THE OHIO STATE UNIVERSITY

OFFICIAL PROCEEDINGS OF THE

TWENTY-THIRD MEETING OF THE

WEXNER MEDICAL CENTER BOARD

Columbus, Ohio, November 1, 2017

The Wexner Medical Center Board met on Wednesday, November 1, 2017 at the Richard M. Ross Heart Hospital in Columbus, Ohio, pursuant to adjournment.

** ** **

Minutes of the last meeting were approved.

** ** **

November 1, 2017, Wexner Medical Center Board meeting

Dr. Thompson called the meeting of the Wexner Medical Center Board to order on Wednesday, November 1, 2017, at 9:05 a.m.

<u>Members Present</u>: Leslie H. Wexner, Alex Shumate, Cheryl L. Krueger, Robert H. Schottenstein, David B. Fischer, Michael V. Drake, Geoffrey S. Chatas, Bruce A. McPheron, K. Craig Kent, Mark E. Larmore, L. Arick Forrest, David P. McQuaid, Andrew M. Thomas, Amanda N. Lucas, Elizabeth O. Seely, Susan D. Moffatt-Bruce, Mary A. Howard and Marti C. Taylor. Abigail S. Wexner, Janet B. Reid, W. G. Jurgensen, Michael A. Caligiuri and Stephen D. Steinour were absent.

Dr. Thompson:

Good morning. I would like to convene the meeting of the Wexner Medical Center Board. I'll note that a quorum is present, Mr. Chairman. To conduct the business in an orderly fashion, I'd ask you to turn off cell phones and other devices and observe decorum proper to the meeting.

The minutes of the August meeting of the Wexner Medical Center Board were distributed. If there are no additions or corrections, the minutes are approved as distributed, and we are ready to move to the first item on the agenda, Mr. Chairman.

Mr. Wexner:

Great, I think the first item is Dr. Kent.

Dr. Kent:

Thank you. At the beginning of each of these meetings, we have a group of individuals and a program at the Wexner Medical Center that we are anxious to feature. In accordance with the theme of the November board meeting, which is Student Success, it's my pleasure to introduce Margaret Graham and her team from the Ohio State Total Health and Wellness Clinic. Margaret is a family and pediatric nurse practitioner with over 40 years of experience. She's a PhD by training and is one of the vice deans and absolute stars in the College of Nursing. Margaret has, over the years, won a number of teaching awards, most importantly The Ohio State University Alumni Award for Distinguished Teaching. Her academic interest is health policy, and she is recognized for her work around the state and across the country. In 2012, Margaret applied for and was the recipient of a grant from the Health Resources and Services Administration, which is a branch of the U.S. Department of Health and Human Services. The grant was titled, "Promoting Total Health and Wellness in Underserved Populations with an Interprofessional Collaborative Practice." With this grant and her enthusiasm, this led to the establishment, in 2013, of an interprofessional clinic at University Hospital East designed to help us treat an underserved population. The clinic has grown into this very robust and successful enterprise. And in 2016, the program was initiated to teach students in interprofessional education and team care. So with today's focus in this area, Margaret has brought with her our current clinic manager, Candy Rinehart, and four of the students that are participating in this clinic. So can you extend a warm welcome to Dr. Graham?

(See Attachment XI for background information, page 25)

Dr. Graham:

Thank you, Dean Kent, and thank you for allowing us to talk to you and showcase the Total Health and Wellness Center. The Total Health and Wellness Center is a nurse practitioner led, interprofessional, primary care health center located at University Hospital East. Today, you're going to hear from students who have rotations there.

In addition, Dr. Candy Rinehart is the director of the clinic and she's here to answer any questions you may have about the clinic.

Interprofessional collaborative practice is not new. In 1999, the Institute of Medicine published, "To Err is Human." In that, we learned that health care errors are the No. 3 cause of death. Strategies suggested to decrease these errors includes educating health care professional students to practice as a team. In 2010, the six health professional organizations that deal with educating health care professional students came together and identified competencies for interprofessional health care. Those competencies were reaffirmed in 2016, under collaborative practice. These competencies include values, ethics for interprofessional practice, roles and responsibilities, interprofessional communication teams and teamwork. In an effort to promote interprofessional education, private foundations and federal agencies provide grant funding to incorporate interprofessional education in health professional schools. This helps engage the students in interactive learning. As Dean Kent said, in 2012, the College of Nursing received one of these grants and we started the center.

This is a picture of the night that we had our grand opening at the Total Health and Wellness Center, which is located on the 12th floor of OSU East Hospital. Here you see our dean, Bern Melnyk, who is a leader in interprofessional education. Others who were key individuals in helping us open our clinic include Elizabeth Seely; Mary Howard, who's not pictured; Dr. MaryJo Welker, who is chair of family medicine here; and Rich Thubre, who helped us with our business model. Community leaders included Dr. Gabbe, Dr. Teresa Long and Mrs. Kasich, who is very interested in the prevention of heart disease, which is disproportionally high in the citizens that we serve. Members of the community were on hand for our open house, and they were most excited about our including access to mental health services at our health center. And those of you who know our dean, Bern Melnyk, know that she is very passionate about providing behavioral health access to all.

The goal of the grant, as stated here, is to develop and sustain a nurse practitioner led, interprofessional collaborative practice clinic that integrates primary care and mental health services to improve health outcomes in an at-risk, underserved population located in eastern Columbus, Ohio. And the second major focus of the grant is to increase the number of health professional students skilled in interprofessional collaborative practice. After only one year of operation, this clinic was recognized as a primary care medical home, and under Candy's leadership, this past July, the center was recognized as a Federally Qualified Health Center Look-Alike, which will help us greatly in sustaining the center.

When we started looking at the model of care that we were going to use at Total Health and Wellness, we looked across the country for best practices, and the decision that we made was to use the team care model, which is featured in this slide. The team care model is out of the University of Washington and the members on the health care team at the University of Washington traveled to Columbus to work with our team in implementing this model. Integrating behavioral health and the management of chronic disease is the key component of this model. The health care delivery team at Total Health and Wellness is comprised of some great health professionals, who do a great job in delivering the care and in teaching our students, and these include a dietician, mental health counselors, midwives, nurses, nurse practitioners, pharmacists, collaborating physicians and social workers, and they deliver great, high-quality care, in a cost-efficient manner. The team achieves excellent patient outcomes, they work with very complicated patients, and they enjoy great patient satisfaction. Students from these five disciplines are at the Total Health and Wellness Center, and in the past year we have had 75 students rotate through the clinic. Student evaluations of their experiences at the clinic are very positive. Currently, the College of Optometry

is looking to see how they can place students there, which will be great for us because we have so many diabetic patients who will benefit from having optometry on site.

In July 2016, the medical school received a $2.4 million HRSA grant for interprofessional education, and Dr. MaryJo Welker is the project director for this grant. Some of the clinical courses and clinical experiences associated with the grant are offered at the Total Health and Wellness Center. One of the greatest challenges that we have as health professional educators is figuring out how we get these students all together, their schedule is one of our challenges. They are great, they love to come together to learn. But figuring out how we get all the competencies they all have to meet with their curriculum, and then get them in classes together, has been one of our great challenges. I recently attended a conference in Canada on interprofessional education, it was an international conference featuring success stories from across the country, and I was able to highlight what we do at Total Health and Wellness. It's difficult to get interprofessional students together in classes in the classroom because of schedule, but getting students together so that they can actually deliver care as a team in a clinic is an even a greater challenge, and we think that we have done that really well. And actually, our clinic was coveted by many across the country when they realized how many students we were able to bring together, where they actually deliver care as a team. You're now going to see a video clip, a short video clip, about the health center, and then you're going to hear from four of our 75 students who've rotated though that center this year.

(Video)

Mr. Wegman:

Good morning everyone, my name is John Wegman. I'm a fourth-year medical student at Ohio State. I was lucky enough to rotate though the Total Health and Wellness Center in July and August of this year. As someone who is going into primary care as my profession, I was struck not only by just the compassionate care that was given there, but how necessary the care was, how valuable it was and the comprehensive nature of that care. I say the care is necessary because it's such a high-risk population who otherwise wouldn't have access to primary care. And kind of time and time again, the value has been proven of engaging these patients in primary care in a preventative way, to prevent ER admissions and hospitalizations. And another way that the value was increased of the care was the comprehensive nature, and really having on site not only medical nurse practitioners, but also a pharmacist, a licensed social worker, mental health specialists and dieticians. One of my favorite experiences was the team care meetings I did on Thursday mornings, where the entire team sat down and talked about 30 or so of the highest risk patients and the most complicated patients, and really discussed in a collaborative manner how to best care for these patients. I also had a number of positive interactions where I learned a great deal from each of the professional members of the team, including the social work [professionals] and [learning] how to connect patients with different resources. I remember one woman, in particular, who was losing her health care and she couldn't afford her medications, and [I learned] how to find a way to get her those medications and what resources were available to her. So, I would say it's a great experience not only for the patients, but also for student members of the team, and I'm going to take away a lot from that experience – not only the direct medical knowledge I learned from that, but also just a general team-based approach to prevention and primary care. Thank you.

Ms. Straka:

Hi, my name is Shana Straka, and I am a third-year nurse practitioner student with OSU's College of Nursing. I am currently placed at Total Health and Wellness, and have been working with the nurse practitioner there over the past several months. One

of those months, a fourth-year medical student had a rotation through Total Health and Wellness, and her purpose there was specifically for interprofessional collaboration with a nurse practitioner student. When we were both there together our approach was to enter all of our patients' rooms at the same time and care for them as a team, so the patient really benefited from getting her medical perspective and my nursing perspective at the same time. And when it really got fun was when we could then go to other students in pharmacy and mental health and dietetics and say, "Hey, what do you think about this patient?" Or, "We're thinking of changing their diabetes medication, what are you recommendations?" to the pharmacy students. So it was really neat to have those interactions. I think that we both were able to improve our skill sets in communication and team building, and really learn each other's roles and responsibilities in health care, whereas before we may not have really understood it. But most importantly, the patients were really able to get comprehensive, well-rounded care at one location and often times within one visit. And a lot of times, transportation is super difficult for these patients. I really hope that we were able to improve their quality of life and their overall wellness by doing this, which is really why we're all here and doing what we do. Thank you.

Ms. Lavelle:

Good morning, my name is Rachel Lavelle, I'm a fourth-year student at the College of Pharmacy. During my month at Total Health and Wellness, I was able to work closely with both the nurse practitioners and the dietician. I also attended the team care meetings where several of the nurse practitioners brought up patients to me, who they thought could benefit from a more thorough medication review. So I went back and talked to theses patients, addressed their concerns and then came back to the nurse practitioners with suggestions to improve their care. Several of my suggestions were implemented, so I felt valued as a member of the health care team and the patients felt valued because their concerns were addressed. I was also able to shadow at some dietician appointments and not only did this help me improve my counseling skills on teaching patients about healthy eating, it also allowed me to develop a relationship with one patient in particular. I attended all of her dietary and pharmacy appointments throughout the month, and she told me at the end of the month that she normally has trouble opening up to health care providers – she normally feels very shy – but that we had made it easy for her. Because of that relationship, I was able to have a greater impact on her care and make her more comfortable with the changes we were making. Thank you.

Ms. Curry:

Hello everyone, my name is Elana Curry, and I'm a second-year medical student at Ohio State. Last year, as a first-year medical student, I had the fantastic opportunity to participate in the interprofessional health-coaching program at the Total Health and Wellness Clinic. A nurse practitioner student and I were assigned to a young woman who we met with three times in her own community to have meaningful conversations. She shared with us her life story, the challenges she was facing, her health conditions, but really, it was all about her goals. Through these conversations, we learned that she had many health conditions, from diabetes to anxiety to insomnia, but she also faced a lot of difficult life circumstances, but in all of this, she had really strong goals to improve her health. We were there to really empathetically listen to what was going on, and to help her guide her own goals. I am so thankful that I was able to care for this patient as part of an interprofessional team at the Total Health and Wellness Clinic. The nurse practitioner student and I both brought a diversity of skills from our professions that we were able to cohesively use to care for our patient. Moreover, we were able to meet with the Total Health and Wellness team, which included pharmacists, social workers, dieticians and nurse practitioners, to have a more comprehensive understanding of our patient. So, as part of this interprofessional team,

I feel like we were truly able to make our patient feel comfortable to share her stories, and to really guide her to her goals. This was a vital experience to my first-year education. First, it allowed me to gain skills in interprofessional collaboration, but possibly more importantly it really showed me the power of an interprofessional approach to look at the many facets that our patients face and to really improve their health throughout their life. Thank you.

Dr. Kent:

Thank you to Margaret and the team. All I can say is, I'm just incredibly proud, and I think Margaret has been modest. We are clearly a national leader in this regard. Interprofessional education in the clinic is very, very difficult to achieve, and we've created a model over the past several years that makes us ahead of the pack in terms of where we are in the nation, so thank you. Open for questions.

Dr. Drake:

An editorial comment, if I may. So great, terrific, good. A couple things, one is that it's great to see a reflection of the importance … what I think is most special about academic medical centers is that as a part of taking care of people, we also are training the next generation of leaders. And there are things that are required in that training that help. One is that we have to model good behaviors, because there are people watching and paying attention to what we are doing, and so it helps the more senior people make sure that they are being their best selves because they know that they are in fact being role models in what they're doing and I think that's very useful. It's also very useful to have students there who are not steeped in the dogma. So they don't know how things are supposed to be, particularly first- and second-year students who don't know how they're supposed to act exactly. Because they don't know how they're supposed to act, they ask questions that may cause the senior people to rethink what they're doing or saying or how they're saying it. We have an old adage that we know so well, and that is as students progress in the hierarchy they finally get to the point that they only will ask the senior people questions that they know the senior people know answers to and want to give them, because that will make them seem like wonderful people. We've all experienced that very actively. First- and second-year students don't know that yet, and so they ask questions about what they're actually thinking or what they'd like to know, and it requires you to keep spinning your mind through things and rethinking your approach. So it really helps us to stay on the cutting edge, and I think that's a very good thing and really a value of academic medical centers to be able to keep stirring the pot and moving things forward.

Doing interprofessional care in an outpatient setting is novel for a variety of reasons. There are economic and other pressures that make that extremely challenging in the world. I would say collecting data on outcomes will be really critical to know whether or not it can be modeled in a way that we could actually use it. So I would really encourage you to set up circumstances where you could gather data on outcomes and efficiencies to be able to compare with more traditional methods to see that patients are actually doing better, and that we are able to do this in a way that's cost effective and everything else. I think that would be important to stir in so that it could be translated more. We've done this for decades on the wards. So the normal inpatient ward team, when we were in medical school, would have pharmacy students and dental students and dieticians all kind of following the patient chart around when you walk to discuss things, when you were in the inpatient hospital setting and had time to do that. The clinics were not the same, though, because there are lots of people coming through in parallel. And so ways to model that in the clinical setting I think is quite useful. It would be great and we'd love to see that model broadly across the enterprise.

And finally, I was pleased to see that … diabetic eye care is very, very important and critical. Multiple studies show that a significant fraction of diabetic patients are not managing themselves appropriately, and a significant fraction of them will have active eye issues that can in fact be treated more effectively – critically diabetic retinopathy that could be treated more effectively earlier. I would just encourage you to contact my colleagues in ophthalmology and to make sure that as the College of Optometry has people there who are doing great things and seeing patients, that there's a connection with the retinal clinic right away, so that those patients who need to have laser or whatever else to help with the retinopathy can get that as quickly as possible. Because time is of the essence and that would be a great place to have a link between the diagnosis and the treatment for those particular conditions.

Dr. Kent:

Other questions for the team?

Mr. Wexner:

A comment would be that in thinking about the agenda for today, recognizing the support functions – particularly focuses around nursing and, obviously, the integration of pharmacy and other things – I think it was very important for the board and important for me to re-ground myself in the complexity of the medical center. The teaching agenda across all fields of medicine is complex, and as Dr. Drake points out, it's interconnected and requires cross training. You can't be in silos. And when it comes to patient care, obviously, that integration happens. I think that from a board point of view, at least as one member of the board, I have to remind myself of the complexity, because it goes by fields of care, by body parts, by disease, by specialties, then by all the support functions and how they're integrated. And then the complexity, again, when it comes to the patient with a variety of illnesses and symptoms and a variety of professionals that have to help them. I think we're very fortunate that we do so well with our teaching, with our research, and with our patient care and get great outcomes. And I don't know if the support fields, including nursing, are the unsung heroes, but it's easy for us, or at least for me, to overlook the magnificence of the nursing college and how that helps us just do better work for society. So at least on my behalf, and I think I probably speak for the board, thank you and thank all your colleagues for the great work that you have done and are doing.

Dr. Kent:

Dr. McPheron?

Dr. McPheron:

Our faculty wake up thinking about how we can challenge our students to be different, to be differentiated, and to be better prepared. So I know we applauded each of the four students as they spoke, but I just want to make sure we shout out that it's those 75 students that have gone through here who are truly making this work. Mr. Wexner is exactly right; this is a complex beast. It's hard to insert all of these pieces into the curricula that we demand of our faculty and our students, but my hat is off to you four as representatives of the 75 for taking the initiative to learn this way. It truly will change the future.

Dr. Kent

Other questions or comments?

November 1, 2017, Wexner Medical Center Board meeting

Dr. Lancaster

I would like to say, you know, I wasn't a dental student too, too long ago, and really do appreciate how difficult it is to participate in an interdisciplinary manner. I think what you all are doing is really exciting, and I hope you know, if I can be any help by getting dental students involved … each of these professions have very rigorous curriculum, and you know sometimes it's just hard enough to, like, pass, get through your competencies or whatever graduation requirements. So this really is something new and exciting. So I wanted to congratulate you all. I did have one quick question. You mentioned that the clinic set up is FQHC-like. I was wondering if that's, like, kind of a best practice thing or does that set us up for external funding opportunities? I just wanted to quickly ask that.

Dr. Drake:

And maybe, just for a moment for other board members, defining for them FQHC would be a great thing to do.

Dr. Rinehart:

In order to sustain our clinic and care for the people that we provide care for, and to allow the opportunities for the students, we had to look for funding sources. A Federally Qualified Health Center receives extra bumped up or wrap-around payments for caring for our people who have Medicaid or Medicare. It is a process though HRSA to apply and we did successfully apply to become recognized as a Federally Qualified Health Center Look-Alike. So with that we have our extra payments and then a better chance of getting, also, the grant money that will come with that later on, all for sustaining and being able to provide this care.

Dr. Drake:

The concept is that the social determinants of health in populations that are underserved chronically, and from regions of the country that are underserved chronically, include things that make it more challenging to care for patients appropriately. And so there needs to be extra support services to make sure to help those patients. So these Federally Qualified Health Centers are places that have support to be able to particularly deal with underserved, undercared for populations. It's a very important designation and a really important program.

Dr. Kent:

So I just want to have a call out to OSU. There are few places that could be capable of achieving this level of leadership, but the fact that we have seven health sciences colleges, we have practitioners in every area in the medical field that come together at this great institution, and we have a plethora of students, I think is what really enabled us to have this great success. So thank you so much for coming, Candy, Margaret and the students. We really appreciate it. Let's give them another round of applause.

I'm still on, so I'd like to begin the College of Medicine Report with an introduction. We were all very sad to know that last meeting was Chris Ellison's last time as president of OSUP. But we're really excited to welcome a new member of our team, Rick Forrest. Rick is the interim president of the Faculty Group Practice and vice dean of Clinical Affairs at the OSU College of Medicine. A little bit about Rick, he's an OSU tried and true; he went to medical school here, his internship and residency and ENT at OSU, and then a laryngology fellowship at Vanderbilt, and then a second fellowship in microvascular reconstruction at OSU. Over the years that he's been here, he has had multiple roles in the Department of ENT, starting as the leader of laryngology, going on

to residency and program director, and then eventually vice chair. In 2010, Rick decided to change directions and received his MBA from the Fisher College of Business, and then in 2011 was named director of Ambulatory Services at the Wexner Medical Center, where he did an absolutely outstanding job. And when we were looking for a new lead as president of OSUP, there was no question that Rick was our first choice. So if you would please give a warm welcome to Rick as a new member of our team.

I'll begin with my report. I've broken it into three sections: research, followed by education, and then clinical care. Beginning with research, you know, I mentioned at our last meeting that we had a really great year in NIH funding last year, where we increased 20% whereas the national budget was flat. We're off to a great first quarter. In our first three months of this year, we're actually $7 million in NIH funding above last year, so we're really pleased with all of that. If you look through our scorecard, we actually have another goal in mind, which is to increase the number of first-time funded investigators at OSU. Our goal is 20 for the year, and it turns out in our first quarter we've actually already achieved eight new funded investigators. I guess four times eight is 32, so I think we're going to beat that 20. We're very excited about that, and what that means is we're growing people within and it also means we are recruiting people from without, and overall growing the amount of research funding that's part of our College of Medicine.

I just wanted to give you a sampling of a few of the new grants that we've had over the last quarter to draw recognition to some of our really fantastic investigators. I'll start with Jennifer Bogner and Anthony Brown, one is in rehabilitation and the other is in neuroscience, and they teamed up together to receive a $4.8 million grant in traumatic brain injury. As many of you know, traumatic brain injury is an area, a focus, of OSU, and we're certainly a national leader in this area. Jill Fortney in physiology and cell biology received a T32 grant, which is a training grant, but the focus is really unique and I think sort of first in its class. This grant is designed to promote women in science. She is just recruiting her first team of trainees into this grant and I think that puts OSU in the lead in terms of women and training. Janice Kiecolt-Glaser, I think everyone knows, is part of the Department of Psychiatry and extremely well-funded. She received a new grant of $3.1 million [to study] marital quality and behavioral pathways. I love Dr. Kiecolt-Glaser because she's always looking after our practical lives, right? I think we'll all learn a great deal from this grant. Next is Joseph Kitzmiller, who is in internal medicine, with a $1.9 million grant in statin myopathy in African Americans. Peter Shields, also in internal medicine, received a $1.4 million grant for e-cigarettes and human lung cancer. And then the last person I'll feature is Gayle Gordillo, a plastic surgeon who received a $1.3 million grant in the treatment of childhood hemangiomas. Now, I could go on. You know that $8 million above budget suggests that we have dozens of grants that are new. But I thought it was worthwhile featuring some of the innovative research that we are doing here at OSU. So, next I'll move to education.

Dr. Drake:

My little editorial insert … it's really important to focus. One of the things that's special about the United States and our higher education system of research is that we have this very well developed program of peer-reviewed research. It's an unusual thing. It doesn't happen in other places around the world, necessarily, and didn't happen really actively until after the Second World War. But this means that there are federal agencies, NIH in the main case, that have a pot of money – and it's a single pot of money – and then people from all over the country compete for that pot of money, and the money is awarded based on the quality of the ideas. So when the dean mentions that we have an increase in our grant funding, it means that the pot is staying that same size, but what's happening here is that more of our people are putting in great ideas that are winning this competition for the best ideas. It's extraordinarily difficult to

be funded. It takes an average of eight to 10 years or more after finishing college to get one's first grant with work, work, work up to that point. I just wanted to make sure that we are focused on the fact that is this a very robust and unique system. It has really helped the United States to rise to the leadership position in the world for new research and it's extraordinarily competitive and merit-based, so these are real achievements.

Mr. Schottenstein:

Other than just saying, "We want to get better at this," because I assume all the other medical centers are just as aware of the stagnant funding – and this is like wanting to be in the College Football Playoffs, everybody wants to be there – we must be doing something. I mean, other than just focus and talking about it. I think it's extraordinary, I agree with everything you just said, but how does that happen and why now?

Dr. Kent:

Well, it's a full-time job, and then some. Peter Mohler, our dean of research, is extraordinary and very talented and is really essentially working 24/7 to try to innovate, build programs and better understand the direction that we should hit to be successful. I would also say thank you to OSU. Many of these grants are collaborative grants between the College of Medicine and Pharmacy, or the College of Medicine and Engineering, and it's really teams of people that could only be achieved at a great university that would allow us to have this success. I think the other part is that we have a vision. I mean, what a great year last year around strategic planning. We know where we want to go, we have a direction, and I think our faculty are excited about that and they're rallying to the cause, they're being very successful.

Dr. Wadsworth:

First of all, congratulations on the incredibly tough competition. You know, the average age of people who are winning keeps going up because you have to have more, so one of the things that is needed is seed money to allow people to research ahead of being able to win these very tough competitions. And it's important that there is a healthy discretionary flow of research money to get people started. I'd be interested in your view on how we do that.

Dr. Kent:

Absolutely, one of the restrictions of the NIH – which, of course, funding from the NIH is wonderful and allows much of the innovation that we're creating – but the NIH says that you can only spend the money on the grant that you received. If you have a new idea, you can't spend that money on your new idea. So we need other sources of funding for that. You know, that's the job of the dean, having the tin cup and going around asking people to help. Philanthropy is something that's really important in that regard. There are many foundations that are willing to support more innovative and original research. I think our university is investing in our research program, and so is the college and our state is, likewise. So wherever we can get the resources. But you're absolutely right, having those starter-up funds is maybe another way of saying it, that allow us to actually innovate, and then we have enough date to actually apply for the NIH grant is critically important.

Dr. Wadsworth

Yeah, some of the young researchers I know will do it. You have a manifold return on the investment of a small discretionary fund, and you can play with shark tanks and a bunch of other things, too.

10

November 1, 2017, Wexner Medical Center Board meeting

Dr. McPheron

I think to your point, Dr. Wadsworth, the startup packages are certainly really critical for the new investigators coming in, and the dean and his team are very, very focused on that. But we're investing several million dollars a year centrally across the university on exactly what Dr. Kent highlighted, which is interdisciplinary research. And it's allowing some innovation in the proposal development and the data that are required to validate that new way of thinking about problems to emerge, and that's happening on a regular and repeated basis. Shortly, we'll be rolling out a program that President Drake has crafted to support, centrally, a post doc pool that will be an absolutely essential addition across the university in bringing really focused, excellent research minds at largely central support for two-year appointments into the system.

Dr. Wadsworth:

Great, thank you.

Dr. Kent:

So, Mr. Wexner, I know you love brevity, so it's not my fault if this report goes on too long. I'll move onto education. This weekend is the beginning of the meeting of the Association of American Medical Colleges, AAMC, and I have the privilege of representing OSU in a presentation about the innovation in the College of Medicine towards diversity. As many of you have heard, our College of Medicine is probably one of the most diverse colleges in the country. You know, one of the fun things about being dean is if you have been here just a year and something great has happened, you take credit for it. And if something not great happens, you know, I've just been here a year. But this is one of these really great things, and I can't take credit for it because this is an innovation that's been in the making for quite a time. If you go back to 2010, it turns out that the percentage of underrepresented minorities in the College of Medicine was around 13% and that's the national average. So, good, we were doing reasonably well. I think the leadership at the time felt that "good" was not enough. We wanted to do better. So they created two initiatives – one was around holistic review of applications for medical school. The idea is, of course, everybody is going to have a good GPA and a good MCAT score, but what we really want is a great person. So the review process was changed dramatically so the sort of the portal of entry was the good scores, and then we looked at the person and changed the way that we accepted individuals into the College of Medicine. The second thing that happened a year later is that there is a requirement that the people who were on the College of Medicine admissions committee take an implicit bias association test. I'm sure most of you are aware of what that is, but it's a way of individuals finding out whether there might be hidden biases in terms of how they look at and review people. So everybody in the admissions committee took that test, and I think most of the people on the admissions committee were surprised at the outcome. There was a discussion afterwards and some interaction. So those were the two events. Well, maybe cause effect, but what's happened over the last six years is that the percentage of underrepresented minorities in the College of Medicine has grown from 13% to now 26%, so it has doubled and we're clearly a national leader. That's the reason we were invited to present this at the AAMC. We're really proud of that. The other part of the story, which is just as impressive, is that the metrics for our students really haven't changed over the last six years. It was mentioned previously in a meeting that the average GPA is 3.77 and last year the average MCAT score was at the 94th percentile, so we've been able to achieve a level of diversity that's probably best in class in the nation and still achieve an extraordinary class of students. So we're very, very proud of that and looking forward to my presentation at the AAMC.

I'll move on to clinical. Each board meeting I like to feature one of our programs that's extraordinary, and the program that I've chosen this time around is our hematology program, our hematology division. Hematology at OSU, many of you know this, is best in class. It's certainly one of the strongest programs at OSU and nationally acclaimed, and 2017 was really a great year for this division. They had in total 166 peer-reviewed publications, many of these in incredibly high-impact journals; $38 million in extramural research funding; and 197 clinical trials where they enrolled over 3,000 patients. And the interesting part of the clinical trials is 60 of those trials were investigator initiated, which means that they were trials from innovation that happened here at OSU – not coming in from industry from the outside, but trials for our own innovation. And along with that, we draw patients from all over the country because of these trials and the innovation of our physicians. Along with that, it turns out that this last year we were No. 1 in the country amongst cancer programs for patient satisfaction. So not only were we innovative, not only did we draw patients from everywhere, but we take really great care of patients and they're very satisfied with their care. I wanted to feature a few of the 40 faculty in hematology. Jennifer Woyach has developed a lot of innovation around targeted therapies for lymphocytic leukemia. She has had multiple publications, and one of her most recent publications was in the New England Journal of Medicine. She has annually about $1.4 million in NIH and industry funding. Rob Baiocchi is interested in AIDS-related cancers, lymphomas. He has brought much of his work to Africa with a huge initiative in Ethiopia, and his innovation is around a new treatment paradigm immunotherapy for Epstein-Barr virus and lymphoma. He currently has $3.9 million worth of funding. Ramiro Garzon investigates T-cell leukemia. His focus is new RNA target molecules to treat leukemia. He has $800,000 in research. Don Benson, who is a world leader in multiple myeloma targeting new therapies. I think many of you saw the announcement the other day about these CAR T cells, these new immune cells that can come in and dissolve cancer. So he's applying those CAR T cells to multiple myeloma, one of the first in the country to do this. And of course, John Byrd, who is extraordinary in his research, has created these new innovative targets and therapies for chronic lymphocytic leukemia. He has a total of $5.5 million in funding, and I just want to draw recognition to John, who has really led this program and developed it to its extraordinary level of strength. This past year, John stepped down from being the leader of hematology so that he could focus more on his research. Don Benson has taken on the interim roll as the leader of hematology and has done just an extraordinary job of continuing to lead that program forward. It is first in class, absolutely outstanding and one of our stellar programs at OSU.

Across the clinical enterprise, we continue to grow. Last quarter our admissions were up 4.6% compared to budget, and our surgeries were up 3.5%, and our outpatient visits were up 3%. Something must be great about the care that we provide because patients keep coming to OSU. A quick note about strategic planning – the board passed our strategic plan for the Wexner Medical Center at the last board meeting in August, and David [McQuaid] and I are working very closely to try to functionalize that strategic plan, starting with research. Peter Mohler first sent out a survey and then has had focus groups around research and then has created three committees: one focused on infrastructure, which is so important to research; another around strategic growths, what areas do we want to invest in; and the third around compensation, so that we reward our researchers well. And then we're beginning the process for strategic planning around the clinical aspects of our program. So this coming November, we're going to get all 18 clinical departments together and in January, the eight areas of concentration that are part of the Wexner Medical Center plan, and have discussions about strategy and moving forward. One of the challenges that David and I gave to all of these groups is that we want you to create one program that is top 10 in the country that is extraordinarily differentiated. We also want you to recognize all of the new innovations in the field, we're going to incorporate those into our program, and then we want to become dominate in the market share and in our local and Ohio

region. So a really grand challenge to these individuals and a lot of planning ahead over the next few months.

I'll finish by saying that we've been actively recruiting. In the first quarter of this year, we welcomed 118 new faculty members into the College of Medicine. We're growing fast, we have lots of patients who need care, and now we have a lot of new caregivers. And we have ongoing recruitments in a number of leadership roles. We're recruiting for a new chair of ENT, a chair of our basic science department, Immunology and Infectious Disease, and a new chief of cardiac surgery. And then I think all of you received yesterday an announcement about a recruitment effort in the neuroscience arena, where we're going to bring in somewhere between seven and 12 new clinicians, clinician scientists and scientists that are focused on the realm of Alzheimer's disease, so we're very excited about that new initiative. In sum, it has really been a great quarter for the Wexner Medical Center and the College of Medicine. Thank you much.

Mr. Wexner:

We're going to move along. Mr. McQuaid.

Mr. McQuaid:

Thank you. I will attempt to catch on time, but I do want to take a couple of moments in the interest of communication and all of the hard work that board members and thousands of employees, faculty, have done on the strategic plan. On your seat is this brochure. This is an accumulation of fiscal 2017, and represents a lot of that work. We've been working hard to communicate better and more broadly, and one of the avenues we have for doing that is a town hall meeting that we hold quarterly. What is included here is a presentation – this is virtually the presentation that Dr. Kent and myself gave after introductory remarks by Dr. Drake, with probably 500 people in the Ohio Union – to talk about our accomplishments and to celebrate individuals across the institution. So when you do have time to look at that, you're very familiar with most of it, but it's very, very impressive.

A point that was made at the meeting, and where we are now, is the hard work of implementing that plan. I, too, would like to make some comments and introduce a few new people as we position ourselves for implementing the plan and further our tripartite mission. We really need to feel strongly that we need to have an organizational structure and a team that can better support the needs of our departments and our functions with really a keen eye on development of talent from within. All of you had received the announcement that was made several weeks ago. In order for us to really deliver on this strategic plan, most of you know, Elizabeth Seeley, formerly the executive director for University Hospital East, is now in a new role as chief administrative officer, and Elizabeth is right there. Also I'd like to introduce Dr. Mary Howard. Mary is now the executive director at East, was formerly the chief nursing officer at East, and we're really excited for her. In order for us to really focus on performance, we felt that the complexity in scale and importance of University Hospital and the Ross Heart Hospital, we felt that in order to move forward we would create two roles. Marti Taylor, everyone knows, is really positioned well to further the heart center, and we're very pleased that Dr. Susan Moffatt- Bruce has agreed to take on the role of executive director for University Hospital. So these are great individuals. As we implement the strategic plan, we ask for your continued support of them and really want to congratulate them on their roles.

I'll just make a couple of other comments. An important part of our role as an academic medical center is to be a pacesetter, to lead the nation in many efforts, and so with

13

respect to national reputation building I have just an additional comment. Dr. Kent mentioned diversity. I've called out Dr. Leon McDougle at several board meetings. He's a wonderful leader. Blackdoctor.org has named the Wexner Medical Center one of the 2017 top hospitals for diversity out of approximately 1,000 hospitals, and we'll be recognized and he'll be representing us this week in Chicago, November 2, to receive that award. Just a couple of other recognitions on this national reputation building. The Mayo Clinic's Division of Hematology presented Dr. Clara Bloomfield with the Robert A. Kyle Award for outstanding clinician scientists, and this was an award that recognized outstanding contributions in the diagnosis and treatment of hematologic cancers, which include leukemia, lymphomas and multiple myeloma. And similarly, the National Cancer Institute appointed Arnab Chakravarti, our chair of radiation oncology, to its advisory board of scientific counselors to help guide the NCI leadership with strategic planning and decision-making. So many of our leaders in this organization are sought out, great thought leaders that will lend to our leadership as an academic medical center.

In your board book, there is a copy of the scorecard and we're making progress in the first quarter. I would tell you that many of the areas that we intentionally place on this scorecard aren't put there because we believe they're easy. We put these things on the scorecard because we believe that ultimately, in order to achieve our ambition, we are going to have to transform in many of these areas. In several, these are not easy things to do, but we are not walking away from the challenge and the work that we need to do, and the team is really working hard to deliver on very, very important areas, in particularly access. So I'll conclude my report to get us back on track, and if there are any questions, I'd be happy to take them.

(See Attachment XII for background information, page 29)

Mr. Shumate:

Mr. Chairman, I don't have a question, but I would like to compliment both Dr. Kent as well as Mr. McQuaid on the reporting of the strategic plan. I think it's critically important for us to be reminded that this is an active document, one that's our guide, and it's not going to be a document that sits on a shelf and gathers dust. Tying the activities of the medical center to the strategic plan and actively and aggressively working on its implementation is something that I want to applaud and assure you that from the university perspective, we will proceed accordingly as well. But thank you very much for your leadership with the strategic plan.

Mr. Larmore:

Just a couple comments and then a couple of slides. Last meeting we presented the June 30 numbers, which is our year-end. Since that time, we've gone through the audit process, the results of the audit are out, and the numbers did not change from what we presented, so we will not go through those again. This meeting we are reporting on the first quarter of fiscal year 2018, and as Mr. Shumate said, 2018 is our base year for our long-term financial plan, which follows the strategic plan. So in the first quarter we are off to a good start, I'd say a great start. Volume is ahead of what we projected, demand is out there, and we continue to see our beds full and our physician templates full. So the result of that is that our bottom line is ahead of what we targeted for both in the budget. And of course, the budget was a considerable growth over the prior year, and we're hitting those targets. So a couple of slides – you can see our admissions. I often like to talk to how we're tracking year over year, so 4.4% growth and I will say that that is considerably ahead of the industry. Normally growth rates are in the 1% to

2%, so you're seeing the demand that we have for our services. To the right, surgeries, a little behind budget but still growth, 1.6% year over year. On the bottom, similar prior year 1.7% growth in our outpatient visits, and we track our worked hours per adjusted admission and we budgeted to grow that and we're on track with budget, but we did budget a slight increase year over year. Top left, operating revenues are all green, 7.7% growth year over year. And then to the right of that, controllable costs have grown 6.7%. I think when I got here two years ago, those percentages were reversed, so we were actually growing expenses faster than revenue. So we've moved that in the right direction, we're seeing that growth, and again that translates into a growth in the margin. On the bottom, you can see our 4.7% above budget on revenue over expenses at $61 million. And we did anticipate that growth with the additional capacity that we brought on, so 33% growth year over year. And then we've always tracked day's cash on hand, so we're up four days since June, which is about $35 million, so $861 million in cash. One more slide, so this is the larger TNL of the health system. So again, top, $724 million in revenue in the quarter, which is almost $4 million ahead of our target. On the expense side, $629 million, which is $1.6 million over. And you can see the number in the middle is $2.8 million. We continue to see new drugs enter the market. I'd say on the ecology side is where we're seeing the bulk of that, so we are overspent on that, and then we also have expanded our outpatient pharmacy so we're seeing drug costs there, but we're actually billing for that, so that's actually part of the positive variance on the revenue side. And then our funding medical center investments, as we call it, is on budget and this is where the health system funds money into the college and into the practice plan for services that it needs to run the hospital. And there are also some support dollars in there for research that does come over. So we talked about earlier where funding comes from through support of the startup research, and some of it does come out of that system. So given our time schedule I'm going to stop here and see if there's any questions.

(See Attachment XIII for background information, page 31)

Mr. Wexner:

Questions, comments?

I think, to kind of embroider a little bit on what Alex said – that we have a strategic plan, and that if you have ambition then we have to figure out the detail on how to execute to that plan to get the result. And as we grow the medical center and we plan for capital expenditures and hiring more people and taking care of more patients, what I've committed to the board is that we'll monitor, if you will, hurdles of performance. So that's the quality of our students, the quality of the education, the quality of the research, and obviously the quality of patient care. If you do all those things well, then the numbers come out pretty well, too. And so from the hurdle point of view, us maintaining excellence and improving in all areas should improve the financial result. But the financial result is important because our investments are guided in dollars and we're about to step into a major investment. So I appreciate the performance.

Dr. Drake:

Let me offer just a tiny comment to summarize those things. People are working really hard and producing really outstanding results. We saw the students at the beginning. We have our most diverse and among our most outstanding classes in history. That's great, that's increasing, that's really a hard thing to do and that's incredible. We are seeing more patients than ever before, are producing more results. Some of our expenses are up, but those are like the drug expenses because we're treating more people. That's an incredible thing. And as we do this year over year, there are more and more people who can benefit from our services. And then it sort of cycles back to

the real importance of us being as aligned and efficient as we can be. Because the demands on our time and services are overwhelming, and anytime that we are not efficient and aligned and doing our best … I mean, that extra noise gets in the way of

providing the care that the people in our region obviously need. So our work on trying to be as efficient and effective as we can is because we have a great demand for our services and that's the only way that we can begin to approach those demands. And all of our growth and all of our looking forward is to make it so we can do a better job of providing service to the people who obviously are lined up to try to get care from us.

Mr. Schottenstein:

Mr. Chairman? Just a quick comment in the same vein. I believe that last year's first quarter was a record quarter for the medical center, in terms of the gain from operations, the $82 million, and we just beat it by 15%. So last year was a record. This year's first quarter beat last year's first quarter by 15%. I know, you know, it's just the first quarter. But I think these results are outstanding. And not only improving day's cash on hand, which has always been a focus, but in terms of efficiencies and just the performance of the operation. It's pretty quiet in this room and I don't know how – we just won 42 to nothing, that's kind of important. I think it's extraordinary.

Dr. Drake:

So maybe a round of applause and thanks.

Mr. Wexner:

Bob, do you have a resolution or a report to make today?

Mr. Schottenstein:

We do and I think Mr. Kasey is going to make it. I'll just say one thing about it. This all relates to the strategic plan, which was a one-year process. I love these materials that are on our desks. I've been trying to look at them quickly as the meeting has been going on. Among other things, there are very significant facility initiatives that are springing forth from the strategic plan. They're just not isolated projects. And this resolution that Jay [Kasey] is going to introduce is a critically important enabling project. It's literally moving things from Starling Loving Hall and, I think, one other building, over to the east side of Neil Avenue in what will be a new building that will house certain optometry and clinic and related kinds of functions that will pave the way for the more significant facility initiative on the west side of Neil, which will be the interdisciplinary health science building that we'll talk more about perhaps later. But Jay, if you want to introduce this resolution, it's really a critically important step one.

Mr. Kasey:

Thank you, Bob. This is really the first step in enabling the strategic plan of both the medical center and the university in the health science history to be enacted. It is a relatively simple building, but it fills a very strategic spot on the east side of Neil Avenue, which is really our academic avenue, our academic main street. We will be very considerate of the look and the feel of the building as it sits with a number of our more classic buildings. Today what we're asking for is $600,000 just to hire a criteria architect, as we believe that this building will be presented and completed through a design-build process. It is primarily some architecture that will support retail on the first floor, that being the optometry retail shops, and office space in the floors above as well as some optometry clinics. It will replace what we call the Fry Bridge, which is the one-story old building that supports optometry, and two wings of the old Starling Loving

16

building, which need to be taken down, ultimately, so that we can bring back the interdisciplinary health sciences complex which is being planned for that site and we'll talk more about at a future date. We are asking for $600,000 just for this criteria, but we're also asking because we have a pretty good feel for this building and the cost and

the initial work we've done, that we'd be allowed to go into construction if the criteria architect comes back and the cost is not to exceed a total project cost of $28 million. That's our request for this building today.

APPROVAL TO ENTER INTO PROFESSIONAL SERVICES CONTRACTS

Resolution No. 2018-29

Health Sciences Faculty Office and Optometry Clinic Building

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

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

	Prof. Serv. Approval Requested	Total Project Cost
Health Sciences Faculty Office and Optometry Clinic Building	$0.6M	$28.0M

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves and proposes that the professional services contracts for the project listed above be recommended to the University Board of Trustees for approval; and

BE IT FURTHER RESOLVED, That the president and/or senior vice president for business and finance be authorized to enter into professional services contracts for the project listed above in accordance with established university and state of Ohio procedures, with all actions to be reported to the board at the appropriate time.

(See Attachment XIV for background information, page 36)

Mr. Schottenstein:

Do we need a motion for this?

Mr. Kasey:

I think we do, and it then will also go to Master Planning and Finance tomorrow.

Dr. Thompson:

So we need a motion and a second.

Mr. Schottenstein:

I'll make the motion.

November 1, 2017, Wexner Medical Center Board meeting

Ms. Krueger:

Second.

Dr. Thompson:

All in favor?

Upon motion of Mr. Schottenstein, seconded by Ms. Krueger, the Wexner Medical Center Board members adopted the foregoing motion by unanimous voice vote.

Motion carries.

Mr. Wexner:

Anything else to report, Bob, on facilities? I think, for the sake of the whole board, the facilities and this physical planning committee of the university is meeting and working on the integration of the medical center plan to the university plan, and I think there's really good work that's happening.

Mr. Schottenstein:

If you don't mind, maybe I'll just take a couple of minutes and sort of give a macro view of where we are. Coming out of the strategic planning process, there are what I would call three major facility initiatives – one is research-related, the other is education-related and the final one is clinical-related. So you've got research, education and clinical facilities being planned. I'll start with research. We talked a lot earlier about just how critically important that is and some of the great successes that we're beginning to see from greater focus and with our NIH grants. The research building will be located on the midwest campus; planning for that is under way at this time. Phase one will be approximately a 400,000-square-foot building and it will be built in two wings. Phase one will literally double what we currently have in the BRT. So just the first phase of this is a big step forward, because it will double what we have at the BRT. A lot of these things are being finalized now, but we should think about this as an approximately $350 million research initiative, phase one of which is roughly 400,000 square feet, phase two of which is 200,000 square feet, multiple buildings, one day becoming part of within the midwest campus, perhaps a series of research buildings. Hopefully this is just the beginning of the beginning when it comes to that. So number one, we've got this research project, that's $350 million, and that will be on the midwest campus. On the educational side, I think one of the more exciting things, and this resolution that we just approved is step one, as we said, is an interdisciplinary health science building that really will bring together a number of key areas that comprise not just the College of Medicine but supports – and the provost could better describe it than me – but basically right now, there is no College of Medicine building per se, there is none. There's specialties that, I think, stretch across five, six, seven different buildings, if I'm not mistaken, but you can correct me.

Dr. McPheron:

Well, I won't correct you. I'll simply say that, you know, this is clearly next generation for the College of Medicine, but you heard it from our students this morning. This is the kind of education we're thinking about in terms of bringing disciplines together into a facility where our doctors can be side-by-side with nurses, pharmacists, dentists, public health trainees, etc.

18

November 1, 2017, Wexner Medical Center Board meeting

Mr. Schottenstein:

And just because buildings are old doesn't mean they're bad. But in this particular instance, we've got some buildings that are 80, 90 years old with low ceilings and windowless classrooms, and I'll leave it at that. But basically, we're talking about approximately 360,000, maybe as much as 400,000 square feet, of new buildings. You

really need to look at a picture of it, but we'll end up with sort of a quad, the front door of which will face Neil Avenue on the west side of Neil. Very exciting designs. First thing to do is to move some things out of Starling Loving, as discussed, over to the east side of Neil. This is an approximately $240 million to $250 million total project, and there's a lot more to discuss on that going forward. So I talked about research, I talked about education, then we talk about clinical. There's really two aspects to clinical – one is ambulatory, which consists of a major new ambulatory facility on the western lands, together with a series of ambulatory facilities around the outer belt. There's an outer belt strategy as well as a campus strategy. One of the really important things to realize is – and Rick Forrest, who is here, has a lot more detail on this than me – but basically today, I think I'm right, that nearly two thirds of all patients that visit the James, Rhodes and Doan, and the Brain and Spine Hospital, are ambulatory. So we think about traffic on the medical center campus as we all drove in here today. Two-thirds of the people visiting these facilities, that doesn't include Ross, are ambulatory patients. There's a tremendous opportunity for us to move a lot of that off the main campus into an ambulatory facility that is more efficient to operate. So there's a financial side to this as well as a convenience. And, I think, just an improvement of patient care, which is very exciting. The ambulatory initiatives are significant, both the one on the western lands as well as the outer belt strategy. And then the other clinical piece, which is the biggest part of all the facility initiatives, is the construction of a new 850-bed hospital. You see the construction and the relocation of Cannon Drive, so you can begin to imagine how much additional land we're creating just to the west of where the new James Cancer tower and those parking garages are. This will be largely a critical care tower and we're well into the planning. A lot of people in this room played a very important role in that. I think it's very exciting. It's very exciting for the next generation of our whole academic medical center and what it will mean to not just the medical center, but to the whole university. And the other thing is I think that it all springs from the strategic plan, which should give everyone in this room comfort that these just aren't someone's pet projects, but that this is part of a robust one-plus year process, where these ideas and these needs have come forward. It's probably a little more detailed than maybe you wanted, Mr. Chairman, but I'm happy to try to answer questions. And there's others in the room here that can comment it they so choose.

Mr. Wexner:

I think from my point of view, and I think Alex [Shumate] shares it because we are both part of it, that there is a strategic plan – the plan is alive and well – and we're executing to the plan, whether it's on talent, financial, or the physical aspects of it, and making sure that we have guard rails and hurdles so that we aren't getting ahead of ourselves. Or, maybe a more positive take, that we're on track on all parts. The physical part is significant in terms of capacity and the quality of the facility that we have for students for research and for patients. The integration of that plan to the university's plan is significant in many aspects, the people aspects, literally the capital nature of it. We're building buildings that hopefully serve the community for at least 50 years or maybe even longer. So I think there has been very careful work on all parts and parallel process so that we're executing really strategically and not creating unanticipated problems for ourselves. Hopefully not very many unanticipated, unintended negative consequences.

November 1, 2017, Wexner Medical Center Board meeting

Mr. Shumate:

Just to again confirm this point, I think that I really appreciate the focus on the strategic plan that tied to our tripartite mission of research, education and clinical care, but I also think it's important to publically discuss what we're doing. I don't think we do a good enough job of really telling our story. There's some fantastic, very positive results and

accomplishments, and I think continuing to remind the public in particular, as well as internally, that we are working consistent with the strategic plan, is very important and I want to emphasize the importance of public reporting and discussion.

Mr. Wexner:

Yes, boss.

Mr. Schottenstein:

And you know, just one last thing with the chair of the board of the university here, as well as the chair of the medical center board, I think that one of the things that we're also now beginning to do as we think about these projects, is make sure that they fit into the comprehensive master plan. By that, I mean – and I'm talking more from a real estate and development standpoint than a strategic plan – a master plan for the western lands. We can't just build a building in the middle of all that land without first taking into account how it would relate to what else might happen there. All of the things we're doing around this medical center campus, with these facilities, we've talked about, both as they relate to Neil Avenue, coming off State Route 315, there's master planning implications of that as well. We have an opportunity, I think, to be very intentional and smart about how we go forward.

Mr. Wexner:

Questions? Comments? We're covering a lot of very big issues, very quickly. We'll have more time in executive session to unpack some of these things or have reflected questions. Cheryl?

Ms. Krueger:

Sure, thank you, Mr. Chairman. This resolution was reviewed and approved by the Quality and Professional Affairs Committee for the Wexner Medical Center Board. It was discussed last Tuesday on the 24th of October. I'm going to turn it over to Dr. Gonsenhauser to discuss the updates to the plan and what's being brought forth so we can approve it for today. Ian?

Dr. Gonsenhauser:

Thank you, Cheryl. Good morning everybody, I'm Ian Gonsenhauser. I've had the privilege of taking on the role of interim chief quality and patient safety officer as of September 1 this year. What I present to you today and submit for your review and approval is a document entitled "Clinical Quality Management Patient Safety and Service Plan". This is a document that really defines the quality program as a whole – the scope of the program as well as the oversight structure, our approach to quality oversight, assessment of our methodology for ongoing assessment of quality and patient safety across the enterprise. It also serves as the document by which we set our 2018 goals for clinical quality safety and service. This document was reviewed and approved at the Leadership Council for Clinical Quality, Safety and Service. It has also been reviewed and approved at the Quality and Professional Affairs Committee. This is included in your board packet for review, and again this takes you through the

program scope for activities within quality, patient safety across the clinical enterprise, our approaches, how we monitor care consistency, level of care, transparency, confidentiality, etc. Not much of this has changed over the course of the past year. What I would call out specifically are the items that I think speak to the theme of the meeting to this point, which is educational excellence. We have a number of programs within the quality structure that I think serve that purpose and continue to create space for excellence in education. Particularly I would call out the House Staff Quality Forum,

which is a forum staffed and executed by house staff and residents within the institution to focus on pertinent issues that address quality and safety across our clinical enterprise and the delivery of care. Most recently, that group, again which is 100% staffed and executed by residents and fellows, is looking at focusing on projects pertaining to post-operative opiate prescription and addressing some of the concerns about the opiate crisis that we are all facing. Another example of the commitment to education in our quality plan is the directorship and facilitation of a curriculum within the College of Medicine, the health systems and informatics of quality program. This is a program by which we introduce every medical student who goes through our College of Medicine to quality improvement, process improvement, as well as patient safety work. We consider ourselves a national leader in that space. We are to date, to our knowledge, the only College of Medicine that requires every single medical student to participate directly in a quality improvement and patient safety program. We take great pride in that. Last year, we had approximately 85 independent med student driven projects that we presented here during Patient Safety Awareness Week. Lastly, I would call out the quality and safety internships. We extend eight to 10 internships for College of Medicine students between their first and second year. This is a six to eight week experience by which students engage with our quality oversight and quality assessment and management structure, participate directly in projects and gain valuable experience. I would call myself out as a product of that program. I'm joining you today as the interim chief quality and patient safety officer, and in fact, I had my first experience in quality and patient safety working with Dr. Moffat-Bruce as a first-year medical student here at OSU. So really calling out the board's commitment to those programs, which are sometimes seen as alternative to the mainstream curriculum, those are opportunity rich and career defining moments and I'd like to serve as an example of that. So, we submit the plan for your review and approval today.

CLINICAL QUALITY MANAGEMENT, PATIENT SAFETY AND SERVICE PLAN

Resolution No. 2018-30

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

November 1, 2017, Wexner Medical Center Board meeting

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 24, 2017:

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 XV for background information, page 37)

Dr. Thompson:

Any questions? I will entertain a motion to approve the Clinical Quality Management, Patient Safety and Service Plan.

Ms. Krueger:

So moved.

Mr. Wexner:

Motion made, seconded.

Dr. Thompson:

Good, I'll note the approval of the plan requires the voting members of the medical center board to have a roll call vote.

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

Motion carries, Mr. Chairman.

I will entertain a motion to recess the committee into executive session.

Dr. Drake:

May I just make a timely interruption? If we just reflect back over the last hour or hour-and-a-half or so, it really does give one a chance to contemplate the complexity of the operations here: the size of our enterprise, the number of people that we're seeing and how that's increasing all the time, the great demand we have for services here in Columbus, the quality of our research programs which are growing and the incredible people who are coming and competing nationally for the best ideas, the quality of our students and the innovative ways they're educating themselves, the financial results and management and how really important those are to being able to fund our mission, and our Framework 2.0 for the university that we talked about earlier this calendar year. But the piece of that that reflects the medical center is an incredible series of construction projects extending out over many years into the future for giving us new capacity and, really quite resource-intense, but focused in master planning. And then the quality and safety, that while we sit here, there are in our hospital and in our clinics – in our hospital hundreds and in our clinics, on a morning like this, thousands – of people are being seen with multiple decisions being made on each of them that are

22

really critical and important. And to do all of that in an aligned and organized fashion is extraordinarily time consuming and effort intensive, but it's the only way that we can

continue to progress forward. And that's why it's such important work and why the dean and the leadership of the academic medical center spend so much of their time focusing on an effective implementation management of the system and our new leaders of our hospitals. All the things we've been talking about are focused on these same efforts to keep this working forward, so we can provide the best care, be the best educator and best researching and innovating institution that we possibly can be. And I just want to make sure everybody takes a moment to think about that and then continue to support us in moving it all forward.

Mr. McQuaid:

I'd like to ask for an amendment to my report. While I was so quick to talk about people in new roles, the round out of the Dodd and Harding Hospital, I want to recognize Amanda Lucas. I failed to do that publically and Amanda has done an absolutely wonderful job with the Neurological Institute, bringing the Brain and Spine Hospital on board, and works hard every day overseeing as executive director for Harding Hospital and Dodd, so I want to have that noted in the session.

Dr. Drake:

Let's have a round of applause for Amanda.

Mr. Wexner:

I think I'm inspired by what Dr. Drake said, about the notion of the amount of change and progress that we're making in the medical center. As medicine is changing, and patient care requirements are changing, and the world is changing, and you look at the financial result and it just struck me that, between outpatient visits and admissions, we're touching a half-a-million lives last year. And all this doing of the doing, and all the alignment – tactical, day-to-day, minute-to-minute things happen – and then connecting them over multiple years. That is the complexity of the institution and the complexity of the leadership. So I'm awed by the challenge and also the progress. It is not easy for eagles to fly in formation and clearly that's what's happening. So, thank you. Let's adjourn.

Dr. Thompson:

At this time, I'll entertain a motion that the committee recess into executive session to consider business sensitive trade secrets required to be kept confidential by federal and state statutes, and to discuss quality matters which are required to keep confidential under Ohio law. Do we have a motion?

Mr. Wexner:

Yes.

Dr. Thompson

And a second?

Mr. Shumate:

Second.

Dr. Thompson:

November 1, 2017, Wexner Medical Center Board meeting

This requires a roll call.

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

Motion carries.

Attest:

Leslie H. Wexner   Blake Thompson
Chairman   Secretary

(ATTACHMENT XI)

THE OHIO STATE UNIVERSITY

Total Health and Wellness Clinic
Interprofessional Learning Experience for Students
Team Training in Primary Care

THE OHIO STATE UNIVERSITY

Presenters

- Margaret Graham, PhD, CRNP – Vice Dean, OSU College of Nursing
- Candy Rinehart, DNP – Director, Ohio State Total Health and Wellness
- John Wegman – 4th year medical student
- Shana Straka – 3rd year nurse practitioner student
- Rachel Lavelle – 4th year pharmacy student
- Elana Curry – 2nd year medical student

2

THE OHIO STATE UNIVERSITY

Interprofessional Collaborative Practice

- Values Ethics
- Roles/ Responsibilities
- Communication
- Teamwork

American Association of Colleges of Nursing
American Association of Colleges of Osteopathic Medicine
American Association of Colleges of Pharmacy
American Dental Education Association
Association of American Medical Colleges
Association of Schools of Public Health

Interprofessional Education Collaborative Expert Panel. (2011). Core competencies for interprofessional collaborative practice: Report of an expert panel. Washington, D.C.: Interprofessional Education Collaborative.

3

THE OHIO STATE UNIVERSITY

External funding for interprofessional care: HRSA Project

1) Sustain a NP-led interprofessional collaborative practice (IPCP) clinic located in East Columbus that integrates primary care and mental health services to improve health outcomes in an at-risk underserved population

2) To increase the number of health professional students skilled in interprofessional collaborative practice

6

THE OHIO STATE UNIVERSITY

TEAMcare Model

- Patient Centered Focus
- Collaborative Goal Setting
- Practical Care Planning
- Consistent targeted multidisciplinary healthcare team management

TEAMcare
Improving chronic illness outcomes in the medical home

(Katon, Lin, Von Korff, Ciechanowski, Ludman, Young, Rutter, Oliver, McGregor, 2010).

7

THE OHIO STATE UNIVERSITY

Student Disciplines in Interprofessional Clinic

- Medical Dietetics
- Medicine
- Nurse Practitioners
- Pharmacy
- Social Work

8

28

(ATTACHMENT XII)

OSU WEXNER MEDICAL CENTER - ENTERPRISE PERFORMANCE SCORECARD
FY2018 September Year-To-Date Results

THE OHIO STATE UNIVERSITY

Strategic Priorities	Champion	Metric(s)	FY 17 Actual	FY18 YTD - September Actual	Status	FY 18 Target	FY24 - 7 Year Aspirational Target
TALENT & CULTURE	Basso/ McQuaid/ Kent	Medical Center Overall Engagement Score	Number of Tier 3 workgroups reduced by 46.8%	Full census survey conducted November 2017		4.15	Top Quartile
	Basso/ Kent	Develop and implement a plan to enhance faculty engagement	N/A	Plan Development in Process	◄►	Plan Developed - Yes/No	N/A
	Basso/ McQuaid	Turnover Rate - Staff	13.4%	4.3%	◄►	13.3% (25th Percentile)	11.8% (10th Percentile)
	Basso/ Kent	Turnover Rate - Physician	9.1%	4.3%	◄►	9.9%	9.7%
	Basso/ McQuaid/ Kent	Women and URM in Leadership Positions	Women (47.4%) URM (10.7%)	Women (47.8%) URM (10.0%)	◄►	Women (46.5%) URM (12%)	Women (53.0%) URM (18.0%)
RESEARCH	Mohler/ Kent	Total Awards	$232.7M	$72.3M	▲	$237.7M	$374.8M
	Mohler/ Kent	NIH Awards	$118.3M	$46.2M	▲	$112.8M	$178.2M
	Mohler/ Kent	New Federally Funded Faculty	19	8	▲	20	20 in FY24 Cumulative 140
EDUCATION	Clinchot/ Kent	US News and World Report Best Medical Schools Ranking	31	Update Available March 2018		31	20
	Clinchot/ Kent/ Holliday	% of top students matched as residents	25.3%	Data Available Summer 2018		27.0%	30.0%
	Clinchot/ Kent	Develop an inter-professional health sciences curriculum	N/A	Under Development	◄►	Develop Curriculum - Yes/No	N/A
HEALTHCARE DELIVERY	Taylor/ Seely/ Lucas/ Kopp	Inpatient Admissions	61,701	16,148	▲	64,000	77,500
	Like/ Forrest	New Patient Visits with a Physician & APP[1]	127,942	21,295	▲	131,580	166,000
	N. Ali/ E. Schumacher/ Kipp	Inpatient Length of Stay Index	1.02	1.03	▲	0.97	Top Decile
	Adkins/ Steinberg	Emergency Department Length of Stay	424 Minutes	431 Minutes	▼	376 Minutes	266 Minutes
	Like/ Forrest	Access - Days to 1st appointment for new patients with a physician & APP - Primary Care	43 days	42 Days	▲	41	7 Days
	Like/ Forrest	Access - Days to 1st appointment for new patients with a physician & APP - Specialty Care	35 days	35 Days	▲	32	14 Days
	Thomas/ Niev/ Gonsenhauser	Patient Satisfaction - HCAHPS[2]	75.30%	79.10%	▼	80%	82%
	Thomas	Readmissions[3]	12.60%	13.58%	▼	11.36%	7.45%
	Thomas/ Gonsenhauser	Mortality[4]	0.77	0.74	▲	0.76	0.73
	Thomas/ Gonsenhauser	Gain from Quality Based Reimbursement Programs	$7,000	Data Available July 2018		$300,000	$2 Million
	Thomas/ Netcamp	USNWR Best Hospitals - Number of Specialties Ranked	7	Update Available July 2018		9	16
RESOURCE STEWARDSHIP	Larmore	Integrated Net Margin	$307.6M (6.8%)	$66.8M (7.6%)	▲	$261.5M (7.29%)	$128M (2.71%)
	Larmore/ Taylor/ Seely/ Lucas/ Like/ Walker	Operating Expenses per AA	$20,710	$20,515	▲	$21,111	$20,195
	Larmore/ Hamilton	Health Plan Per Member Per Year Costs[5]	$5,007	$5,007	◄►	$5,168	Beat National Trend by 1%
	McQuaid/ Kent/ Larmore	Efficiency Target	N/A	Data available January 2018		$20M	Cumulative $420M
	Hill/ Callahan	Philanthropy $	$180.4M	$48.3M	▲	$130.8M	$250.0M
	McQuaid/ Kent	Priority facilities' programming on schedule and under budget	N/A	Programming is on schedule for all 4 projects	◄►	4 out of 4	All Facilities Opened
HEALTHY COMMUNITIES	Netcamp/ Blincoe/ Thomas	Develop focused programs to address community health needs in the areas of chronic diseases, opioid addiction and infant mortality	N/A	Under Development	◄►	Program Developed - Yes/No	N/A
	Blincoe/ Gluck	Tertiary/Quaternary Critical Care Access for Patients From Regional Areas	15,308	4,133	▲	13,965	17,625
	Mars/ Blincoe	Number of patient encounters in affiliated regional locations	167,259	38,906	▲	178,491	210,067

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

1. New Patient Metric updated to only include July 16, 17
2. HCAHPS updated through August 2017
3. Readmissions updated through July 2017
4. Mortality updated January - August 2017
5. Due to Run-Out transition this Year, Costs represent the 12-month period of June 2016 through June 30, 17

▲ Performance Up from last Scorecard Update
◄► No Performance Change from last Scorecard Update
▼ Performance Down from last Scorecard Update

Confidential   Trade Secret   Proprietary   Do Not Copy

29

OSU WEXNER MEDICAL CENTER
FY18 ENTERPRISE PERFORMANCE SCORECARD DEFINITIONS

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Metric(s)	Definition
Engagement Score	Press Ganey determines the metric of workforce engagement based on employees' response to three metrics. 1. Willingness to refer OSUWMC to family, friends and colleagues for employment and healthcare 2. Pride in affiliation with OSUWMC 3. Overall satisfaction in employment at OSUWMC
Develop and implement a plan to enhance faculty engagement	N/A
Turnover Rate - Staff	Turnover Rate - Staff is the count of Staff members who actually exit the system, leave the Medical Center.
Turnover Rate - Physician	Turnover Rate - Physician is the count of Physicians who actually exit the system, leave the Medical Center.
Women and URM in Leadership Positions	Percent of women and underrepresented minorities in leadership positions. Underrepresented minorities: Asian, Black and Hispanic Health System management positions: Director/Sr. Director/Administrative Director/Associate Exec Director/Chief XX Officers, COM management positions: Dean, Vice Deans, Chairs, Division Directors, Vice Chairs, Center Directors, College-level staff leaders and Department Administrators.
Total Awards	The sum of all research award funding received by the College of Medicine during the period in question.
NIH Awards	The sum of all NIH Award funding segments (less sub-Awards) received by the College of Medicine during the period in question.
New Federally Funded Faculty	Report of faculty receiving either their first federal funding (current faculty) or new faculty with new federal funding for OSU.
US News and World Report Best Medical Schools Ranking	The overall rank of the medical school among all the medical schools ranked by U.S. News and World Report's Best Medical Schools.
% of top students matched as residents	The percentage of students, residents or fellows matching to train at OSUWMC that graduate(d) from top-ranked USNWR Best Medical Schools or has been inducted into AOA National Medical Honor Society. Top ranked is the top 30 USNWR Best Medical Schools for that specific year.
Develop an inter-professional health sciences curriculum	N/A
Inpatient Admissions	A count of patients admitted to the Health System during the reporting period. Inpatients are defined by the patient class assigned in IHIS. Excludes normal newborns. Excludes Observations and Outpatients in a Bed.
New Patient Visits with a Physician & APP	The number of unique new ambulatory patients seen in an OSUWMC outpatient location by a provider (physician, NP or PA). Will be tracked monthly and report fiscal YTD figures. A unique new ambulatory patient" is a patient that has no OSUWMC activity (IP or OP) in last rolling three years with a triggering event of a billable encounter with a provider in one of our ambulatory locations. Will be calculated for all departments/divisions and include AfterHours and the ED but will show separately. A unique patient will only be counted once.
Inpatient Length of Stay Index	The ratio of length of stay to Vizient expected length of stay for a given population and time period.
Emergency Department Length of Stay	Median time in minutes from ED arrival to ED departure for patients admitted to the facility from the ED.
Access - Days to 1st appointment for new patients with a physician - Primary Care	The average wait time for a new patient appointment with a Physician in a Family Medicine or General Medicine office as measured by when the appointment was requested to the scheduled date of service for the appointment.
Access - Days to 1st appointment for new patients with a physician - Specialty Care	The average wait time for a new patient appointment with a Physician in a Specialty Care office as measured by when the appointment was requested to the scheduled date of service for the appointment.
HCAHPS Score	Percent of inpatients who gave the hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest) - across all system hospitals including The James.
Readmissions	Estimates of unplanned readmission for any cause to an acute care hospital within 30 days of discharge from a hospitalization.
Mortality	This measure is expressed as the observed (actual) mortality in the inpatient hospital (deaths per 100 patients), compared to the "expected" mortality rate for similar patients at academic medical centers in the United States who participate in the University Healthsystem Consortium's Clinical Data Base.
Gain from Quality Based Reimbursement Programs	Financial gain (penalty) from CMS based programs i.e. Value Based Purchasing, Reimbursement Reduction Program and Hospital Acquired Conditions
USNWR Specialties Ranked	Total number of specialties OSUWMC was ranked in by U.S. News and Word Report's Best Hospitals. A specialty is ranked if it is among the Top 50 hospitals for that specialty. This applies to specialties with a data-driven ranking methodology, for specialties that have a reputation-only methodology, the number of hospitals that make the ranked list varies depending on the specialty.
Integrated Net Margin	Combined financial reporting represents entire financial position of the OSU Wexner Medical Center including the OSU Health System, OSU Physicians Inc, and College of Medicine. Combined Medical Center Margin includes operating revenues, operating expenses, and Medical Center investments.
Operating Expenses per AA	Serves as an indicator that presents a metric that accounts for both inpatient and outpatient activities and indicates how well expenses are in line with volumes for the health system.
Health Plan Per Member Per Year Costs	Per member per year costs (PMPY) are based on the sum of all medical/Rx costs including 90 day run out and IBNR (incurred but not reported) factors divided by the number of members with medical coverage. It is the sum of Net Pay PMPY for medical claims and Net Pay PMPY for pharmacy claims. PMPY will be calculated on a calendar year to align with the benefit year and allow for the reporting lag due to 90 days claim run out.
Efficiency Target	Operational efficiency will be achieved by streamlining our core processes in order to more effectively respond to the continually changing healthcare environment in a cost-effective manner. In order to obtain operational efficiency, the Medical Center will evaluate ways to maximize and leverage the resources that contribute to success and utilize the best of its workforce, technology and business processes. The reduced internal costs that result from operational efficiency will enable the Medical Center to achieve the financial targets required to achieve the Medical Center's long term strategic mission to provide world class healthcare to our patients.
Philanthropy $	This metric represents new fundraising activity comprised of Development Dollars (including OSP) including outright gifts and pledges, planned gifts (irrevocable and revocable) and private grants (industry, foundations and other organizations).
Priority facilities' programming on schedule and under budget	This metric represents status of programming for the 4 priority facilities namely - Replacement Hospital, West Campus Ambulatory Center, Interdisciplinary Research Tower, and Inter-Professional Education Center
Develop focused programs to address community health needs in the areas of chronic diseases, opioid addiction and infant mortality	N/A
# Hospital Transfers	Outside hospital/facility patient transfers for inpatients accepted as direct admissions or transfers to the Emergency Department (Main, OSUE)
Number of patient encounters in affiliated regional locations	Total count of patient encounters resulting from the following Outreach initiatives: OSU Physician Placement, Clinical Service Line Development/Expansion, and Virtual Health Consulting Services. All encounters outside of Franklin county as well as encounters identified as a virtual encounter are included in the total.

Enterprise Performance Scorecard Definitions - 2 of 2

(ATTACHMENT XIII)

Improving People's Lives Through Innovations in Personalized Health Care

Wexner Medical Center Board
Public Session
Health System Financial Summary

November 1, 2017

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

The Ohio State University Health System
Financial Highlights
For the YTD ended: September 30, 2017

Admissions	
Budget	0.6%
Prior Yr	4.4%
Actual	16,148
Budget	16,051
Prior Yr	15,469

Surgeries	
Budget	-0.9%
Prior Yr	1.6%
Actual	10,962
Budget	11,058
Prior Yr	10,788

O/P Visits	
Budget	-1.7%
Prior Yr	1.7%
Actual	444,198
Budget	451,982
Prior Yr	436,783

Worked Hrs / Adjusted Admit	
Budget	0.0%
Prior Yr	-3.6%
Actual	202
Budget	202
Prior Yr	195

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

2

The Ohio State University Health System
Financial Highlights
For the YTD ended: September 30, 2017

Operating Revenue	
Budget	0.5%
Prior Yr	7.7%
Actual	$723,952
Budget	$720,200
Prior Yr	$672,072

Controllable Costs	
Budget	-0.3%
Prior Yr	-6.7%
Actual	$555,281
Budget	$553,511
Prior Yr	$520,656

Excess Revenue over Expense	
Budget	4.7%
Prior Yr	33.3%
Actual	$60,710
Budget	$57,983
Prior Yr	$45,532

Days Cash on Hand		
Jun FY17	2.8%	
PY MTD	17.4%	
Actual	131.0	$861M
Jun FY17	127.5	$826M
PY MTD	111.6	$680M

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

3

The Ohio State University Health System
Consolidated Statement of Operations
For the YTD ended: September 30, 2017
(in thousands)

OSUHS

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	$ 723,952	$ 720,199	$ 3,753	0.5%	$ 672,074	7.7%
Operating Expenses						
Salaries and Benefits	312,383	312,789	406	0.1%	292,978	-6.6%
Resident/Purchased Physician Services	27,237	27,296	59	0.2%	25,093	-8.5%
Supplies	77,528	77,248	(280)	-0.4%	74,820	-3.6%
Drugs and Pharmaceuticals	73,520	70,748	(2,772)	-3.9%	67,708	-8.6%
Services	76,846	77,662	816	1.1%	72,043	-6.7%
Depreciation	38,439	38,495	56	0.1%	35,098	-9.5%
Interest	9,640	9,723	83	0.9%	10,029	3.9%
Shared/University Overhead	13,360	13,360	-	0.0%	12,226	-9.3%
Total Expense	628,953	627,321	(1,632)	-0.3%	589,995	-6.6%
Gain (Loss) from Operations (pre MCI)	94,999	92,877	2,122	2.3%	82,076	15.7%
Medical Center Investments	(37,525)	(37,467)	(58)	-0.2%	(37,513)	0.0%
Income from Investments	2,908	2,573	335	13.0%	983	195.8%
Other Gains (Losses)	327	-	327	---	(14)	---
Excess of Revenue over Expense	$ 60,710	$ 57,983	$ 2,727	4.7%	$ 45,532	33.3%

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

4

The Ohio State University Health System
Consolidated Activity Summary
For the YTD ended: September 30, 2017

OSUHS

CONSOLIDATED ACTIVITY SUMMARY	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
Activity						
Admissions	16,148	16,051	97	0.6%	15,469	4.4%
Surgeries	10,962	11,058	(96)	-0.9%	10,788	1.6%
Outpatient Visits	444,198	451,982	(7,784)	-1.7%	436,783	1.7%
Average Length of Stay	6.31	6.20	(0.10)	-1.7%	6.10	-3.4%
Case Mix Index (CMI)	1.80	1.85	(0.05)	-2.5%	1.81	-0.6%
Adjusted Admissions	30,066	29,978	87	0.3%	29,512	1.9%
Operating Revenue per AA	$ 24,079	$ 24,024	55	0.2%	$ 22,773	5.7%
Operating Expense per AA	$ 20,919	$ 20,926	7	0.0%	$ 19,992	-4.6%

5

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

The Ohio State University Health System
Consolidated Outpatient Visit Summary
For the YTD ended: September 30, 2017

CATEGORY	ACTUAL	BUDGET	ACT-BUD VAR	BUDGET % VAR	PRIOR YEAR	PY % VAR
Surgeries	6,675	6,821	(146)	-2.1%	6,750	-1.1%
ED Visits	26,818	26,555	263	1.0%	28,939	-7.3%
Procedures	30,363	30,968	(605)	-2.0%	30,443	-0.3%
Cath Lab	786	880	(94)	-10.7%	914	-14.0%
EP Lab	606	690	(84)	-12.2%	658	-7.9%
Interventional Radiology	1,270	1,093	177	16.2%	1,008	26.0%
Radiation Oncology	11,921	11,959	(38)	-0.3%	11,719	1.7%
All Other	15,780	16,346	(566)	-3.5%	16,144	-2.3%
Clinic Visits	112,448	113,250	(802)	-0.7%	110,373	1.9%
Clinic/Office Visits	104,830	106,191	(1,361)	-1.3%	103,192	1.6%
Chemo Visits	7,618	7,059	559	7.9%	7,181	6.1%
Rehab Services	51,487	53,596	(2,109)	-3.9%	50,197	2.6%
Radiology	45,882	45,615	267	0.6%	42,693	7.5%
Lab	67,378	65,894	1,484	2.3%	65,582	2.7%
Pharmacy	4,481	4,892	(411)	-8.4%	4,419	1.4%
Other OP Visits	1,654	1,235	419	33.9%	1,204	37.4%
Physician Visits	97,012	103,156	(6,144)	-6.0%	96,183	0.9%
TOTAL OUTPATIENT VISITS	444,198	451,982	(7,784)	-1.7%	436,783	1.7%

6

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER
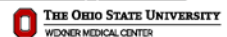
OSU Wexner Medical Center
Combined Statement of Operations
For the YTD ended: September 30, 2017
(in thousands)

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	$ 884,893	$ 885,630	$ (737)	-0.1%	$ 819,839	7.9%
Operating Expenses						
Salaries and Benefits	459,351	463,373	4,022	0.9%	429,258	-7.0%
Resident/Purchased Physician Services	27,237	27,296	59	0.2%	25,093	-8.5%
Supplies	83,568	83,144	(424)	-0.5%	80,944	-3.2%
Drugs and Pharmaceuticals	76,294	73,462	(2,832)	-3.9%	70,150	-8.8%
Services	96,324	99,870	3,546	3.6%	90,639	-6.3%
Depreciation	41,775	43,138	1,363	3.2%	37,604	-11.1%
Interest/Debt	12,486	12,422	(64)	-0.5%	12,912	3.3%
Shared/University Overhead	10,125	10,787	662	6.1%	11,257	10.1%
Other Operating Expense	8,454	8,663	209	2.4%	7,550	-12.0%
Medical Center Investments	2,427	2,370	(57)	-2.4%	2,635	7.9%
Total Expense	818,041	824,525	6,484	0.8%	768,042	-6.5%
Excess of Revenue over Expense	$ 66,851	$ 61,103	$ 5,748	9.4%	$ 51,793	29.1%
Financial Metrics						
Integrated Margin Percentage	7.6%	6.9%	0.7%	9.5%	6.3%	19.6%
Adjusted Admissions	30,066	29,978	87	0.3%	29,512	1.9%
OSUP Physician Encounters	660,403	679,263	(18,860)	-2.8%	636,768	3.7%
Operating Revenue per AA	$ 24,079	$ 24,024	$ 55	0.2%	$ 22,773	5.7%
Total Expense per AA	$ 20,919	$ 20,926	$ 7	0.0%	$ 19,992	-4.6%

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.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

7

OSU Wexner Medical Center
Combined Statement of Operations
For the YTD ended: September 30, 2017
(in thousands)

	ACTUAL	BUDGET	ACT-BUD VARIANCE	BUDGET % VAR	PRIOR YEAR	PY % Var
Health System						
Revenues	$ 723,952	$ 720,199	$ 3,753	0.5%	$ 672,074	7.7%
Expenses	663,243	662,215	(1,028)	-0.2%	626,539	-5.9%
Net	60,710	57,983	2,727	4.7%	45,532	33.3%
OSUP						
Revenues	$ 101,291	$ 105,506	$ (4,215)	-4.0%	$ 97,262	4.1%
Expenses	102,599	106,804	4,205	3.9%	93,090	-10.2%
Net	(1,309)	(1,299)	(10)	-0.8%	4,172	-131.4%
COM/OHS						
Revenues	$ 59,650	$ 59,925	$ (275)	-0.5%	$ 50,503	18.1%
Expenses	52,199	55,506	3,307	6.0%	48,413	-7.8%
Net	7,450	4,419	3,031	68.6%	2,089	256.6%
Total Medical Center						
Revenues	$ 884,893	$ 885,630	$ (737)	-0.1%	$ 819,839	7.9%
Expenses	818,041	824,525	6,484	0.8%	768,042	-6.5%
Net	66,851	61,103	5,748	9.4%	51,793	29.1%

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.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

8

OSU Wexner Medical Center
Combined Balance Sheet
As of: September 30, 2017
(in thousands)

		September 2017		June 2017		Change
Cash	$	767,842	$	734,302	$	33,540
Net Patient Receivables		429,372		410,404		18,968
Other Current Assets		392,060		395,833		(3,773)
Assets Limited as to Use		403,110		403,052		58
Property, Plant & Equipment - Net		1,487,190		1,503,002		(15,812)
Other Assets		434,808		428,241		6,567
Total Assets	$	3,914,381	$	3,874,834	$	39,547
Current Liabilities	$	325,224	$	323,892	$	1,332
Other Liabilities		92,033		93,741		(1,708)
Long-Term Debt		837,431		852,129		(14,698)
Net Assets - Unrestricted		2,085,292		2,026,145		59,147
Net Assets - Restricted		574,401		578,927		(4,526)
Liabilities and Net Assets	$	3,914,381	$	3,874,834	$	39,547

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

9

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

(ATTACHMENT XIV)

Project Data Sheet for Board of Trustees Approval

Health Sciences Faculty Office and Optometry Clinic Building
Project Location: West 11th Ave & Neil Ave

- **approval requested and amount**
  professional services $0.6M

- **project budget**

professional services	$2.8M
construction w/contingency	$25.2M
total project budget	$28.0M

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

- **project schedule**

BoT prof serv approval	11/17
design/bidding	TBD
construction	TBD

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

- **planning framework**
  - ○ project programming completed October 2017
  - ○ the FY 2018 Capital Investment Plan will be amended to include the professional services amount

- **project scope**
  - ○ demolish three existing buildings at the corner of W. 11th Ave and Neil Ave
  - ○ construct approximately 93,000 GSF for optometry clinics, retail, faculty offices and support spaces
  - ○ key enabling project for the Interdisciplinary Health Sciences Center

- **approval requested**
  - ○ approval is requested to amend the Capital Investment Plan accordingly
  - ○ approval is requested to enter into professional services contracts

planning team	project team
university planning project manager: Rebekah Gayley	university project manager:TBD
AE: Ford Architects	criteria AE:TBD
CM estimator: Corna Kokosing	design-builder:TBD

Office of Administration and Planning   November 2017

(ATTACHMENT XV)

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

LEADERSHIP COUNCIL
FOR CLINICAL QUALITY, SAFETY AND SERVICE

The Ohio State University Wexner Medical Center

Clinical Quality Management, Patient Safety, & Service Plan

FY18
July 1, 2017 -June 30, 2018

Clinical Quality Management, Patient Safety, & Service Plan

ATTACHMENTS

39

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 that are reported in the Quality & Safety Scorecard [Attachment II].

41
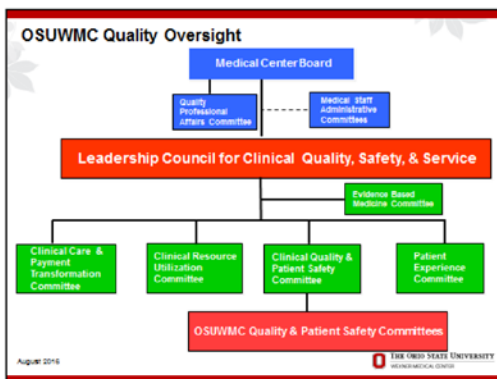
COMMITTEES:

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.

44

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 executive, physician, and nursing leadership spanning the inpatient and outpatient care settings. The Council is co-chaired by the Chief Nurse Executive for the Health System, Executive Director of Patient Services and Chief Nursing Officer of The James, and Chief Quality and Patient Safety Officer. The committee reports to the Leadership Council and reports out to additional committees as applicable.

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. Set strategic goals and priorities for improving the patient experience to be implemented by area specific patient experience councils.
3. Serve as a communication hub reporting out objectives and performance to the system.
4. Serve as a coordinating body for subcommittees working on specific aspects of the patient experience.
5. 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.
6. Monitor publicly reported and other metrics used by various payers to ensure optimal reimbursement.

7. Collaborate with other departments to reward and recognize faculty and staff for service excellence performance.

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 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 Technology Steering (HSITS)

Composition:

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

Function:

The HSITS 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 Officers
The Associate Chief Quality and Patient Safety Officers 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.

The DMAIC Roadmap

D Define	M Measure	A Analyze	I Improve	C Control
Develop the charter	Determine current performance	Develop focused problem statement	Creative possible solutions for root causes	Develop and document standard practices
Map the process	Refine the problem statement	Explore potential causes	Select solutions	Train teams
Understand the voice of the customer (VOC)	Plan & execute data collection plan	Use tools to determine cause & effect relationships	Develop improvement plan	Monitor performance
Define the problem	Identify the key measures you will be monitoring	Determine root causes of problem	Pilot plans	Summarize and communicate learnings
			Implement plans	Recommend future plans
			Measure results	
			Evaluate benefits	

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

Methods for Monitoring

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 registries and databases

- Retrospective and concurrent medical record review (e.g., infection surveillance)

- Reporting systems (e.g., patient safety reporting system)

- Surveys (i.e. patients, families, and staff)

Assessment 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, hospital-acquired infections, falls, patient safety indicators, mortality, length of stay, readmissions, and patient experience. 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 II]**.

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 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

- Newsletters

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

    - Individual physician access to their profiles 24/7

- Discussion at Credentialing Committee

- Final Recommendation & Approval:

    o Medical Staff Administrative Committees

    o Medical Director

    o 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 & Scorecard

FY 2018 Targets – Vizient Based Data

Performance Incentive Metrics	Current Performance	Peer Rank (Bot)	FY 18 Target	Target Standard
Mortality Index – Medical Center	0.77	6	0.76	Top Decile
Mortality Index – System (No James)	0.75	5	0.75	Best Perf
LOS Index	1.02	9	0.99	Top Quartile
PSI 90	0.66	12	0.62	Top Quartile
PSI-10 – Acute Kidney Injury	2.97	22	1.65	Median
PSI-11 – Post Op Resp Failure	5.16	15	4.65	Median
PSI-13 – Post Op PE/DVT	5.17	12	4.18	Top Quartile
PSI 15 – Post OP Sepsis	6.27	14	5.48	Median
Overall 30 Day All Cause Readmission Rate	12.62%	22	11.59	Median
Overall 30 Day All Cause Readmission Rate (without James)	10.66%	7	8.91%	Top Decile
Overall 30 Day All Cause Readmission Rate – AMI	14.26	16	12.32%	Median
Overall 30 Day All Cause Readmission Rate – HF	19.89	9	18.24%	Median
Overall 30 Day All Cause Readmission Rate – Pn	17.06	4	10.14%	Top 2
Overall 30 Day All Cause Readmission Rate – COPD	17.12	14	17.08%	Median
Overall 30 Day All Cause Readmission Rate – THA/TKA	4.27	15	4.0%	Median
Overall 30 Day All Cause Readmission Rate – CABG	14.50%	16	13.9%	Median

FY 2018 Targets – Hospital Compare Data

Performance Incentive Metrics	Current Performance	Peer Rank	FY 18 Target	Target Standard
CLABSI – SIR	0.581	n/a	0.788	Maintain
CAUTI – SIR	0.305	n/a	0.380	Maintain
CDI – SIR	0.777	n/a	0.771	Maintain
MRSA – SIR	0.662	n/a	0.579	Maintain
SSI – Colon SIR	0.431	n/a	1.000	Expected rate
SSI – Ab Hysterectomy SIR	0.894	n/a	1.000	Expected Rate
ED-1b: Door to Departure for Admitted ED Patients	431	14	379	Top Quartile
ED-2b: Admit Decision to ED Departure	185	16	182	Median
OP-18b: Door to Departure for Discharged ED Patients	220	12	192	Top Quartile
OP-20: ED Door to Evaluation	27	15	22	Top Quartile
OP-21: Time to Pain Management LBP	71	21	61	Median
OP-22: ED Left Without Being Seen	4.68%	22	3%	Median

Attachment IV: Physician Performance Based Profile
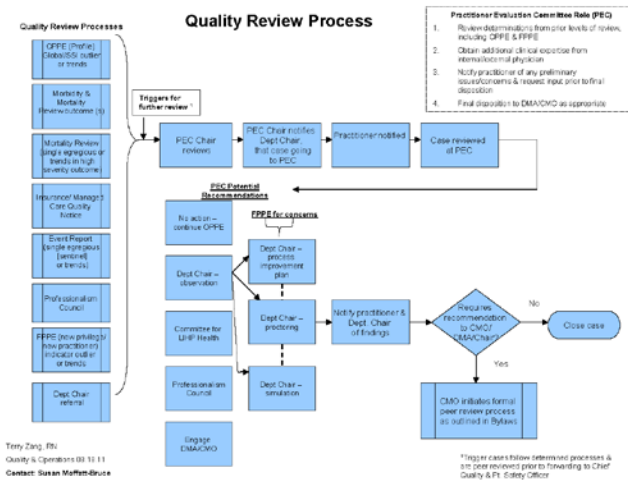
63

Profile for vwexner
SERVICE: INTERNAL MEDICINE-CARDIOVASCULAR MEDICINE