has to be not only bidirectional but multidirectional. The AIDS epidemic is a perfect example of that multidirectional because it was a group of clinicians who saw a group of young men who developed this autoimmune disease that was immunosuppressive. They talked to other scientists and said, you know this seems to be a new syndrome. Those scientists brought it back to the laboratory, identified the problems, and put the focus on the development of therapeutics. We have taken an absolutely fatal disease when I was a resident and now made it a product disease that people live well with. That is the promise of translational science.

In order to be able to really address these kinds of challenges, groups of individuals across the entire university in 2006 from almost every single college came together to work to develop the Center for Clinical and Translational Science. We currently have more than 2800 members who are involved in this kind of initiative and come from 14 different colleges. We have active partnerships with Nationwide Children's and Battelle Memorial Institute. We were funded in 2008 in the second round of the CTSA program with our first round of funding and we now have gone through our second cycle of funding in 2013 and will be coming forward for our third round of funding for 2017-2018. As Craig said, we are one of 62-64 of the funded institutes that actually make up the CTSA consortium. The goal of the consortium and the goal for us at Ohio State is relatively straightforward; it is to speed the translation of scientific discoveries to clinical therapies that improve human health and is that not in fact what we all want to do? That is why we deliver healthcare.

This is a new paradigm because most scientists are used to working in isolation. Most of them are very focused, driven, and disciplined. They have some of the greatest vaults of information in one area, but translational science is not individual science, it is team science. It really engages the entire group of stakeholders that are involved on the process of translational science spectrum. From basic scientists to clinical investigators to clinicians in health systems as well as patients, public policy, society, and public and private partnerships all to work and to actually cross these translational gaps that have really slowed the process. Currently the process of taking a new discovery to the bed side and to the community takes a minimum of about 17 years and that is simply not acceptable. When you add on that in fact, less than one out of every 500-1000 discoveries ever moves forward to ever actually having some impact on human health. You can see that this is a system that is actually crying out for some new solutions in the future.

Our call to action in the Clinical and Translational Science Center and our focus over the last year has been to bring together groups across the university to actually address these issues. Our foundation is the strength of our informatics programs in order to be able to focus on big data and learning from our patients is to integrate the scientific cores that we have. We are really very lucky at Ohio State to have such a large investment in that area to bring together that wealth of educational programs to be able to work in synergy rather than in a competitive fashion. Then to look to our engaged stakeholders, our patients, clinicians, and other groups to actually begin to define some of the most pressing problems. Our research engine that we talk about is to train and cultivate the translational science workforce because the types of skills that are necessary to do translational science are very different. It is a new set of language in order to be able to actually go across those disciplines. It is new ways of working together and new ways of leading a team. It is to foster and enhance scientific innovation through pilot funding mechanisms and other things that actually incentivize innovation. Then, it is the same types of things a health system works on in a regular day, which is to improve actual operational efficiency and quality. We really applied the same type of lean six sigma processes to clinical and translational research to actually decrease the time to study start up, to move things forward, and to enhance communications. All of those things that are ultimately what we think will contribute to that objective of sustained and innovative translational research that makes a difference for our patients.

What has been our impact since we were initially funded in 2008? Over the first two cycles we received over $68 million in direct funding to the CCTS (Center for Clinical and Translational Science) to support our activities across the university. We have had major leadership in a number of consortium activities, I was the national consortium chair in 2010 and currently serve on the executive steering committee for the entire consortium. As a result of the support of our research community we have had over 1294 public publications in high impact journals that are directly attributable to receiving resources and other types of support from the CCTS. When you look at that from a clinical research perspective, in the clinical research center alone, there have been more than 2687 patient visits and simply in the last year that supported $28.8 million of funded

research activities that went on in the CRC (clinical research center). We have also become competitive going after some of these very large national grants that are both program project grants, which has been a major focus of the Comprehensive Cancer Center, but also to go after other mechanisms and other types of things and we have successfully competed for those now at more than a dozen institutions.

How have we gone about doing that? The first thing is really developing the translational science workforce. We recognize that in fact, not only were people not going into research as a career, but in fact it that was a very leaky pipeline. That career sustainability is critical. If we are going to invest in people and take our best and our brightest, we want to be able to have them continue to be successful along the way. One of our strategies was to have a pre-doctoral and early student career training program in translational science that laid the foundation and then support for early clinical and career faculty to be able to move forward and to develop their own laboratories and move forward. Next was to train the entire research teams and we have done that by having large numbers of workshops and online training resources so there is on-demand access to information and work together with the university and others to really incentivize research as a viable and sustainable career.

Have we been effective? In the last eight years alone, those individuals that we have invested with have in fact not only moved forward along in their career, but continue to remain engaged in translational science. Looking at our early stage faculty that have been directly supported by the CCTS, they have published more than 100 high impact publications and have been awarded more than $9.3 million in grants individually to them to continue to move those things forward. Clear leading indicators of a sustainable research career. To our pilot programs and other activities where we actually invest in individuals, new teams, and new ideas we have also worked closely to think of another area of translation and that is in the area of entrepreneurship and commercialization. As a result of the efforts and the support of the CCTS up through last year we had 19 invention disclosures and in fact two new startup companies, one by a young early career faculty member in otolaryngology who developed a new way of diagnosing otitis media at point-of-care testing and the second, which you have heard of is Signet Accel, which came out biomedical informatics and was built on a lot of investment by the CCC and the CCTS.

How do we advance innovation and translation? This is really a way of changing the culture. Rather than thinking about innovation the way scientists do, as creativity and following where the science takes you, we really try to envision this concept of innovation from a business perspective. Understanding what is important, what are the most pressing problems, what are acceptable solutions, and working together with the stakeholders in order to be able to do that. That is across the entire process of translation. From the very basic science level all the way through that community implementation. One of the ways we did that was developing a course that is required of everyone in our pilot programs, as well as required of all of our trainees, which is the Business of Science. This is a three-day workshop given at least annually that really focuses on principals of team leadership, project management, innovation, leaving a legacy, as well as communication. All of our pilot programs, and in fact in the developmental careers of our trainees who have taken a project management approach. We do hold people accountable for milestones and metrics, which is a coming to Jesus moment for many investigators because that is not in fact the way we go. We go where the science takes us, rather than thinking of the deliverables that we really committed to, because really what is a grant but a business plan. It is a business plan of a scientific idea that you are moving forward to answer a specific set of hypotheses. Taking all of those for a course all around the university we actually work to integrate these. One of the most unique, and now best in class nationally of our approaches, is something that we call the translational therapeutics think tank where we brought together all of the groups that are involved in supporting pre-clinical drug therapeutics to work together and develop a design studio together with investigators to give them feedback early on and

to meet regularly with them to help them understand how to more efficiently move their processes forward.

What have been the outcomes of doing all of this? When we surveyed people more than a year after they completed the Business of Science workshops or were involved in our project management, one of the things that they incorporated were the tools and the skills that we gave them into their daily practice. In fact, 100% of the people who attended that said it was the single most valuable workshop that they have every attended during their time as a trainee and as a faculty member. Our longitudinal pilot program before we instilled project management, 90% of our projects did not complete within the year of funding. When we added milestones, metrics, and accountability to it, 86% of the projects met all of the project timelines. What is even more impressive, 90% of the projects have actually moved on the translational pipeline in less than three years. This is an amazing shortening of seeing scientific innovation move forward. The other major change with clinical and translational science is that area of engagement and collaboration. Frequently, our concept of community involvement was to go to the communities and recruit them to be in our studies rather than to actively engage them to be the drivers of identifying the problems, working together with the study teams, and answering the most pressing problem. When talking about communities, I am not just talking about patients, I am talking about clinicians, health systems, public policy, and the government. We have developed a number of community engagement wards and in fact every project that is courted in the CCTA actually has to go to the community engagement board and work with them to try to get some feedback and representation. We have developed pilot funding initiatives to further develop these community academic partnerships and we have worked very closely with the health system here in the OSU Wexner Medical Center to begin to make those first real integrations into delivery of care with research.

What have our outcomes been over the last eight years? Currently, we have 74 active community partners that are engaged in community projects who work with investigators across the university. By working together with the health system, we identified the need for greater access to electronic health record data. Since the time that we began financially supporting the cost of extracting some of that data for investigators we have been able to serve about 593 requests for information that actually drove preliminary or in fact final based upon the actual data of the patients that we care for regularly. In collaboration with the health system, two years ago they added a link to participate in research. In just that two year period of time, 120,000 of our patients have clicked on that link, 20% moved forward to go to the registry and more than 10% of them signed up to be an active research participant. Our patients want that opportunity to be part of the answer.

Dr. Kent:

Becky, I know that we are going to have lots of questions and you are so excited about all that you do, would it be okay if we finish up at this point?

Dr. Jackson:

Yes, I am just going to give two quick impact examples.

Going back to our original goal, why are we doing this, the reason we are doing this is because we ultimately want to impact health.

I want to give you two very quick examples and the first of those is a study and a project that was done by Dr. Sashwati Roy. They dealt with the issue of chronic wounds that you probably know is the leading cause of non-traumatic amputations. Basic science discoveries, defined over the last couple of years, that biofilms with bacteria and this collagenous, fibrous film does not allow antibiotics to penetrate and therefore the wound cannot heal. Three years ago a team of investigators that included engineers, clinicians,

and basic scientists went together and with support of the CCTS developed a portable adhesive patch that actually has low electrical currents that disrupts the biofilms and allows antibiotic penetration. From the start of that project to the first demand studies it was less than three years and that device continues to impressively speed up the time of healing.

The last example is one that I want to bring because I think it really highlights that work with community. Lorraine Smith is a faculty member in the College of Nursing and she is very interested in reducing the impact of diabetes in underserved populations where there are large amounts of health inequity or health disparities. In the middle of her focus groups it became obvious that the communities that she was working with were concerned about diabetes but they were more concerned about the increasing incidence of diabetes and obesity in their teenagers. The leading cause in the increase in obesity seemed to be the consumption of sugar sweetened beverages. She worked together with the community members and with team advisory councils in two different schools to put together a pilot program to say 'how could we actually reduce the amount of sugar sweetened beverage intake and ultimately, potentially improve health?' Teams developed this approach toward motivational interviewing. They did not take sodas and sweets out of the machine, what they did was offer people other alternatives to think about. It was called the Sodabriety Challenge. In just 60 days, more than half of the students who took the challenge dropped their intake of sugar sweetened beverages by more than one per day and interestingly increased their intake of water by 19%, which was not a primary message. They had an unintentional, but a wonderful outcome of about two to three pounds of weight loss and they maintain that now over a two-year period of time. In fact, those results were so impressive that the Tennessee Water Network has now funded this intervention, this community based participatory research intervention, to be done in all high schools in the Tennessee area in the Appalachian communities over the next four years. Dr. Smith and her colleagues are going to do the scientific analysis to go along with it.

To finish, I do not think anyone says this more succinctly than Henry Ford. "Coming together is a beginning, keeping together is a progress, but working together is success." Thank you.

Dr. Kent:

Becky, that was absolutely fantastic. Thank you for everything that you do. Are there any questions?

Mr. Wexner:

It is very hard to get tech transfer and practical things through universities. Ours is no exception. I spent a little time at Dr. Drake's alma mater, Stanford, is probably the best because it is the priority of the university to get stuff to the real world. In the skunk work kind of labs in the buildings on the campus and they really champion it. In that context, if you had a magic wand to create magic resources to do more, better, and faster what would be your wish?

Dr. Jackson:

I think there are a couple of things. I think the primary thing is culture. Incentivizing research and actually showing that entrepreneurship, commercialization, and dissemination are critical components of our daily job and that there are multiple ways to disseminate that. The cost for example of the Sodabriety Challenge is relatively low. It is simply motivational messages that could have a huge impact on health over a period of time. In other areas like tech licensing in order to get those types of new drugs or devices in the hands of clinicians and health systems is really critical. Universities do not do that best. We really need to develop those kinds of partnerships. I would say number one is continuing to incentivize those areas and recognize that there are multiple

different ways to disseminate and translate our information and that all of those things are critically important. Two is continuing to invest in the research infrastructure and invest in people. I was really close to Woody Hayes and in fact he was in my wedding. I always use his quote, “you win with people.” It is really bringing the best and the brightest, to invest in them, and then to put the teams and the resources around them to allow them to be successful. Third is to bring that group of team science together because as I said, it really does take a village. It is a new way of interacting and working together. Ways of doing that and developing those trusting relationships between different groups of sciences and changes in the promotion and tenure guidelines that really recognize the importance of team science. All of those things are critical for moving things forward. If you want to give me $100 million that is okay too.

Mr. Wexner:

I was not planning on it, but I am really interested in this subject and I know that the university board is and the cultural part of how to get entrepreneurs inside an institution that is not entrepreneurial. It is obvious to me from listening to you that you are, and have been, a successful entrepreneur in how you get people to team and do stuff at measurable result. We can talk offline, but if you had resources at a place, as in an angel fund, is it a bigger megaphone? The university needs these champions like you that get into the real world. It is very hard to do it within the institution because the institution has a cadence and a culture that goes with a large bureaucracy.

Dr. Kent:

I think that is true of any university and I want to go back to Becky’s comment that it is about the people. I think that trying to recruit a group of people that like to translate and then creating an environment for them where it is easy to do and is comfortable is really the solution. That is part of our agenda moving forward.

Mrs. Wexner:

Dr. Kent and I heard a presentation at Nationwide Children’s this week about the biofilm research that Dr. Sashwati Roy is doing and it sounds like this is a different approach. Are you coordinating?

Dr. Jackson:

They are coordinated and in fact we help to support that research as well. As I said, Nationwide is an active partner and the CCTS is every bit as active at Nationwide as it is at Ohio State. The Center for Clinical Research there really is our effector arm at Nationwide. We work closely with Bill Smoyer and his group in that area. The early career faculty went on to develop the company. It was actually Dr. Lauren Bakelatz’s mentee in moving forward on that area. There are large amounts of efforts and one of the things is bringing those teams together. In our longitudinal pilot program for example, scientists are often reluctant to share early information because of that first publication or that first thing. What we do is, we basically bring them all into a room, have them present to each other three slides and major impact and then we ask questions. We try to improve their presentations. What you find is that within those things now you start getting those cross collaborations because they say, “I did not know you were doing that. We can complement that.” That is the beauty of translational science. I think that is the strength of Ohio State. What we have at Ohio State that very few other places have is that ability to look at a problem from multiple different perspectives and to bring all of those perspectives together to do that. That is our competitive advantage and we need to continue to develop that.

Mr. Wexner:

We can talk offline to discuss what you need. Is it a place? Is it an angel fund? We need that spark at the university, let alone the medical center. It is so hard and obviously you are doing it. I am just so elated. Have you ever heard of a lady named Tina Seelig?

Dr. Jackson:

Yes.

Mr. Wexner:

Good. I was going to send you her book, but since you have heard of her I bet you have it.

Dr. Retchin:

Great job, Becky. Thank you for your leadership.

(See Attachment XI for background information, page 161)

Ms. Link:

The board will now recess into executive session to consider business sensitive trade secret matters required to be kept confidential by federal and state statues and to consult with legal counsel regarding pending or imminent litigation.

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

Attest:

Leslie H. Wexner Chairman	Heather Link Associate Secretary

(ATTACHMENT VIII)

November 2, 2016 meeting, Wexner Medical Center Board

(ATTACHMENT IX)

Health System Financial Summary

September 2016

The Ohio State University Health System

Financial Highlights

For the YTD ended: September 30, 2016

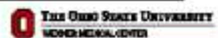
Admissions	
Budget	2.4%
Prior Yr	2.8%
Actual	15,469
Budget	15,106
Prior Yr	15,050

Surgeries	
Budget	1.4%
Prior Yr	3.5%
Actual	10,788
Budget	10,636
Prior Yr	10,424

O/P Visits	
Budget	-3.3%
Prior Yr	2.1%
Actual	436,783
Budget	451,548
Prior Yr	427,831

Worked Hrs / Adjusted Admit	
Budget	4.1%
Prior Yr	0.8%
Actual	195
Budget	199
Prior Yr	197

2



The Ohio State University Health System

Financial Highlights

For the YTD ended: September 30, 2016
($ in thousands)

Operating Revenue	
Budget	0.3%
Prior Yr	5.6%
Actual	$672,074
Budget	$670,077
Prior Yr	$636,321

Controllable Costs	
Budget	-0.3%
Prior Yr	-8.4%
Actual	$520,655
Budget	$518,967
Prior Yr	$480,453

Excess Revenue over Expense	
Budget	-1.4%
Prior Yr	-14.1%
Actual	$45,535
Budget	$46,198
Prior Yr	$53,011

Days Cash on Hand		
PY FY16	-2.4%	
PY MTD	16.0%	
Actual	111.6	$680M
PY FY16	114.3	$674M
PY MTD	96.2	$543M

The Ohio State University Health System

Consolidated Activity Summary

For the MTD ended: September 30, 2016

OSUHS	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
CONSOLIDATED ACTIVITY SUMMARY						
Activity						
Admissions	4,997	4,959	38	0.8%	4,886	2.3%
Surgeries	3,589	3,528	61	1.7%	3,492	2.8%
Outpatient Visits	147,092	150,379	(3,287)	-2.2%	143,913	2.2%
Average Length of Stay	6.10	6.18	0.09	1.4%	6.43	5.2%
Case Mix Index (CMI)	1.85	1.86	(0.01)	-0.7%	1.79	3.1%
Adjusted Admissions	9,530	9,463	67	0.7%	9,126	4.4%
Operating Revenue per AA	$ 23,139	$ 23,350	(211)	-0.9%	$ 22,921	1.0%
Operating Expense per AA	$ 20,852	$ 20,704	(148)	-0.7%	$ 20,397	-2.2%

The Ohio State University Health System

Consolidated Statement of Operations

For the MTD ended: September 30, 2016

(in thousands)

OSUHS	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	$ 220,517	$ 220,967	$ (450)	-0.2%	$ 209,177	5.4%
Operating Expenses						
Salaries and Benefits	100,971	98,342	(2,629)	-2.7%	94,769	-6.5%
Supplies	25,293	23,356	(1,937)	-8.3%	21,398	-18.2%
Drugs and Pharmaceuticals	20,701	22,839	2,138	9.4%	22,200	6.8%
Services	23,957	24,299	342	1.4%	22,391	-7.0%
Depreciation	11,779	11,267	(512)	-4.5%	11,622	-1.4%
Interest	3,342	3,329	(13)	-0.4%	3,493	4.3%
Other	12,677	12,493	(184)	-1.5%	10,275	-23.4%
Total Expense	198,720	195,925	(2,795)	-1.4%	186,148	-6.8%
Gain (Loss) from Operations (pre MCI)	21,797	25,042	(3,245)	-13.0%	23,029	-5.3%
Medical Center Investments	(12,518)	(12,414)	(104)	0.8%	(11,407)	-9.7%
Income from Investments	560	228	332	145.6%	265	111.3%
Other Gains (Losses)	(8)	-	(8)	—	455	—
Excess of Revenue over Expense	$ 9,831	$ 12,856	$ (3,025)	-23.5%	$ 12,342	-20.3%

5

The Ohio State University Health System

Consolidated Activity Summary

For the YTD ended: September 30, 2016

OSUHS	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
CONSOLIDATED ACTIVITY SUMMARY						
Activity						
Admissions	15,469	15,106	363	2.4%	15,050	2.8%
Surgeries	10,785	10,636	149	1.4%	10,423	3.5%
Outpatient Visits	436,783	451,548	(14,765)	-3.3%	427,831	2.1%
Average Length of Stay	6.10	6.17	0.07	1.1%	6.33	3.7%
Case Mix Index (CMI)	1.81	1.86	(0.05)	-2.5%	1.80	0.7%
Adjusted Admissions	29,512	28,735	777	2.7%	27,943	5.6%
Operating Revenue per AA	$ 22,773	$ 23,319	(546)	-2.3%	$ 22,772	0.0%
Operating Expense per AA	$ 19,992	$ 20,439	447	2.2%	$ 19,719	-1.4%

6

The Ohio State University Health System

Consolidated Outpatient Visit Summary

For the MTD & YTD ended: September 30, 2016

MONTH							YTD					
ACTUAL	BUDGET	ACT-BUD VAR	BUDGET % VAR	PRIOR YEAR	PY % VAR	CATEGORY	ACTUAL	BUDGET	ACT-BUD VAR	BUDGET % VAR	PRIOR YEAR	PY % VAR
2,256	2,160	96	4.4%	2,150	4.9%	Surgeries	6,750	6,489	261	4.0%	6,437	4.9%
9,649	10,254	(605)	-5.9%	9,900	-2.5%	ED Visits	28,937	31,140	(2,203)	-7.1%	29,521	-2.0%
10,582	10,354	228	2.2%	10,249	3.2%	Procedures	31,612	31,755	(143)	-0.5%	30,197	4.7%
316	[illegible]	[illegible]	-7.6%	[illegible]	7.0%	Cath Lab	[illegible]	[illegible]	[illegible]	-8.0%	[illegible]	7.0%
225	223	2	0.9%	189	19.0%	IP Lab	710	668	42	6.3%	582	22.0%
342	379	(36)	-9.5%	346	-1.4%	Interventional Radiology	1,008	1,134	(126)	-11.1%	1,059	-4.8%
4,022	3,579	443	12.4%	3,639	10.5%	Radiation Oncology	11,719	11,303	416	3.7%	10,744	9.1%
5,679	5,838	(160)	-2.7%	5,761	-1.4%	All Other	17,237	17,656	(419)	-2.3%	16,942	1.7%
36,320	37,156	(836)	-2.2%	35,599	2.0%	Clinic Visits	108,050	111,383	(3,333)	-3.0%	105,743	2.2%
33,991	34,487	(495)	-1.4%	31,177	9.0%	Clinic/Office Visits	100,869	103,413	(2,544)	-2.5%	96,459	4.6%
2,329	2,669	(340)	-12.7%	2,589	-10.0%	Chemo Visits	7,181	7,970	(789)	-9.9%	7,403	-3.0%
17,086	16,840	246	1.5%	15,697	8.9%	Rehab Services	50,208	51,074	(866)	-1.7%	46,724	7.5%
14,043	13,977	66	0.5%	13,690	2.6%	Radiology	41,829	41,778	51	0.1%	39,991	4.0%
21,758	22,582	(824)	-3.7%	22,849	-4.9%	Lab	65,983	67,843	(1,860)	-2.8%	66,650	-1.0%
1,988	2,008	(20)	-1.0%	1,955	1.7%	Pharmacy	5,988	6,023	(35)	-0.6%	5,889	1.7%
341	556	(215)	-38.7%	324	5.2%	Other OP Visits	1,243	1,670	(427)	-25.6%	1,387	-10.4%
33,089	34,512	(1,423)	-4.1%	31,507	5.0%	Physician Visits	96,103	102,307	(6,204)	-6.1%	95,284	0.9%
147,092	150,379	(3,287)	-2.2%	143,913	2.2%	TOTAL OUTPATIENT VISITS	436,783	451,548	(14,765)	-3.3%	427,831	2.1%

The Ohio State University Health System

Consolidated Statement of Operations

For the YTD ended: September 30, 2016

(in thousands)

OSUHS	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	$ 672,074	$ 670,077	$ 1,997	0.3%	$ 636,321	5.6%
Operating Expenses						
Salaries and Benefits	292,978	292,911	(67)	0.0%	275,966	-6.2%
Supplies	74,820	70,714	(4,106)	-5.8%	67,983	-10.1%
Drugs and Pharmaceuticals	67,708	69,392	1,684	2.4%	65,498	-3.4%
Services	72,043	72,653	610	0.8%	67,289	-7.1%
Depreciation	35,098	34,132	(966)	-2.8%	34,955	-0.4%
Interest	10,029	9,998	(31)	-0.3%	10,515	4.6%
Other	37,319	37,500	181	0.5%	28,808	-29.5%
Total Expense	589,995	587,300	(2,695)	-0.5%	551,014	-7.1%
Gain (Loss) from Operations (pre MCI)	82,079	82,777	(698)	-0.8%	85,307	-3.8%
Medical Center Investments	(37,513)	(37,252)	(261)	0.7%	(34,222)	-9.6%
Income from Investments	983	673	310	46.1%	584	68.3%
Other Gains (Losses)	(14)	-	(14)	---	1,342	---
Excess of Revenue over Expense	$ 45,535	$ 46,198	$ (663)	-1.4%	$ 53,011	-14.1%

The Ohio State University Health System

Consolidated Balance Sheet

As of: September 30, 2016

(in thousands)

	September 2016	June 2016	Change
Assets			
Cash	$ 544,314	$ 538,576	$ 5,738
Net Patient Receivables	340,523	324,460	16,063
Other Current Assets	66,402	69,490	(3,088)
Assets Limited as to Use	255,616	255,498	118
Property, Plant & Equipment - Net	1,393,389	1,370,708	22,681
Other Assets	14,408	35,588	(21,180)
Total Assets	$2,614,652	$2,594,320	$ 20,332
Liabilities & Net Assets			
Current Liabilities	$ 253,194	$ 266,841	$ (13,647)
Other Liabilities	99,577	99,335	242
Long-Term Debt	781,967	793,762	(11,795)
Net Assets - Unrestricted	1,479,914	1,434,382	45,532
Net Assets - Restricted	-	-	-
Total Liabilities & Net Assets	$2,614,652	$2,594,320	$ 20,332

OSU Wexner Medical Center

Combined Statement of Operations

For the YTD ended: September 30, 2016

(in thousands)

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	$ 828,446	$ 824,697	$ 3,750	0.5%	$ 785,912	5.4%
Operating Expenses						
Salaries and Benefits	429,136	434,593	5,453	1.3%	403,145	-6.4%
Supplies	80,957	75,972	(4,985)	-6.6%	74,204	-9.1%
Drugs and Pharmaceuticals	74,132	76,925	2,793	3.6%	72,480	-2.3%
Services	94,853	93,368	(1,485)	-1.6%	84,822	-11.8%
Depreciation	37,604	37,268	(336)	-0.9%	38,138	1.4%
Interest/Debt	12,912	12,843	(69)	-0.5%	13,336	3.2%
Other Operating Expense	43,947	44,337	389	0.9%	32,561	-35.0%
Medical Center Investments	2,987	2,455	(532)	-22%	4,149	28.0%
Total Expense	776,522	777,750	1,228	0.2%	722,836	-7.4%
Excess of Revenue over Expense	$ 51,924	$ 46,946	$ 4,978	10.6%	$ 63,075	-17.7%
Financial Metrics						
Adjusted Admissions	29,512	28,735	777	2.7%	27,943	5.6%
OSUP Physician Encounters	636,769	665,520	(28,751)	-4.3%	597,369	6.6%
Operating Revenue per AA	$ 22,773	$ 23,319	$ (546)	-2.3%	$ 22,772	0.0%
Total Expense per AA	$ 19,992	$ 20,439	$ 447	2.2%	$ 19,719	-1.4%

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

10

OSU Wexner Medical Center

Combined Statement of Operations

For the YTD ended: September 30, 2016
(in thousands)

	ACTUAL	BUDGET	ACT-BUD VARIANCE	BUDGET % VAR	PRIOR YEAR	PY % Var
Health System						
Revenues	$ 672,074	$ 670,077	$ 1,997	0.3%	$ 638,321	5.3%
Expenses	626,539	623,879	(2,660)	-0.4%	583,310	-7.4%
Net	45,535	46,198	(663)	-1.4%	53,011	-14.1%
OSUP						
Revenues	$ 105,519	$ 105,990	$ (472)	-0.4%	$ 98,065	7.6%
Expenses	101,346	102,029	683	0.7%	91,469	-10.8%
Net	4,172	3,961	211	5.3%	6,596	-36.7%
COM/OHS						
Revenues	$ 50,854	$ 48,629	$ 2,224	4.6%	$ 51,525	-1.3%
Expenses	48,637	51,841	3,205	6.2%	48,054	-1.2%
Net	2,217	(3,212)	5,429	169.0%	3,471	-36.1%
Total Medical Center						
Revenues	$ 828,446	$ 824,697	$ 3,750	0.5%	$ 785,912	5.4%
Expenses	776,522	777,750	1,228	0.2%	722,836	-7.4%
Net	51,924	46,948	4,976	10.6%	63,076	-17.7%

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

OSU Wexner Medical Center

Combined Balance Sheet

As of: September 30, 2016
(in thousands)

	September 2016	June 2016	Change
Cash	$ 688,834	$ 680,218	$ 8,616
Net Patient Receivables	378,329	362,813	15,517
Other Current Assets	340,127	300,305	39,822
Assets Limited as to Use	255,616	255,498	118
Property, Plant & Equipment - Net	1,510,678	1,497,572	13,106
Other Assets	412,927	417,545	(4,618)
Total Assets	$ 3,586,511	$ 3,513,952	$ 72,560
Current Liabilities	$ 302,527	$ 305,907	$ (3,380)
Other Liabilities	99,577	99,335	242
Long-Term Debt	890,454	911,469	(21,015)
Net Assets - Unrestricted	1,767,254	1,707,935	59,320
Net Assets - Restricted	526,699	489,306	37,393
Liabilities and Net Assets	$ 3,586,511	$ 3,513,952	$ 72,560

OSU Wexner Medical Center

Combined Balance Sheet

As of: September 30, 2016
(in thousands)

	September 30, 2016				June 30, 2016			
	Health System	OSUP	COM	Medical Center Total	Health System	OSUP	COM	Medical Center Total
Cash	$ 544,314	$ 84,984	$ 59,536	$ 688,834	$ 538,376	$ 85,777	$ 55,803	$ 680,218
Net Patient Receivables	341,523	37,806	–	379,329	324,460	38,353	–	362,813
Other Current Assets	66,402	33,544	240,181	340,127	85,490	22,920	207,890	306,300
Assets Limited as to Use	255,616	-	-	255,616	250,438	-	-	250,438
Property, Plant & Equipment - Net	1,393,389	23,582	93,707	1,510,678	1,370,708	24,297	102,567	1,497,572
Other Assets	14,408	4,893	393,628	412,937	35,588	4,573	376,384	417,545
Total Assets	$ 2,014,052	$ 184,807	$ 787,052	$ 3,986,011	$ 2,894,328	$ 176,320	$ 743,313	$ 3,813,962
Current Liabilities	$ 255,154	$ 42,811	$ 6,522	$ 302,527	$ 268,841	$ 38,136	$ 930	$ 305,907
Other Liabilities	39,577	–	–	39,577	39,335	–	–	39,335
Long-Term Debt	701,367	14,779	93,707	809,454	733,762	15,140	102,567	811,469
Net Assets - Unrestricted	1,473,914	127,217	160,123	1,767,254	1,434,382	123,844	136,508	1,707,335
Net Assets - Restricted			526,659	526,659			485,306	485,306
Liabilities and Net Assets	$ 2,014,052	$ 184,807	$ 787,052	$ 3,986,011	$ 2,894,328	$ 176,320	$ 743,313	$ 3,813,962

13

The Ohio State University
Wexner Medical Center

(ATTACHMENT X)

Leadership Council

FOR CLINICAL QUALITY, SAFETY AND SERVICE

The Ohio State University Wexner Medical Center

Clinical Quality Management, Patient Safety, & Service Plan

FY17

July 1, 2016 -June 30, 2017

Clinical Quality Management, Patient Safety, & Service Plan

MISSION, VISION, AND VALUES 4

DEFINITION 4

PROGRAM SCOPE 4

PROGRAM PURPOSE 5

OBJECTIVES 5

STRUCTURE FOR QUALITY OVERSIGHT 5

APPROACH TO QUALITY, SAFETY & SERVICE MANAGEMENT 16

CONSISTENT LEVEL OF CARE 18

PERFORMANCE TRANSPARENCY 18

CONFIDENTIALITY 18

CONFLICT OF INTEREST 19

DETERMINING PRIORITIES 19

DATA MEASUREMENT AND ASSESSMENT 20

- Determination of data needs 20
- Collection of data 20
- Assessment of data 20
- Surveillance system 21

PERFORMANCE BASED PHYSICIAN QUALITY & CREDENTIALING 22

ANNUAL EVALUATION 24

ATTACHMENTS

I. PRIORITY CRITERIA....... 25

II. LOCQSS PRIORITIES 26

III. QUALITY & SAFETY SCORECARD..................................... 27

VI. PHYSICIAN PERFORMANCE-BASED PROFILE 30

Clinical Quality Management, Patient Safety, & Service Plan

Mission, Vision and Values

Our Mission:

To improve people's lives through innovation in research, education and patient care

Our 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 and Compassion
- Leadership

Our Vision:

Working as a team, we will shape the future of medicine by creating, disseminating and applying new knowledge, and by personalizing health care to meet the needs of each individual

Definition

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

Program Scope

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

Program Purpose

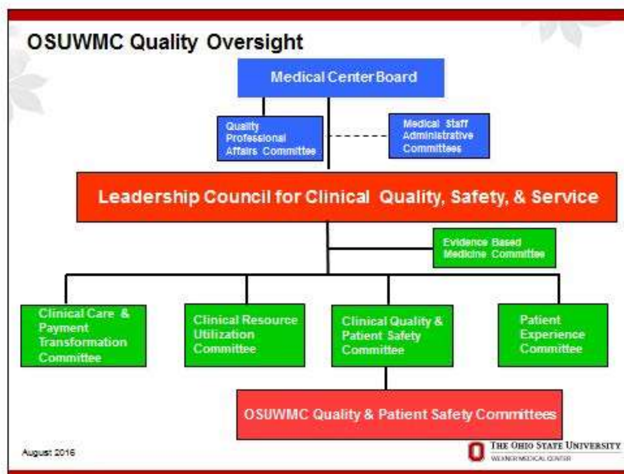
The purpose of the Clinical Quality Management, Patient Safety & Service Plan is to show measurable improvements in areas for which there is evidence they will improve health outcomes and value of patient care provided within The OSUWMC. The OSUWMC recognizes the importance of creating and maintaining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

Objectives

1) Continuously monitor, evaluate, and improve outcomes and sustain improved performance.
2) Recommend reliable system changes that will improve patient care and safety by assessing, identifying, and reducing risks within the organization and responding accordingly when undesirable patterns or trends in performance are identified, or when events requiring intensive analysis occur.
3) Assure optimal compliance with accreditation standards, state, federal and licensure regulations.
4) Develop, implement, and monitor adherence to evidenced-based practice guidelines and companion documents in accordance with best practice to standardize clinical care and reduce practice variation.
5) Improve patient experience and their perception of treatment, care and services by identifying, evaluating, and improving performance based on their needs, expectations, and satisfaction.
6) Improve value by providing the best quality of care at the minimum cost possible.
7) Provide a mechanism by which the governance, medical staff and health system staff members are educated in quality management principles and processes.
8) Provide appropriate levels of data transparency to both internal and external customers.
9) Assure processes involve an interdisciplinary teamwork approach.
10) Improve processes to prevent patient harm.

Structure for Quality Oversight

The Leadership Council for Clinical Quality, Safety & Service serves as the single, multidisciplinary quality and safety oversight committee for the OSUWMC. The Leadership Council utilizes criteria **[Attachment I]** to determine annual priorities for the health system **[Attachment II]**.



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

Quality Professional Affairs Committee

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. Such 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 quality and professional affairs committee shall be responsible for the following specific duties:

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

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

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

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

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

(6) Reviewing and approving clinical privilege forms;

(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.

Medical Staff Administrative Committees (MSACs)
Composition: Refer to Medical Staff Bylaws and Rules and Regulations
Function: Refer to Medical Staff Bylaws and Rules and Regulations

The organized medical staff, under the direction of the Medical Director and the MSAC(s) for each institution, implements the Clinical Quality Management and Patient Safety Plan throughout the clinical departments.

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

Leadership Council for Clinical Quality, Safety and Service (LCCQSS):
Composition: Refer to Medical Staff Bylaws and Rules and Regulations
Function: Refer to Medical Staff Bylaws and Rules and Regulations

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

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

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

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

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

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

Function:

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

Patient Experience Council

Composition:

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

Function:

1. Create a culture and environment that delivers an exceptional patient experience consistent with the OSU Medical Center's mission, vision and values focusing largely on service quality.
2. Measure and review voice of the customer information in the form of Patient and Family Experience Advisor Program and related councils, patient satisfaction data, comments, letters and related measures.
3. Monitor publicly reported and other metrics used by various payers to ensure optimal reimbursement.
4. Recommend system goals and expectations for a consistent patient experience.
5. Collaborate with other departments to reward and recognize faculty and staff for service excellence performance.
6. Provide guidance and oversight on patient experience improvement efforts ensuring effective deployment and accountability throughout the system.
7. Serve as a communication hub reporting out objectives and performance to the system.

8. Serve as a coordinating body for subcommittees working on specific aspects of the patient experience.

Clinical Resource Utilization Committee (CRU)

Composition:

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

Function:

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

Key areas of focus:

Availability and appropriateness of clinical resources and services

- OP/IP beds appropriateness
- Availability of necessary services
- Timeliness of necessary services
- Appropriate use of necessary services

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

Clinical Care & Payment Transformation (CPPT) Governance Committee

Composition:

The CCPT Governance Committee consists of multidisciplinary representatives from Administration, Medical Staff, Nursing, Information Technology, Financial Services, Government Affairs and the OSU Health Plan. The Committee is co-chaired by the Chief Quality Officer and the CEO of University Hospital. The committee reports to LCCQSS and shares pertinent information with other committees as needed. The Committee's charter is to "Transform our care delivery model, across the continuum. We will accomplish this through the alignment of people, processes and technology in order to create measurable value for the organization and the people we serve."

Function:

1. •Provides strategic vision and oversight of all clinical transformation activities, which include alternative payment model programs such as bundled payments, population health management and care redesign.
2. •Prioritizes episodes of care for transformation based on their overlap with payer initiatives, quality improvement efforts, financial performance, consumer preferences and leadership engagement.
3. •Oversees care redesign efforts to ensure alignment across business units and holds leaders accountable for improved quality and financial outcomes.
4. •Ensures awareness of and preparation for payer-mandated alternative payment programs.

Practitioner Evaluation Committee (PEC)

Composition:

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

Function:

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

Health System Information Systems Steering Team (HSISST)

Composition:

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

Function:

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

Sentinel Event Team

Composition:

The OSU Health System Sentinel Event Team (SET) includes an Administrator, the Chief Quality and Patient Safety Officer, the Associate Executive Director for Quality & Patient Safety, a member of the Physician

Executive Council, a member of the Nurse Executive Council , representatives from Quality and Operations Improvement and Risk Management and other areas as necessary.

The Sentinel Event Determination Group (SEDG)
The SEDG is a sub-group of the Sentinel Event Team and determines whether an event will be considered a sentinel event or near miss, assigns the Root Cause Analysis (RCA) Executive Sponsor, RCA Workgroup Leader, RCA Workgroup Facilitator, and recommends the Workgroup membership to the Executive Sponsor. The Sentinel Event Team facilitator will attend to support the members.

Composition:
The SEDG membership includes the CMO or designee, Director of Risk Management, and Quality Director of respective business unit for where the event occurred (or their designee).

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

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

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

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

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

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

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

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

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

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

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

Medical Director/Director of Medical Affairs
Each business unit Medical Director is responsible for the implementation and oversight of the Clinical Quality Management, Patient Safety & Service Plan. Each Medical Director is also responsible for reviewing the recommendations from the Clinical Quality Management, Patient Safety & Service Plan.
Associate Medical Directors
The Associate Medical Directors assist the CQPSO in the oversight, development, and implementation of the Clinical Quality Management, Patient Safety & Service Plan as it relates to the areas of quality, safety, evidence-based medicine, clinical resource utilization and service.

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

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

Clinical Department Chief and Division Directors:

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

Medical Staff

Medical staff members are responsible for achieving the highest standard of care and services within their scope of practice. As a requirement for membership on the medical staff, members are expected and must participate in the functions and expectations set forth in the Clinical Quality Management, Patient Safety, & Service Plan. In addition members may be asked to serve on quality management committees and/or quality improvement teams.

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

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 an opportunity to participate in clinical quality, patient safety and service-related initiatives while incorporating the perspective of the frontline provider. HQF will work on quality, safety and service-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 Improvement and Patient Safety Department is to coordinate and facilitate nursing quality improvement, participation/collaboration with system-wide patient safety activities, the use of evidence-based practice (EBP) and research to improve both the delivery and outcomes of personalized nursing care, and the submission of outcome data to the National Database for Nursing Quality Indicators (NDNQI). The primary responsibility for the implementation and evaluation of nursing quality improvement, patient safety, and EBP resides in each department/program; however, the Nursing Quality Improvement and Patient Safety staff members also 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. The Nursing Quality Improvement and Patient Safety Department collaborates with the OSUWMC Hospital Quality and Operations Department.

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 & Service Plan or participate in corrective action plans for individual employees or the department as a whole. Department directors provide input regarding committee memberships, and serve as participants on quality management committees and/or quality improvement teams.

Health System Staff

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

- Reporting events that reach the patient and those that almost reach the patient via the internal Patient Safety Reporting System
- 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 Department:

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

Patient Experience Department

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

Approach to Quality, Safety & Service Management

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

Principles

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

- Safe
- Timely
- Effective
- Efficient
- Equitable
- Patient-centered

These principles are:

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

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

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

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

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

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

Continuous: Measurement and improvement are ongoing.

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

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

Model

Systematic Approach/Model to Process Improvement

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

***The Process Improvement Toolkit**

Methodology
PDCA
Rapid Cycle Improvement
DMAIC
Lean Principles

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

Consistent Level of Care

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

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

Performance Transparency

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

Performance data are also shared internally with faculty and staff through a variety of methods. The purpose of providing data internally is to assist faculty and staff in having real-time performance results and to use those results to drive change and improve performance when applicable. On-line performance scorecards have been developed to cover a variety of clinical quality, safety and service metrics. When applicable, on-line scorecards provide the ability to "drilldown" on the data by discharge service, department and nursing unit. In some cases, password authentication also allows for practitioner-specific data to be viewed by Department Chairs and various Quality and Administrative staff. Transparency of information will be provided within the limits of the Ohio law that protects attorney –client privilege, quality inquiries and reviews, as well as peer review.

Confidentiality

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

Conflict of Interest

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

Determining Priorities

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

Data Measurement and Assessment

Determination of data needs

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

External reporting requirements

There are a number of external reporting requirements related to quality, safety, and service. These include regulatory, governmental, payer, and specialty certification organizations.

Collection of data

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

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

Assessment of data

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

Surveillance system

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

Quality & Safety Scorecard

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

Vital Signs of Performance

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

Patient Satisfaction Dashboard

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

Quality, Patient Safety, and Service Educational Information

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

- On line videos
- Quality & Patient Safety Simulcasts
- News Letters

- Classroom forums
- Simulation Training
- Computerized Based Learning Modules
- Partnerships with IHI Open School
- Curriculum Development within College of Medicine
- Websites (internal OneSource and external OSUMC)
- Patient Safety Lessons Learned
- Patient Safety Alerts

Benchmark data

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

Internal Benchmarking

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

External Benchmarking

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

Design and evaluation of new processes

- New processes are designed and evaluated according to the Health System's mission, vision, values, priorities, and are consistent with sound business practices.
- The design or re-design of a process may be initiated by:
- Surveillance data indicating undesirable variance
- Patients, staff, or payers perceive the need to change a process
- Information from within the organization and from other organizations about potential risks to patient safety, including the occurrence of sentinel events
- Review and assessment of data and/or review of available literature confirm the need

Performance Based Physician Quality & Credentialing

Performance-based credentialing ensures processes that assist to promote the delivery of quality and safe care by physicians and advanced practice licensed health care providers. Both Focused Professional

Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) occur. Focused Professional Practice Evaluation (FPPE) is utilized on 3 occasions: initial appointment, when a Privileged Practitioner requests a new privilege, and for cause when questions arise regarding the practitioner's ability to provide safe, high quality patient care. Ongoing Professional Practice Evaluation (OPPE) is performed on an ongoing basis (every 6 months).

Profiling Process:

- Data gathering from multiple sources
- Report generation and indicator analysis
- Department chairs have online access to physician profiles for their ongoing review
    - Individual physician access to their profiles will be rolled out in FY 2017
- Discussion at Credentialing Committee
- Final Recommendation & Approval:
    - Medical Staff Administrative Committees
    - Medical Director
    - Hospital Board

Service-Specific Indicators

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

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

Purpose of Medical Staff Evaluation

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

Annual Evaluation

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

Attachment I: Priority Criteria

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

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

Attachment II: LCCQSS FY17 Priorities

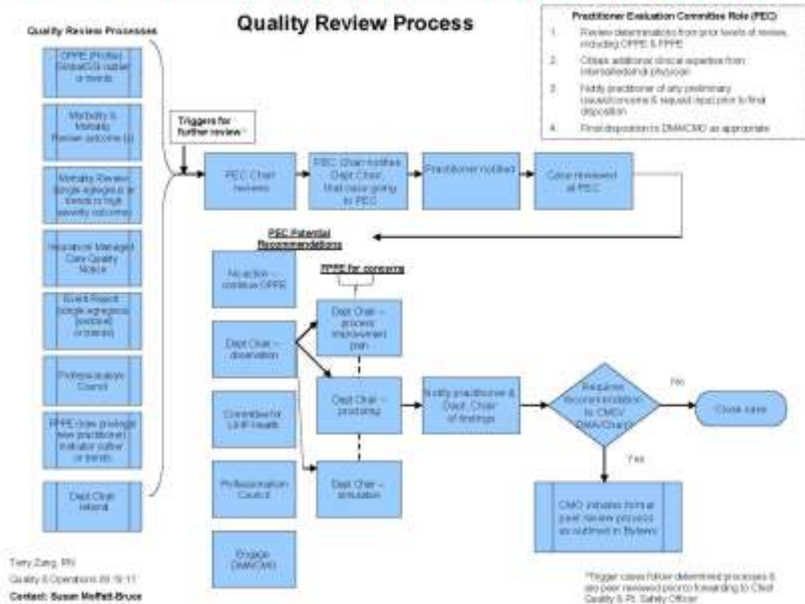
Performance Incentive Metrics	Baseline Year ("Threshold") FY15	FY16 ("Target") Goals	Current Performance	Description (Health System)
CAUTI (per 1000 foley days/Standardized Infection Ratio -SIR)	1.156	0.854	0.60	All patients anywhere in the hospital that develop a UTI with a foley in (Dec)
CLABSI (per 1000 line days/SIR)	0.577	0.46	0.79	All patients anywhere in the hospital that develop a BSI from a Central Line (Dec)
cDiff (per 10000 patient days/SIR)	0.824	0.75	0.68	All patients anywhere in the hospital that develop C diff (Dec)
SSI Colon Surgery (per 100 procedures/SIR)	0.982	0.751	0.91	Deep infections after any sort of colon surgery (Dec)
Hand Hygiene	90%	95%	92%	Rate from OHA observation program of clean in/clean out (May)
Mortality Index	0.68	0.66	0.72	UHC all inpatient mortality index (May)
Sepsis Mortality Index	0.92	0.87	0.89	UHC mortality index for patients with a Sepsis diagnosis code (May)
PSI 90	0.64	0.62	0.61	Composite measure: PSI 03 Pressure Ulcer Rate; PSI 06 Iatrogenic Pneumothorax Rate; PSI 07 Central Venous Catheter-Related Blood Stream Infection Rate; PSI 08 Postoperative Hip Fracture Rate; PSI 09 Perioperative Hemorrhage or Hematoma Rate; PSI 11 Postoperative Respiratory Failure Rate; PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate; PSI 13 Postoperative Sepsis Rate; PSI 14 Postoperative Wound Dehiscence Rate; PSI 15 Accidental Puncture or Laceration Rate (Mar)
PSI 12 Post Op PE/DVT Rate	9.18	7.87	6.44	Rate per 1000 discharges (May)
Total Falls per 1000 patient days	1.64	1.55	2.43	All falls and benchmarked with NDNQI (May)
Injury Falls per 1000 patient days	0.37	0.32	0.75	Falls with injury level 1 or higher benchmarked with NDNQI (May)
Overall 30 Day All Cause Readmission Rate	13.20%	11.90%	13.10%	All cause readmissions back to OSUWMC for any reason (Apr)
HCAHPS Overall Rating	75.3%	79.4%	76.8%	Percent of those surveyed who gave scores of "9" or "10" if patients would recommend OSUWMC (May)
HCAHPS Doctor Communication	81.1%	82.8%	82.1%	"How well did the doctors treat with courtesy and respect, listen carefully, explain things" (May)
HCAHPS Nurse Communication	80.3%	81.0%	81.1%	How well did nurses treat with courtesy and respect, listen carefully, explain things, answer the call button (May)
CGCAHPS	90.8%	96.0%	91.3%	Would you recommend this provider's office (Yes-Definitely) (May)
CGCAHPS Test Results	76.9%	94.0%	78.2%	Follow up to give test results (yes) (Mar) - Retired
Medicare Spending Per Beneficiary	0.998	0.98	1.00	Cost for three days prior, inpatient stay, and 30 days post

Attachment III: Quality and Safety Scorecard

Performance Incentive Metrics
CLINICAL TRANSFORMATION
Care and Payment Transformation
Number of Episodes
Percent Savings
Medicare Spending Per Beneficiary
Composite Quality & Cost Score
HOSPITAL ACQUIRED INFECTIONS
CAUTI
# of Infections
Rate per 1000 Foley Days
Standardized Infection Ratio (UH)
CLABSI
# of Infections
Rate per 1000 Line Days
Standardized Infection Ratio (UH)
cDiff
# of Infections
Rate per 10000 Patient Days
Standardized Infection Ratio (UH)
MRSA
# of Infections
Rate per 10000 Patient Days
Standardized Infection Ratio (UH)
Surgical Site infections
# of Infections - Colon (UH)
Rate per 100 Procedures - Colon (UH)
Standardized Infection Ratio - Colon (UH)
# of Infections - Abdominal Hysterectomy (UH)
Rate per 100 Procedures - Abdominal Hysterectomy (UH)
Standardized Infection Ratio - Abdominal Hysterectomy (UH)
Possible & Probable Ventilator Associated Pneumonias
# of Infections
Rate per 1000 Patient Days
Hand Hygiene
Compliance Most Recent Month
Compliance Year to Date

OUTCOMES/PATIENT SAFETY
Mortality Index
AMI Inpatient Mortality
CABG Inpatient Mortality
COPD Inpatient Mortality
Heart Failure Inpatient Mortality
Pneumonia Inpatient Mortality
Stroke Inpatient Mortality
Joint Replacement Safety
Complication Rate Following Elective Total Hip or Total Knee Arthroplasty
Patient Safety Indicators
PSI 90 Composite from UHC
Smoking Cessation
Clinic Patients enrolled in cessation
EFFECTIVENESS OF CARE
Influenza Immunization
Influenza Immunization
Healthcare Personnel Influenza Vaccination
Perinatal Care
Elective Delivery Prior to 39 weeks
Stroke Care
Venous Thromboembolism Prophylaxis
Thromboloytic Therapy
Discharged on Statin Medication
Stroke Education
Venous Thromboembolism Care
Venous Thromboembolism Prophylaxis
Intensive Care Unit Venous Thromboembolism Prophylaxis
Venous Thromboembolism Patients with Anticoagulation Overlap Therapy
Venous Thromboembolism Warfarin Therapy Discharge Instructions
Hospital Acquired Potentially-Preventable Venous Thromboembolism
Patient Falls
Total Falls per 1000 patient days - Health System
Injury Falls per 1000 patient days - Health System
Total Falls per 1000 patient days - James
Injury Falls per 1000 patient days - James

PATIENT EXPERIENCE
HCAHPS
HCAHPS Overall Rating
HCAHPS Doctor Communication
HCAHPS Nurse Communication
CGCAHPS
CGCAHPS Overall Rating
CGCAHPS Test Results
CGCAHPS Care Coordination
EFFICIENCY
30 Day Readmissions
Overall 30 Day All Cause Readmission Rate
Length of Stay Index
Harding
CMS QUALITY BASED PAYMENT PROGRAMS
Value Based Purchasing
Total Performance Score
Reimbursement Impact
Readmission Reduction Program
Conditions with Excess Readmissions (6 possible)
Reimbursement Impact
Hospital Acquired Conditions
Total HAC Score (Lower is Better)
Reimbursement Impact
TIMELINESS OF CARE
Emergency Department
Left Without Being Seen
Median Time from ED Arrival to Departure for Admitted Patients
Admit Decision Time to ED Departure for Admitted Patients
Median Time from ED Arrival to Departure for Discharged Patients
Door to Diagnostic Evaluation by a Qualified Medical Professional
Median Time to Pain Management for Long Bone Fracture


Attachment IV: Physician Performance Based Profile
Quality Review Process
Quality Review Processes
Practitioner Evaluation Committee Role (PEC)
1. Review determinations from prior levels of review, including OPPE & FPPE
4. Final disposition to DMA/CMO as appropriate
Triggers for further review*
PEC Chair reviews
PEC Chair notifies Dept Chair, that case going to PEC
Practitioner notified
Case reviewed at PEC
PEC Potential Recommendations
FPPE for concerns
No action – continue OPPE
Dept Chair – observation
Dept Chair – process improvement plan
Dept Chair – proctoring
Dept Chair – simulation
Professionalism Council
Engage DMA/CMO
Notify practitioner & Dept. Chair of findings
No
Yes
Close case
CMO initiates formal peer review process as outlined in Bylaws
Contact: Susan Moffatt-Bruce

[illegible]
SERVICE: INTERNAL MEDICINE-CARDIOVASCULAR MEDICINE
[illegible]

Status	Indicator	My Score	Peers Score	Target	SPC alert	Current Period	6 Month Values: My Score	Peer Score	Start Month
A - Volume and Acuity									
	CMI	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
	IP Discharges	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
	IP LOS Index (Obs_Exp Total Days)	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
	IP Procedures	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
	Observation Cases	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
	Outpatient Visits	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
B - Patient Care									
	Autopsy Discrepancy	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
	Cath PCI Post-procedure AMI	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
	Cath PCI Retro-peritoneal Bleed	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
	CM - AMI_2 Aspirin Prescribed at Discharge	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
	CM - AMI_3 ACEI or ARB for LVSD	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
	CM - AMI_5 Beta Blocker at Discharge	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
	CM - AMI_9 Inpatient Mortality	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
	CM - HF_2 Evaluation of LVS Function	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
	CM - HF_3 ACEI or ARB for LVSD	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
	ICD Registry CVA	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
	IP Mort Index (Obs_Exp)	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
	Mortalities Reviewed	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
	Mortalities Sent for Peer Review	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
	Mortality Peer Review #1 Score 4 or 5	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
	Quality Management Events - Standard of Care Not Met	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
	Related Readmit 30 days	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
	SSI CABG Procedures	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
	SSI Pacemaker and AICD	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
C - Medical and Clinical Knowledge									
	Formal Peer Reviews	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
E - Interpersonal and Communication									
	Patient Complaints	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]

Status	Indicator	My Score	Peer Score	Target	SPC Alert	Current Period	6 Month Values: My Score	Peer Score	Start Month
	Patient Satisfaction Ave Score	[illegible]	[illegible]	n/a		[illegible]	[illegible]	[illegible]	[illegible]
G – Practice Based Learning and Improvement									
	Surgical Team Safety Checklist Variances	0	0.00	0		[illegible]	0	0.00	[illegible]

Profile Generated [illegible]
Next Review Due: [illegible]

	Reviewed By	Outcome	Notes
[illegible]	[illegible]	Maintain privileges without modification	The Provider's performance meets expectations

SPC Alert Legend

Most recent period is below Lower Control Line

Most recent period is above Upper Control Limit

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

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

Most recent 6 periods are all increasing

Most recent 6 periods are all decreasing

Green border: The alert is in a positive direction

Red border: The alert is in a negative direction

No border: There is no target direction for the indicator

(ATTACHMENT XI)

Found in Translation: The OSU Center for Clinical and Translational Science

Rebecca D Jackson MD
November 2, 2016

Re-Engineering the Research Enterprise (Go - Clinical Research)

SOUNDING BOARD

Translational and Clinical Science — Time for a New Vision

Elias A. Zerhouni, M.D.

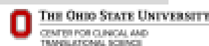
N Engl J Med 2005 Oct 13;353(15):1621-3

Re-Engineering the Research Enterprise (Go - Clinical Research)

- Over 1/3 of NIH dollars were devoted to clinical research (2005) !
- This number is continuing to increase !

2015 (estimated) over 50%

NIH (Clinical Research)	15-17 billion
NIH (Total Research)	28-30 billion



NIH Clinical Translational Science Awards (CTSA)

Goal:
Enhance institutional infrastructure for clinical and translational research

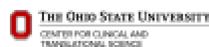
- Clinical research cores
- Awards (T32, K23, K12) awards
- biostatistics cores, etc

NIH Clinical Translational Science Awards (CTSA)

$4-6M annually

62 institutions

31 states



Improving Clinical Care

- Comparative effectiveness
- Cost of Care
- Patient Satisfaction
- Readmissions
- Care pathways
- Patient selection for surgery
- Reengineering health systems

THE OHIO STATE UNIVERSITY
CENTER FOR CLINICAL AND TRANSLATIONAL SCIENCE

1

"a mission to translate new knowledge *as a sacred social compact*"

Basic Science | *Clinical Research* | *Implementation and Population Health*

Bench **Bedside** **Community**

THE OHIO STATE UNIVERSITY
CENTER FOR CLINICAL AND TRANSLATIONAL SCIENCE

1

What is the OSU Center for Clinical and Translational Science (CCTS)?

- Founded in 2006
- Multi-college effort centered out of the College of Medicine
- Partnership with Nationwide Children's Hospital and Battelle
- Funded by a multi-year Clinical and Translational Science (CTSA) Award from the National Institutes of Health since 2008
- One of 64 funded institutes in the nation

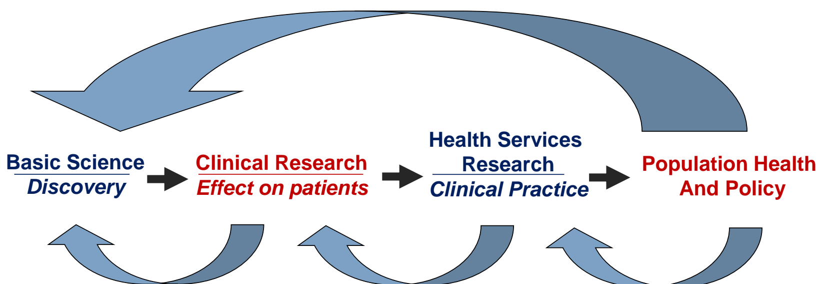
2799 active CCTS members

Research collaborations with over **60** academic, community & industry partners

Goal:
To speed the translation of scientific discoveries into clinical therapies to improve human health

1

Challenges Facing Clinical and Translational Research



Unique skills required for career success
Long time frame for adoption of new discoveries to improved health

Most discoveries fail to translate

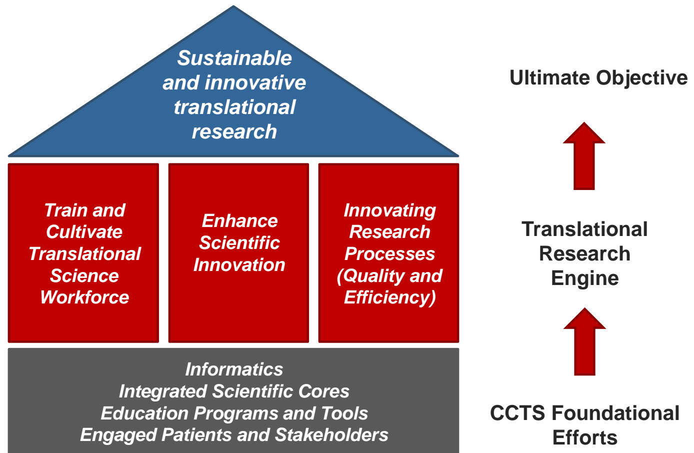
1

Translational Science = Team Science

The Ohio State University
Center for Clinical and Translational Science

1

The OSU CCTS Call to Action



The Ohio State University
Center for Clinical and Translational Science

1

CCTS Impact since 2008

$68 Million
NIH Funding to support CCTS

Leadership
in National Consortiums

1,294
Publications

24,687
Clinical Research Visits

$28.8 Million
in Other Grants supported

10+
Research Program Grants

1

Developing the Translational Science Workforce

Strategies

- Protected career development from student to early stage faculty
- Workshops and on-line training resources
- Incentivize research as a viable career path

Outcomes

>85% of trainees and scholars remain in research workforce

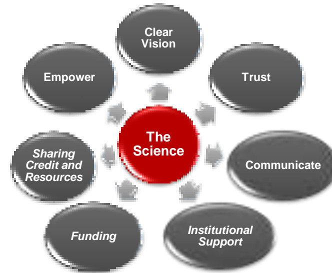
>100 high impact publications

19 invention disclosures and **2** start up companies

$9.3M in grants Awarded to early career faculty

1

Advancing Innovation and Translation



Strategies

- "Business of Science"
- Project management
- Innovative Longitudinal Pilot Funding Program
- Integrated scientific research cores

Outcomes

- **>90%** of scholars adopted team science leadership skills
- **86%** of projects met milestones
- **90%** of projects have translated along continuum in less than 3 years

1

Collaboration and Engagement

Strategies

- Community Engagement Boards
- Pilot funding initiatives to develop community-academic partnerships
- Begin to integrate delivery of care with research

Outcomes

- **74** community partners
- **593** requests for Information Warehouse to support research
- **120k** visitors to OSUWMC web link to "Participate in Research" since Dec 2014

The Ohio State University
Center for Clinical and Translational Science

1

CCTS Impact on Health

Case Examples

1

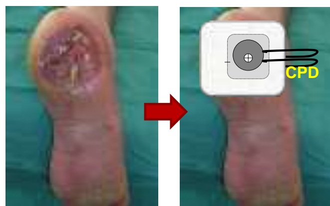
Example 1: Healing of Chronic Wounds (*S Roy and Team)*

Problem

- Chronic wounds affect 6.5 million patients
- Leading cause of non-traumatic amputation
- Biofilms interfere with penetration of antibiotics to wound

Solution

- Developed a portable adhesive patch that drives a continuous, small electrical current to disrupt biofilm
- Collaboration between Mechanical & Aerospace Engineering, and Medicine



Outcomes

- Better and more rapid healing
- First application in humans in October 2016
- **Translation** to humans in < 3 yrs

1

Example 2: A Story of "Sodabriety" *(L Smith and Team)*

Problem

- Adolescent obesity and diabetes pressing public health issues
- At least 25% higher in Appalachia
- 18-25% total daily calories due to sugar sweetened beverages

Solution

- Collaboration with OSU scientists to decrease intake of sugar sweetened beverages
- High School students and their parents defined problem and designed interventions

Outcomes

- Sugar sweetened beverage intake decreased by > 1/d
  - Water intake increased 19%
  - Weight loss ~2-3 pounds/60 d
  - Teachers and family members also improved intake
- Tennessee Clean Water Network
  - Implementing intervention in all schools in region over next 4 years

1

OSU CCTS Impact on National CTSA Consortium (NCATS)

- Founding member of:
  - Ohio Clinical Trials Collaborative
  - Strategic Pharma-Academic Research Collaborative
  - Appalachian Translational Research Network
- Member of CCTS Steering Committee, Lead of Workforce Development Taskforce
- Co-investigators on National CTSA Recruitment Innovation Center
- Awarded 2 Administrative supplements (2016)

1

The OSU Center for Clinical and Translational Science

"Coming together is a beginning.
Keeping together is progress.
Working together is success."
Henry Ford

1