

WEXNER MEDICAL CENTER BOARD

Leslie H. Wexner
Abigail S. Wexner
Cheryl L. Krueger
Hiroyuki Fujita
John W. Zeiger
Janet Porter
Stephen D. Steinour
Robert H. Schottenstein
W.G. Jurgensen
Cindy Hilsheimer
Michael J. Gasser (ex officio, voting)
Michael V. Drake (ex officio, voting)
Bruce A. McPheron (ex officio, voting)
Michael Papadakis (ex officio, voting)
K. Craig Kent (ex officio, non-voting)
L. Arick Forrest (ex officio, non-voting)
David P. McQuaid (ex officio, non-voting)
Mark E. Larmore (ex officio, non-voting)
Andrew M. Thomas (ex officio, non-voting)
Elizabeth O. Seely (ex officio, non-voting)
Susan D. Moffatt-Bruce (ex officio, non-voting)
Mary A. Howard (ex officio, non-voting)
William B. Farrar (ex officio, non-voting)
Thomas J. Ryan (ex officio, non-voting)
Amanda N. Lucas (ex officio, non-voting)

Location: Richard M. Ross Heart Hospital
Ross Heart Hospital Auditorium

Time: 10:00am-2:00pm

Public Session

1. Approval of February 20, 2019, Wexner Medical Center Board Meeting Minutes 10:00-10:05am
2. Opening Remarks – Dr. Paz 10:05-10:15am
3. Pelotonia Update – Mr. Ulman, Dr. Pollock 10:15-10:35am
4. The Future of Learning – Dr. Kent 10:35-10:55am
5. The James Report – Dr. Farrar 10:55-11:00am
6. College of Medicine Report – Dr. Kent 11:00-11:15am
7. Wexner Medical Center Operations Report – Mr. McQuaid 11:15-11:30am
8. Wexner Medical Center Financial Summary and FY20 Budget Review – Mr. Larmore 11:30-11:50am
9. Recommend for Approval to Enter Into and Increase Professional Services and Construction Contracts – Mr. Kasey 11:50-11:55am
10. Approval of the Healthy Communities Health Map – Ms. Marsh 11:55am-12:00pm
11. Quality and Professional Affairs Committee: Items for Action – Ms. Krueger 12:00-12:10pm

Executive Session

12:10-2:00pm



SUMMARY OF ACTIONS TAKEN

February 20, 2019 - Wexner Medical Center Board Meeting

Voting Members Present:

Leslie H. Wexner
Michael J. Gasser
Abigail S. Wexner
Cheryl L. Krueger
Hiroyuki Fujita

John W. Zeiger
Janet Porter
Stephen D. Steinour
Robert H. Schottenstein
Cindy Hilsheimer

Michael V. Drake (ex officio)
Bruce A. McPheron (ex officio)
Michael Papadakis (ex officio)

Non-Voting, Ex-Officio Members Present:

K. Craig Kent
L. Arick Forrest
David P. McQuaid
Mark E. Larmore

Andrew M. Thomas
Elizabeth O. Seely
Susan D. Moffatt-Bruce
Mary A. Howard

William B. Farrar
Thomas Ryan
Amanda N. Lucas

Members Absent:

W.G. "Jerry" Jurgensen

PUBLIC SESSION

The Wexner Medical Center Board convened for its 29th meeting on Wednesday, February 20, 2019, in the Ross Auditorium of the Richard M. Ross Heart Hospital. Board Secretary Jeff M.S. Kaplan called the meeting to order at 9:02 a.m.

Item for Action

1. Approval of Minutes: No changes were requested to the November 14, 2018, meeting minutes; therefore, a formal vote was not required and the minutes were considered approved.

Items for Discussion

2. Time and Change Strategic Plan Update: For the first time ever, the medical center's strategic plan is a prominent pillar in the overall strategic plan of the university. Gail Marsh gave an update on the progress made in the past year. The medical center is leading the way in patient satisfaction, clinical outcomes and creating high-impact translational research that benefits not only faculty and students from an academic perspective, but also the community from a healthcare perspective.
3. Cancer Program Update: Dr. Raphael Pollock shared an interim progress report on the Cancer Center's immuno-oncology efforts, an ambitious undertaking that involves collaboration with many of the colleges across the university. It is anticipated that, when the immuno-oncology efforts are up and running, it will be one of the best-funded efforts of its kind in the nation.
4. College of Medicine Report: Dr. Craig Kent introduced three new recruits — Ben Polouse, chief of the Division of Gastrointestinal Surgery and the Robert Zollinger Memorial Endowed Chair; Allan Tsung, director of the Division of Surgical Oncology; and Ben Segal, chair of the Department of Neurology. The board then heard a presentation from Dr. Tom Ryan and the directors of the cardiovascular service line. They talked about a one-of-a-kind innovation that can only be found at Ohio State called Transcatheter Aortic Valve Replacement, which is a minimally invasive, nonsurgical alternative for treating severe aortic stenosis.
5. Wexner Medical Center Operations Report: David McQuaid announced that the American Association of Critical-Care Nurses has awarded gold and silver Beacon Awards for Excellence to the Medical Intensive Care Units at the James Cancer Hospital and the Wexner Medical Center, respectively. He also discussed a variety of ways the medical center is responding to patients' needs for differentiated services. For example, the Upper Arlington ambulatory facility has become very popular in the community, averaging 825 patient visits per day compared to last year's average of 767 patients per day.
6. Wexner Medical Center Financial Summary: Mark Larmore shared that there are a few areas in the financial summary that are not growing at the predicted rate, but that is expected to change. Admissions are 2.6 percent behind budget and flat compared to the prior year, partially due to the closure of a floor during renovations at Harding Hospital and a change to the reimbursement methodology for inpatient drug rehab at Talbot Hall. While there is a decline on the admissions metric, year-over-year it is still growing at 1.3 percent. Length of stay has increased about 5 percent above budget.



Items for Action

7. Resolution No. 2019-53, Approval for Acquisition and Potential Sale of Real Property

Synopsis: Authorization to purchase real property located along U.S. 33 at Shier Rings Road in Dublin, Franklin County, Ohio, and authorization to sell real property located along U.S. 33 at Shier Rings Road in Dublin, Franklin County, Ohio, is proposed.

WHEREAS The Ohio State University seeks to purchase approximately 34 +/- acres of unimproved real property located along U.S. 33 and Shier Rings Road in Dublin, Ohio; and

WHEREAS the property is strategically important in supporting the objectives of the Wexner Medical Center ambulatory care strategy; and

WHEREAS the city of Dublin will be responsible for the installation and construction of public infrastructure improvements identified in a separate Economic Development Agreement; and

WHEREAS as partial consideration for the city of Dublin's agreement to transfer and convey ownership of the property to the university, Dublin and The Ohio State University have agreed that under certain limited circumstances following the closing of the sale and conveyance of the property from Dublin to the university, Dublin may elect to have the university reconvey the property to Dublin after payment of the original purchase price by Dublin to the university, all upon such terms and conditions as outlined in the Property Reconveyance Escrow Agreement (PREA) to be signed simultaneously with the Economic Development Agreement (EDA) and the Real Estate Purchase and Sale Agreement; and

WHEREAS the PREA will require the university to obtain state of Ohio legislative approval for a potential sale with the resulting Governor's Deed to be held in escrow and released only in accordance with the terms and conditions of the PREA; and

WHEREAS the Wexner Medical Center will provide funding for the acquisition and subsequent development of the property:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves and proposes that the purchase and potential sale of said property 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 take any action required to effect the purchase of the referenced property in the name of the state of Ohio for the use and benefit of The Ohio State University upon terms and conditions deemed to be in the best interest of the university and at a purchase price determined to be fair market value for the property; and

BE IT FURTHER RESOLVED, That the President and/or Senior Vice President for Business and Finance be authorized to take any action required to effect the sale of the referenced property upon terms and conditions deemed to be in the best interest of the university and pursuant to the terms of the PREA.

(See Attachment X for background information, page XX)

8. Resolution No. 2019-54, Approval of the Execution of an Economic Development Agreement

Synopsis: Authorization to enter into an Economic Development Agreement related to property located along U.S. 33 at Shier Rings Road in Dublin, Franklin County, Ohio, is proposed.

WHEREAS The Ohio State University seeks to enter into an Economic Development Agreement (EDA) for development of approximately 34 +/- acres of real property located along U.S. 33 at Shier Rings Road in Dublin, Ohio; and

WHEREAS the property is strategically important in meeting the objectives of the Wexner Medical Center ambulatory care strategy; and

WHEREAS the EDA will memorialize, among other items, agreements regarding certain public infrastructure work to be performed by the city of Dublin and municipal income tax incentives to be paid to the university:

NOW THEREFORE

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



Items for Action (cont'd)

BE IT FURTHER RESOLVED, That the President and/or Senior Vice President for Business and Finance be authorized to take any action required to enter into the Economic Development Agreement upon terms and conditions deemed to be in the best interest of the university.

(See Attachment X for background information, page XX)

9. Resolution No. 2019-55, Approval to Enter Into/Increase Professional Services and Construction Contracts

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

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

	Prof.Serv. Approval Requested	Construction Approval Requested	Total Requested	
Wexner Medical Center Inpatient Hospital – Central Sterile Supply	\$11.8M	\$33.9M	\$45.7M	Auxiliary Funds
Wexner Medical Center Inpatient Hospital – Garage (Infrastructure and Road Work)	\$19.7M	\$54.3M	\$74.0M	Auxiliary Funds

NOW THEREFORE

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

BE IT FURTHER RESOLVED, That the President and/or Senior Vice President for Business and Finance be authorized to enter into professional services and construction contracts for the 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 X for background information, page XX)

Action: Upon the motion of Mr. Zeiger, seconded by Mrs. Wexner, the board adopted the foregoing motions by unanimous voice vote with the following members present and voting: Mr. Wexner, Mr. Gasser, Mrs. Wexner, Ms. Krueger, Dr. Fujita, Mr. Zeiger, Dr. Porter, Mr. Steinour, Mr. Schottenstein, Ms. Hilsheimer, Dr. Drake, Dr. McPheron and Mr. Papadakis. Mr. Jurgensen was absent.

All three of the above resolutions were recommended by the Wexner Medical Center Board and forwarded to the University Board of Trustees for review and approval.

EXECUTIVE SESSION

It was moved by Dr. Porter, and seconded by Ms. Krueger, that the board recess into executive session to consider business-sensitive trade secrets required to be kept confidential by federal and state statutes, to discuss quality matters which are required to be kept confidential under Ohio law, to consult with legal counsel regarding pending or imminent litigation, and to discuss the purchase of real property and personnel matters regarding the employment, appointment, compensation, discipline and dismissal of public officials.

A roll call vote was taken and the board unanimously voted to go into executive session, with the following members present and voting: Mr. Wexner, Mr. Gasser, Mrs. Wexner, Ms. Krueger, Dr. Fujita, Mr. Zeiger, Dr. Porter, Mr. Steinour, Mr. Schottenstein, Ms. Hilsheimer, Dr. Drake, Dr. McPheron and Mr. Papadakis. Mr. Jurgensen was absent.

The board entered executive session at 10:50 a.m. and the board meeting adjourned at 1:05 p.m.

Johns Hopkins University



University of Texas at Austin



University at Buffalo



University of
South Florida



Meiling Hall

Then



Now



This is the future of learning...



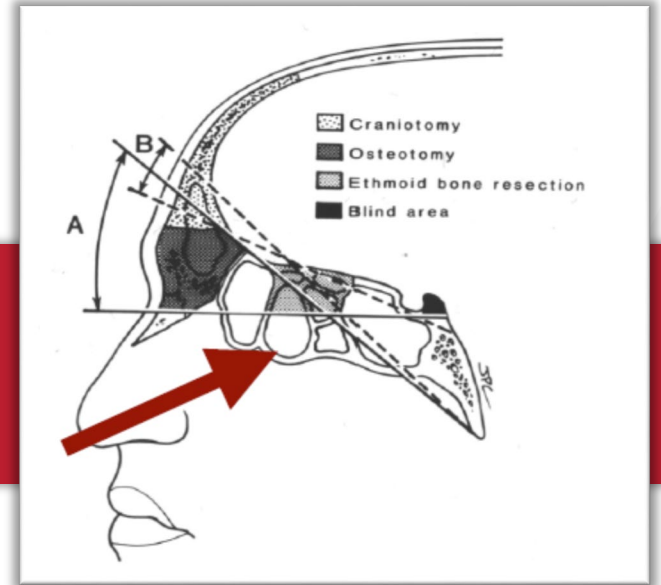
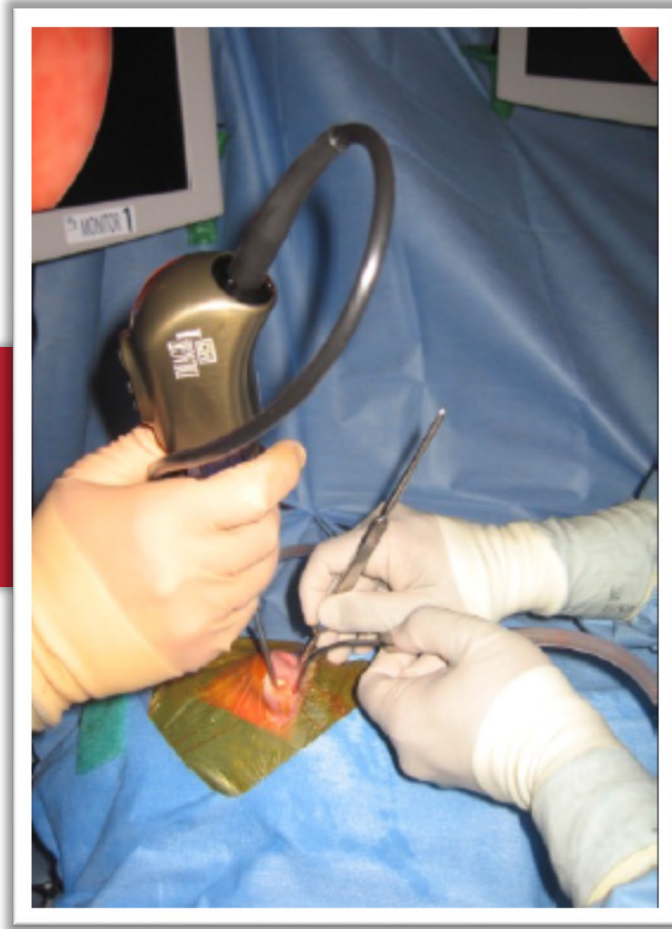
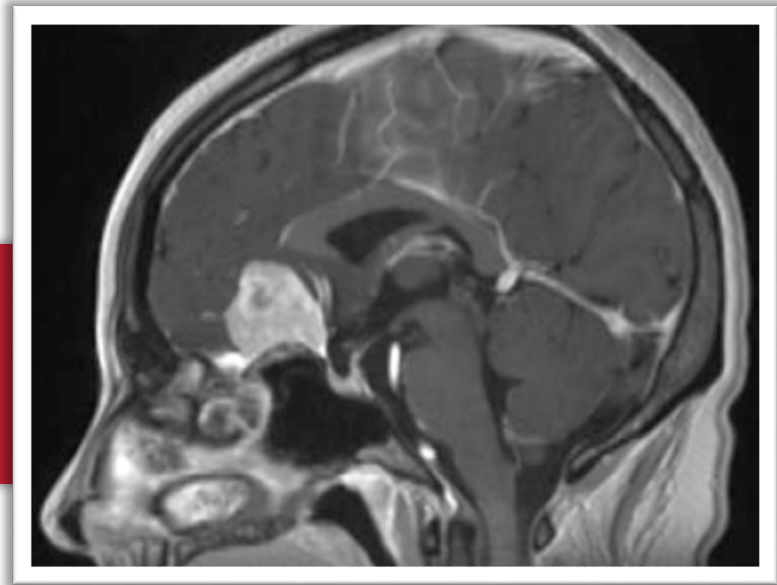


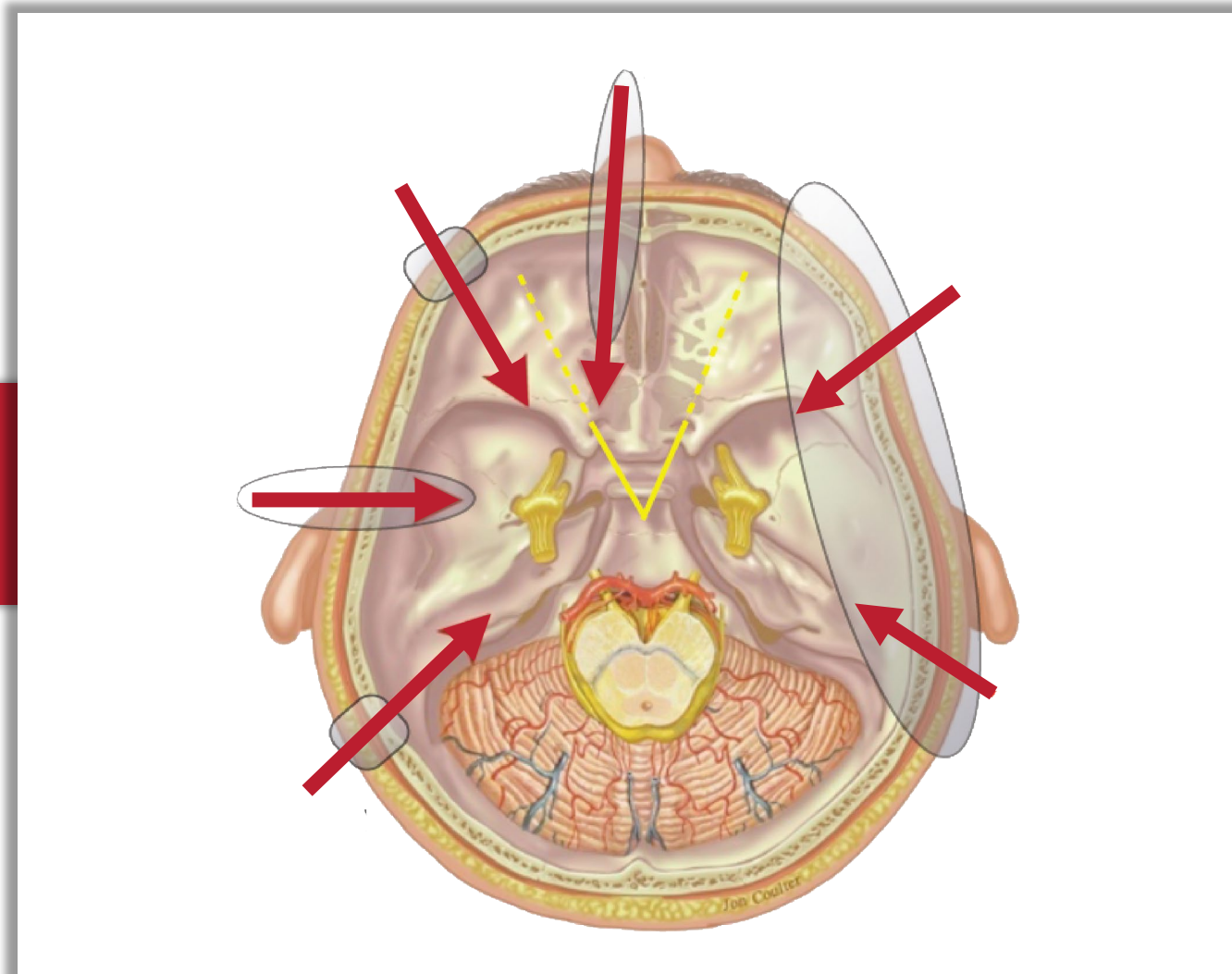
THE OHIO STATE
UNIVERSITY

WEXNER MEDICAL CENTER

SKULL BASE SURGERY

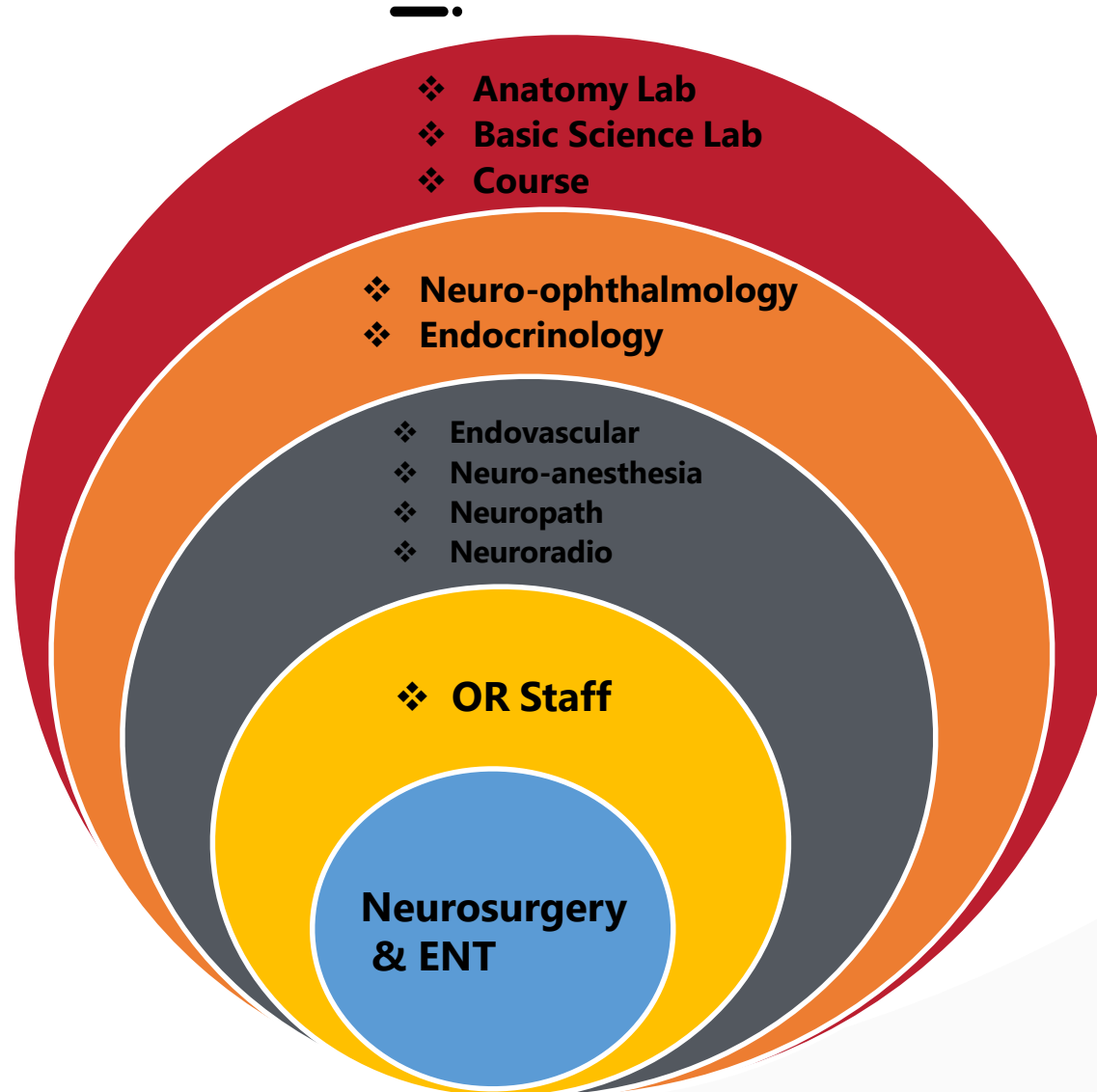
Daniel Prevedello, MD
Ricardo Carrau, MD
Brad Otto, MD
Doug Hardesty, MD





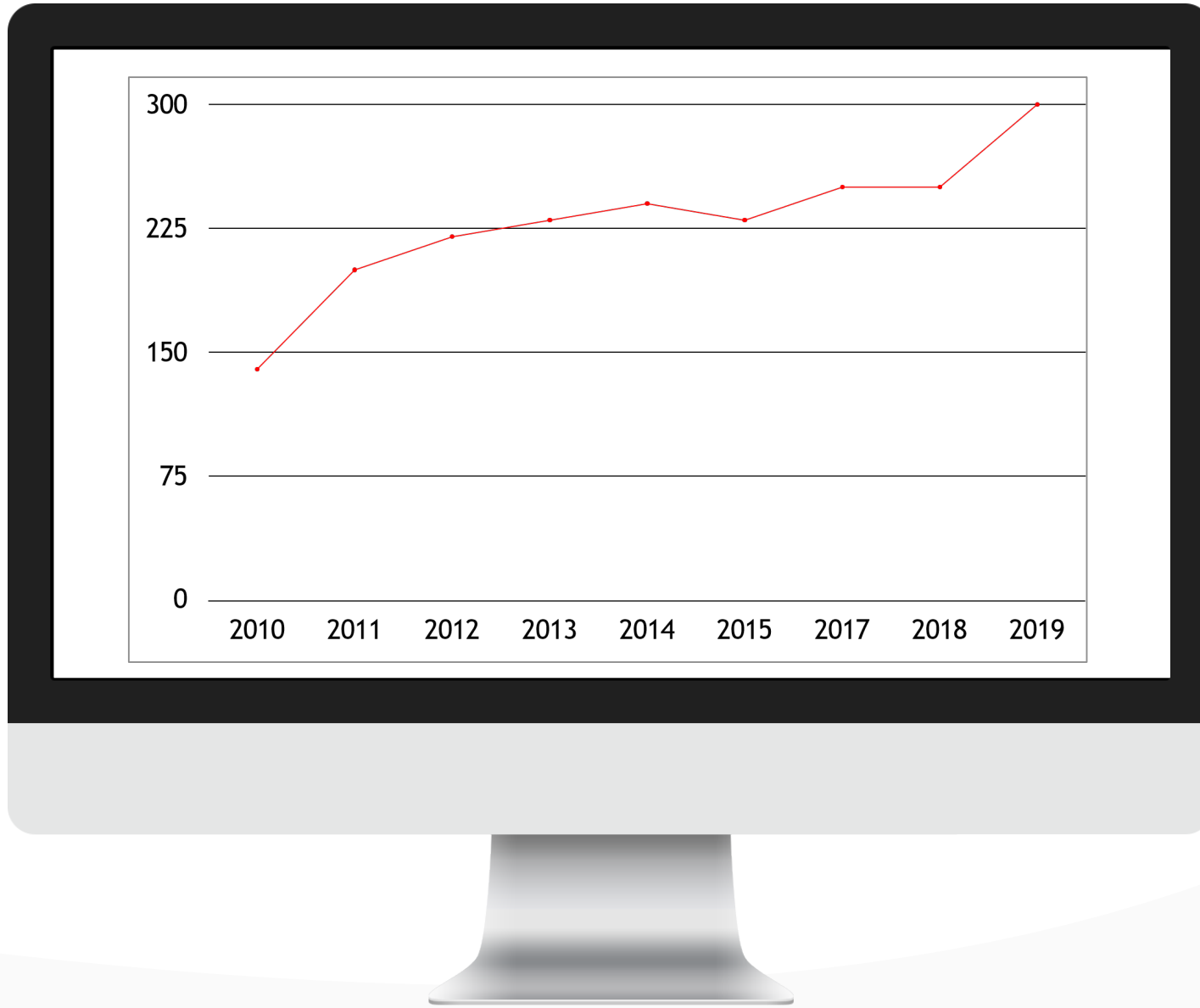


THE "SKULL BASE" TEAM





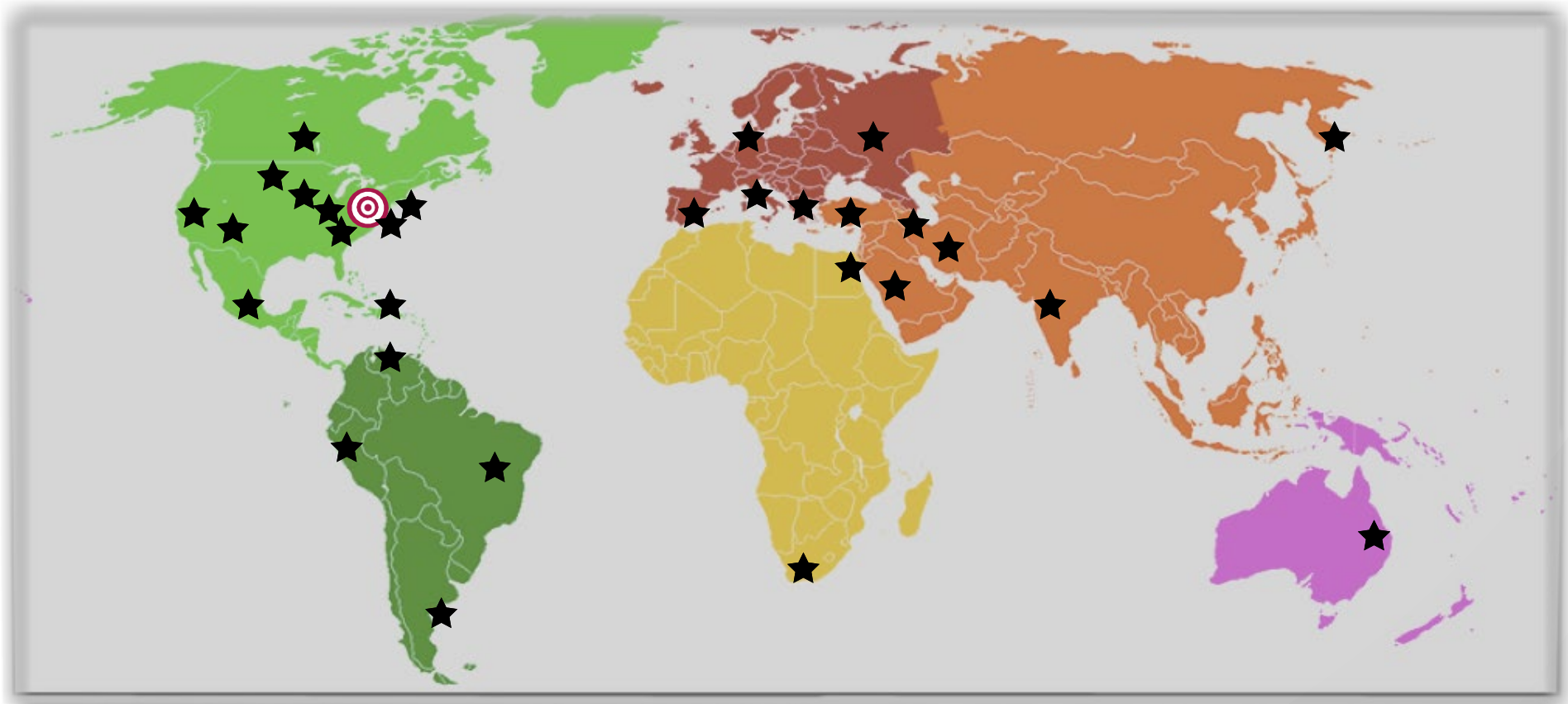
ENDOSCOPIC SKULL BASE SURGERIES



OSU has one of the largest skull based surgery programs in the world.



Wexner
Medical
Center



International Patients (> 100)
Other States (~200)



Wexner
Medical
Center

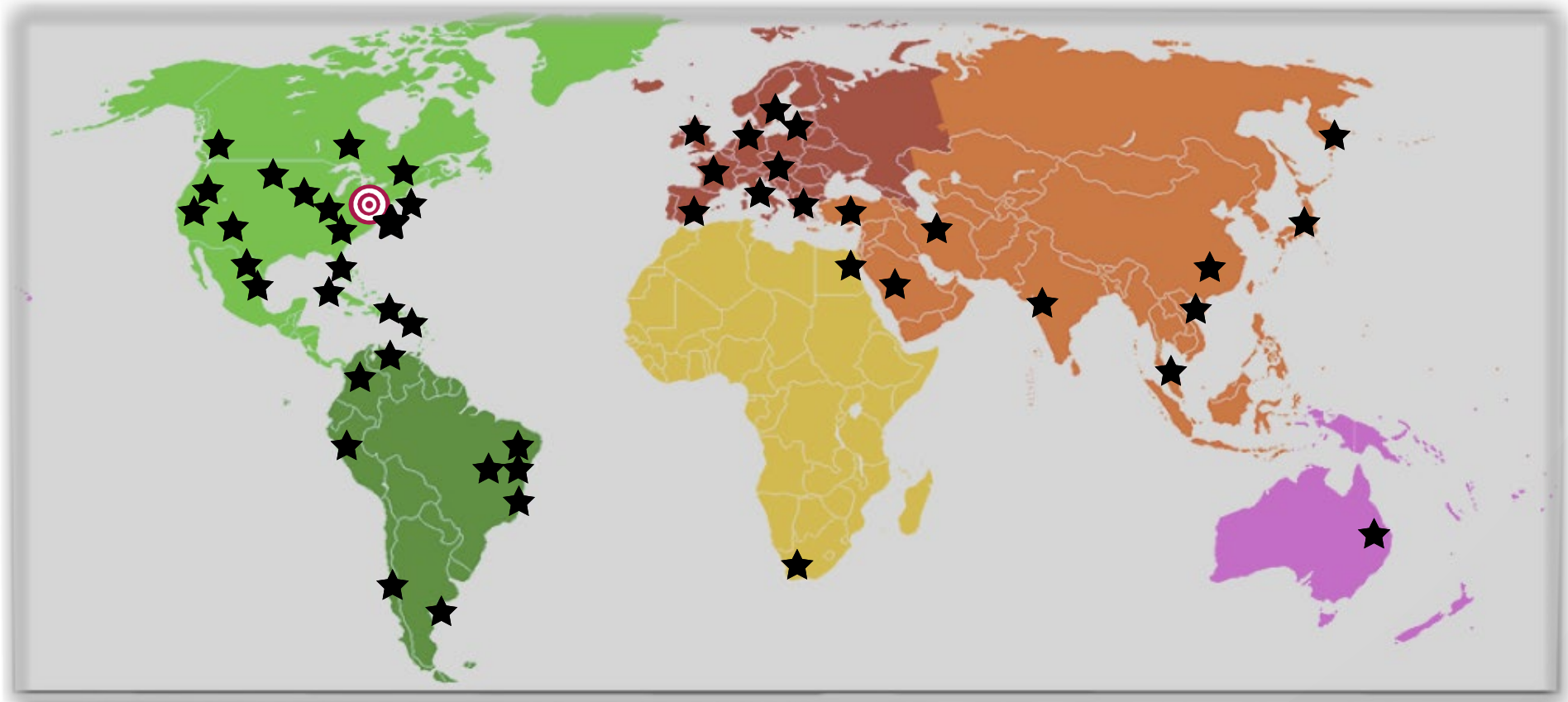
EDUCATION

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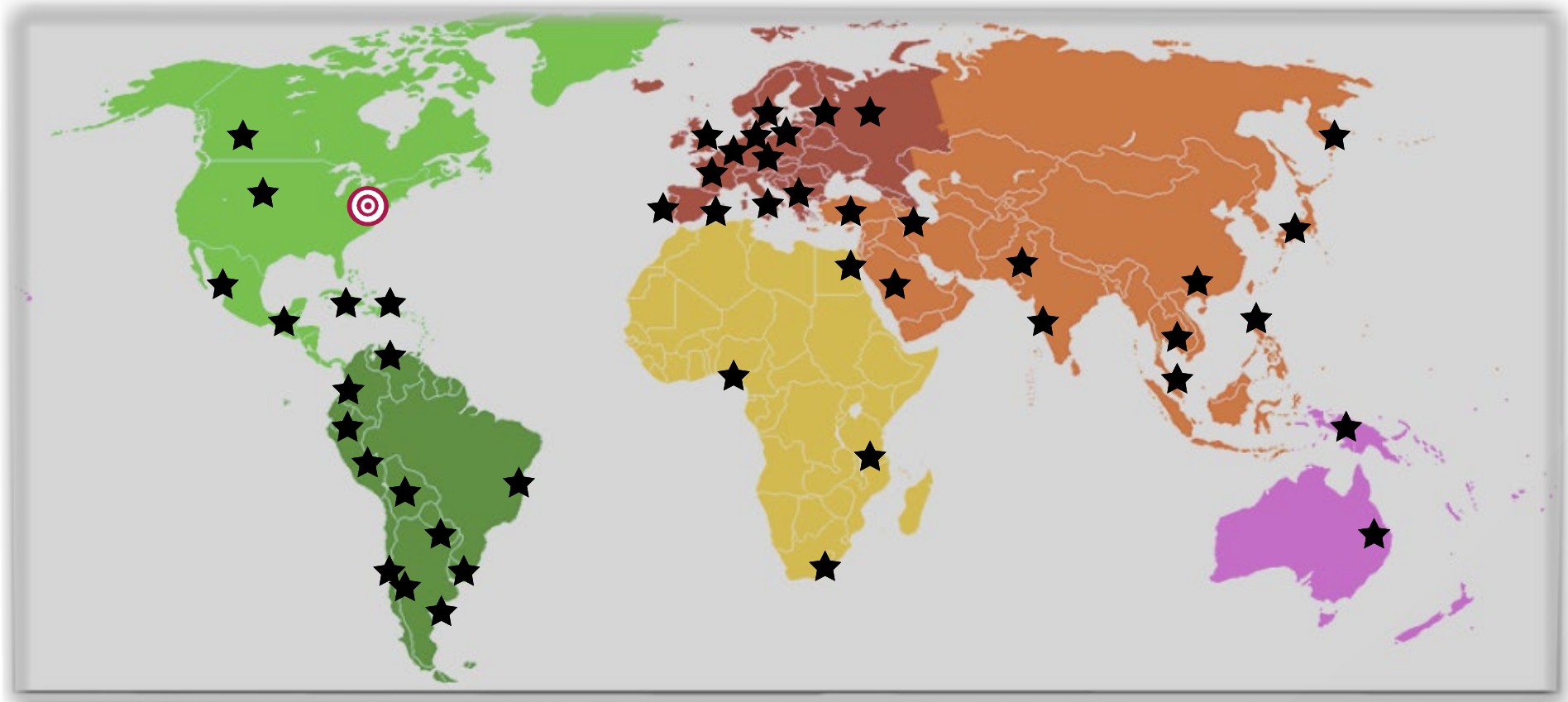
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International + National Courses (~150)

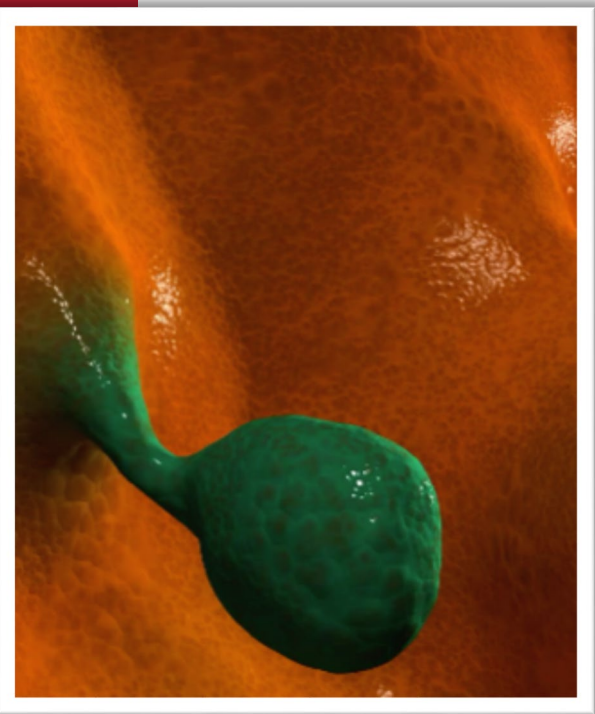
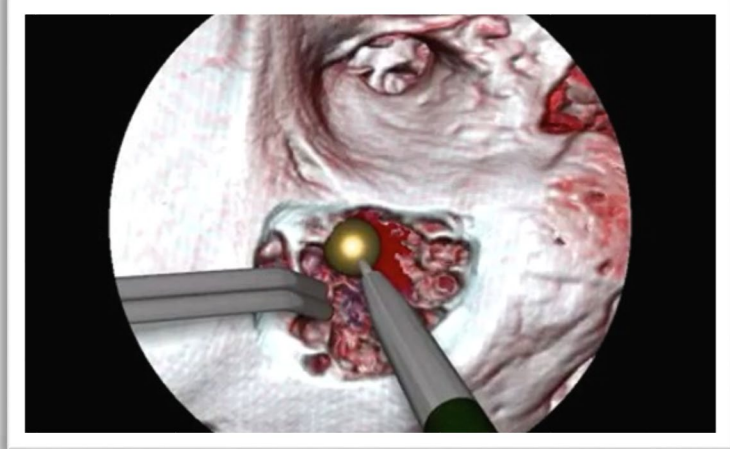
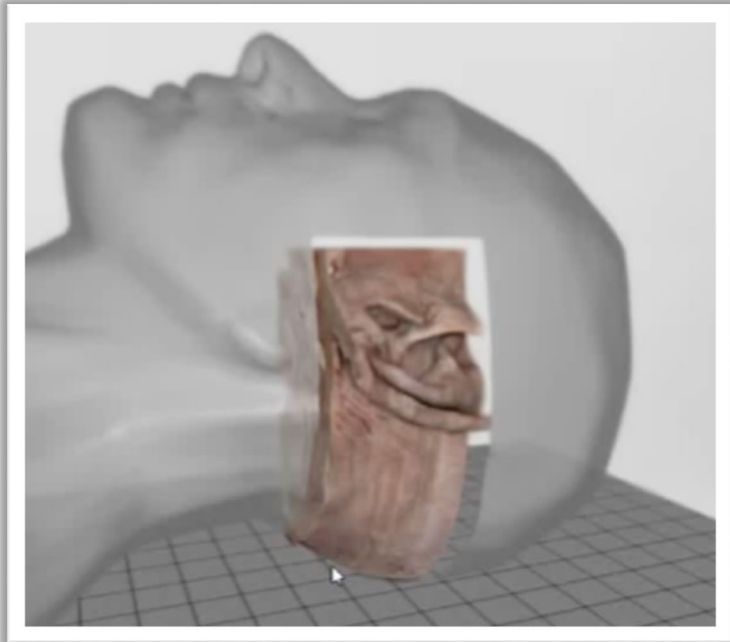


Wexner
Medical
Center



International Visiting Scholars (~200)

RESEARCH AND INNOVATION



- ❖ Simulators (3D printers)
- ❖ Virtual Reality
- ❖ Augmented Reality
- ❖ New Technology



Clinical Learning Environment – Leading the Way in Health Equity

Scott A. Holliday, MD; Associate Dean for GME

Jannel Lee-Allen, MD, MUP, Resident – Internal Medicine

5/29/2019

ACGME – Clinical Learning Environment Review (CLER)

- Clinical Learning Environment Review
 - Formative feedback to drive change in healthcare institutions and the learning environment
 - Six focus areas:
 - Patient Safety
 - Healthcare Quality + Healthcare Disparities
 - Transitions of Care
 - Supervision
 - Wellbeing of physicians and other health care workers
 - Professionalism
- 18 month collaborative to address Healthcare Disparities through QI

Leader: Pursuing Excellence Initiative

- OSU's Proposal: **Aligning Health Care Equity, Outcomes and the Enterprise Scorecard: A QI Initiative**
- OSU GME one of nine organizations selected
 - The Ohio State University
 - Icahn School of Medicine at Mt. Sinai
 - University of Michigan
 - Children's Hospital Los Angeles
 - Citrus Health Network (FQHC in Hialeah, FL)
 - VA Caribbean Healthcare System (San Juan, PR)
 - Healthcare Partners Institute (Bloomington, MN)
 - Kaiser Permanente (Oakland, CA)
 - Newark Beth Israel Medical Center (Newark, NJ)

Two Overarching Goals

1. Through QI efforts –
 - Engage teams (including residents) to consider **healthcare** disparities (i.e. – disparities within our walls) when outcomes fall short
 - Learn QI methodology to support clinical improvements aligned with patient needs and institutional priorities
2. Develop an institutional culture in which disparities are sought out and addressed and cultural humility is the norm

Progress to Date

- Recruitment of residents interested in promoting health equity here at OSUWMC
- Curriculum development around improving health equity
- Leadership engagement (including this presentation to the Board of Trustees)
- Review of baseline healthcare equity data here at OSU for some common conditions

Why

- At OSUWMC we practice evidence-based care so that we can give our patients the best outcomes
- However, we also need to ensure we focus on the delivery of that evidence-based care & meet our patients where they are.





**Wexner Medical Center Board
Public Session
Health System Financial Summary**

May 29, 2019

The Ohio State University Health System

Financial Highlights

For the YTD ended: March 31, 2019

Admissions	
Budget	-2.6%
Prior Yr	0.1%
Actual	48,089
Budget	49,357
Prior Yr	48,061

Surgeries	
Budget	0.7%
Prior Yr	3.4%
Actual	34,429
Budget	34,202
Prior Yr	33,310

O/P Visits	
Budget	-0.1%
Prior Yr	5.1%
Actual	1,410,538
Budget	1,411,897
Prior Yr	1,341,783

Worked Hrs / Adjusted Admit	
Budget	-2.8%
Prior Yr	-1.5%
Actual	205
Budget	199
Prior Yr	202

The Ohio State University Health System

Financial Highlights

For the YTD ended: March 31, 2019

Operating Revenue	
Budget	1.2%
Prior Yr	7.6%
Actual	\$2,389,416
Budget	\$2,362,000
Prior Yr	\$2,219,771

Controllable Costs	
Budget	-0.9%
Prior Yr	-9.0%
Actual	\$1,864,716
Budget	\$1,848,169
Prior Yr	\$1,711,272

Excess Revenue over Expense	
Budget	9.5%
Prior Yr	4.3%
Actual	\$189,697
Budget	\$173,247
Prior Yr	\$181,920

Days Cash on Hand	
Jun FY18	13.1%
PY MTD	16.5%
Actual	165.0 \$1.23B
Jun FY18	145.9 \$1.02B
PY MTD	141.7 \$0.97B

The Ohio State University Health System

Consolidated Statement of Operations

For the YTD ended: March 31, 2019

(in thousands)

OSUHS						
	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	\$ 2,389,416	\$ 2,362,000	\$ 27,416	1.2%	\$ 2,219,771	7.6%
Operating Expenses						
Salaries and Benefits	1,041,223	1,025,385	(15,838)	-1.5%	970,517	-7.3%
Resident/Purchased Physician Services	83,853	87,265	3,412	3.9%	80,932	-3.6%
Supplies	257,486	255,263	(2,223)	-0.9%	238,596	-7.9%
Drugs and Pharmaceuticals	291,277	277,875	(13,402)	-4.8%	229,754	-26.8%
Services	227,149	240,190	13,041	5.4%	228,136	0.4%
Depreciation	125,094	126,075	981	0.8%	115,853	-8.0%
Interest	26,580	27,142	562	2.1%	28,661	7.3%
Shared/University Overhead	34,571	37,069	2,498	6.7%	31,685	-9.1%
Medical Center Investments	112,487	112,487	-	0.0%	113,716	1.1%
Total Expense	2,199,720	2,188,751	(10,969)	-0.5%	2,037,850	-7.9%
Excess of Revenue over Expense	\$ 189,697	\$ 173,247	\$ 16,450	9.5%	\$ 181,920	4.3%
Financial Metrics						
Adjusted Admissions	94,576	95,926	(1,349)	-1.4%	90,786	4.2%
Operating Revenue per AA	\$ 25,264	\$ 24,623	\$ 641	2.6%	\$ 24,450	3.3%
Total Expense per AA	\$ 22,186	\$ 21,733	\$ (453)	-2.1%	\$ 21,287	-4.2%
Operating EBIDA Margin	18.5%	18.2%	0.3%	1.7%	19.5%	-4.7%
Days Cash on Hand	165.0				141.7	16.5%
Debt Service Coverage	7.1	6.8	0.3	4.3%	6.7	5.6%

The Ohio State University Health System

Consolidated Activity Summary

For the YTD ended: March 31, 2019

(in thousands)

OSUHS						
	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
CONSOLIDATED ACTIVITY SUMMARY						
Activity						
Admissions	48,089	49,357	(1,268)	-2.6%	48,061	0.1%
Surgeries	34,429	34,202	227	0.7%	33,310	3.4%
Outpatient Visits	1,410,538	1,411,897	(1,359)	-0.1%	1,341,783	5.1%
Average Length of Stay	6.61	6.21	(0.40)	-6.5%	6.38	-3.5%
Case Mix Index (CMI)	1.89	1.85	0.04	2.0%	1.85	1.9%
Adjusted Admissions	94,576	95,926	(1,349)	-1.4%	90,786	4.2%
Operating Revenue per AA	\$ 25,264	\$ 24,623	641	2.6%	\$ 24,450	3.3%
Operating Expense per AA	\$ 22,186	\$ 21,733	(453)	-2.1%	\$ 21,287	-4.2%

OSU Wexner Medical Center

Combined Statement of Operations
For the YTD ended: March 31, 2019
(in thousands)

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	\$2,939,934	\$2,893,403	\$ 46,531	1.6%	\$2,717,596	8.2%
Operating Expenses						
Salaries and Benefits	1,512,052	1,496,907	(15,145)	-1.0%	1,414,193	-6.9%
Resident/Purchased Physician Services	83,853	87,265	3,412	3.9%	80,932	-3.6%
Supplies	277,744	272,029	(5,715)	-2.1%	255,464	-8.7%
Drugs and Pharmaceuticals	299,352	284,650	(14,702)	-5.2%	238,491	-25.5%
Services	298,222	309,916	11,694	3.8%	288,427	-3.4%
Depreciation	136,662	139,237	2,575	1.8%	128,046	-6.7%
Interest/Debt	35,138	35,635	497	1.4%	37,191	5.5%
Shared/University Overhead	34,571	37,069	2,498	6.7%	31,685	-9.1%
Other Operating Expense	24,849	27,189	2,340	8.6%	25,702	3.3%
Medical Center Investments	13,502	15,908	2,406	15.1%	5,829	-131.6%
Total Expense	2,715,945	2,705,805	(10,140)	-0.4%	2,505,960	-8.4%
Excess of Revenue over Expense	\$ 223,992	\$ 187,596	\$ 36,396	19.4%	\$ 211,638	5.8%
Financial Metrics						
Integrated Margin Percentage	7.6%	6.5%	1.1%	17.5%	7.8%	-2.2%
Adjusted Admissions	94,576	95,926	(1,349)	-1.4%	90,786	4.2%
OSUP Physician Encounters	2,089,430	2,062,791	26,639	1.3%	2,019,479	3.5%
Operating Revenue per AA	\$ 25,264	\$ 24,623	\$ 641	2.6%	\$ 24,450	3.3%
Total Expense per AA	\$ 22,186	\$ 21,733	\$ (453)	-2.1%	\$ 21,287	-4.2%
This statement does not conform to Generally Accepted Accounting Principles. Different accounting methods are used in each of these entities and no eliminating entries are included.						

OSU Wexner Medical Center

Combined Statement of Operations
For the YTD ended: March 31, 2019
(in thousands)

	ACTUAL	BUDGET	ACT-BUD VARIANCE	BUDGET % VAR	PRIOR YEAR	PY % Var
Health System						
Revenues	\$ 2,389,416	\$ 2,362,000	\$ 27,416	1.2%	\$ 2,219,771	7.6%
Expenses	2,199,720	2,188,751	(10,969)	-0.5%	2,037,850	-7.9%
Net	189,697	173,247	16,450	9.5%	181,920	4.3%
OSUP						
Revenues	\$ 350,950	\$ 343,834	\$ 7,116	2.1%	\$ 321,174	9.3%
Expenses	334,968	339,893	4,925	1.4%	311,898	-7.4%
Net	15,983	3,941	12,042	305.6%	9,277	72.3%
COM/OHS						
Revenues	\$ 199,568	\$ 187,569	\$ 11,999	6.4%	\$ 176,651	13.0%
Expenses	181,257	177,161	(4,096)	-2.3%	156,212	-16.0%
Net	18,312	10,408	7,903	75.9%	20,441	-10.4%
Total Medical Center						
Revenues	\$ 2,939,934	\$ 2,893,403	\$ 46,531	1.6%	\$ 2,717,596	8.2%
Expenses	2,715,945	2,705,805	(10,140)	-0.4%	2,505,960	-8.4%
Net	223,992	187,596	36,396	19.4%	211,638	5.8%
This statement does not conform to Generally Accepted Accounting Principles. Different accounting methods are used in each of these entities and no eliminating entries are included.						

OSU Wexner Medical Center

Combined Balance Sheet

As of: March 31, 2019

(in thousands)

	March 2019	June 2018	Change
Cash	\$ 1,168,197	\$ 938,920	\$ 229,277
Net Patient Receivables	435,506	443,206	(7,700)
Other Current Assets	437,407	461,459	(24,052)
Assets Limited as to Use	412,341	411,545	796
Property, Plant & Equipment - Net	1,566,455	1,544,692	21,763
Other Assets	474,882	462,759	12,123
Total Assets	\$ 4,494,787	\$ 4,262,581	\$ 232,206
Current Liabilities	\$ 424,230	\$ 378,803	\$ 45,427
Other Liabilities	126,611	104,599	22,012
Long-Term Debt	743,805	793,311	(49,506)
Net Assets - Unrestricted	2,560,135	2,360,121	200,014
Net Assets - Restricted	640,007	625,747	14,260
Liabilities and Net Assets	\$ 4,494,787	\$ 4,262,581	\$ 232,206

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.



**The Ohio State University
Wexner Medical Center
FY2020 Budget**

DRAFT

OSU Wexner Medical Center

*Combined Income Statement
For the years ended June 30*

	Forecast 2019	Budget 2020	% Change
OPERATING STATEMENT (in thousands)			
Total Operating Revenue	\$4,102,841	\$4,314,831	5.2%
Operating Expenses			
Salaries and Benefits	2,173,640	2,326,079	7.0%
Supplies and Pharmaceuticals	785,541	837,396	6.6%
Services	466,377	497,954	6.8%
Depreciation	184,605	192,559	4.3%
Interest/Debt	46,835	42,983	-8.2%
Other Operating Expense	126,689	121,308	-4.2%
Medical Center Investments	5,103	470	-90.8%
Total Expense	3,788,789	4,018,748	6.1%
Excess of Revenue over Expense	\$ 314,052	\$ 296,083	-5.7%
Financial Metrics			
Adjusted Admissions	126,893	130,214	2.6%
Total Revenue per AA	\$ 25,452	\$ 25,669	0.9%
Total Expense per AA	\$ 22,161	\$ 22,592	1.9%

OSU Wexner Medical Center

*Combined Income Statement
For the years ended June 30*

(in thousands)	Forecast 2019	Budget 2020	% Change
Health System			
Revenues	\$3,219,203	\$3,350,685	4.1%
Expenses	2,946,600	3,087,623	4.8%
Net	272,603	263,062	-3.5%
OSUP			
Revenues	\$ 453,154	\$ 505,265	11.5%
Expenses	437,076	488,458	11.8%
Net	16,078	16,807	4.5%
COM/OHS			
Revenues	\$ 430,484	\$ 458,881	6.6%
Expenses	405,114	442,667	9.3%
Net	25,370	16,214	-36.1%
Total Medical Center			
Revenues	\$4,102,841	\$4,314,831	5.2%
Expenses	3,788,789	4,018,748	6.1%
Net	314,052	296,083	-5.7%

The Ohio State University Health System

FY20 Capital Budget

Routine Capital Summary

CATEGORY	Description	FY20 Amount
Imaging	CT Scanners, MRI, Fluoroscopy Room	\$8.2M
Clinical Laboratory	Chemistry Analyzers/Instruments	3.8M
Clinical Equipment - Other	OR Robot, Monitors, Defib. Telestroke, etc.	14.1M
Information Technology	Servers, Storage and Network Devices	26.3M
Hospital Equipment	Non-Threshold Allocation < \$500K	18.5M
New Bed Replacement	5 th Year of Six Year Replacement Plan	3.1M
Hospital Facilities	Upgrades and Refresh	20.8M
Ambulatory Facilities	Upgrades and Refresh	14.1M
Facilities - Infrastructure	Elevators, Roofs, HVAC	16.1M
Contingency		<u>8.0M</u>
Total Funding		\$133.0M

The Ohio State University Health System

FY20 Strategic Capital Budget

PROJECT DESCRIPTION	FY20 Funding
West Medical Campus (Ambulatory & Proton)	\$9.3M
Dublin Ambulatory	\$6.0M
New Albany/ Licking County Ambulatory	\$32.0M
Outpatient Site Development	
Inpatient Hospital	\$28.3M
Medical Center Hospital Garage	\$28.1M
Central Sterile Supply	\$23.1M
Total Medical Center Inpatient Hospital	\$79.5M
Cannon Drive	\$3.7M
Strategic Information Technology	
Total Strategic Capital	\$130.5M

Thank You

Wexnermedical.osu.edu

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

APPROVAL TO ENTER INTO PROFESSIONAL SERVICES CONTRACTS
WMC Regional Ambulatory Facilities – Dublin

APPROVAL TO ENTER INTO/INCREASE PROFESSIONAL SERVICES AND CONSTRUCTION CONTRACTS
Morehouse Tower – 7th & 8th Floor Updates
WMC Regional Ambulatory Facilities – Hamilton Rd

APPROVAL TO ENTER INTO CONSTRUCTION CONTRACTS
WMC West Campus Ambulatory Facilities

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

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

	Prof. Serv. Approval Requested	Total Project Cost	
WMC Regional Ambulatory Facilities – Dublin	\$12.0M	TBD	Auxiliary Funds

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

	Prof. Serv. Approval Requested	Construction Approval Requested	Total Project Cost	
Morehouse Tower – 7 th & 8 th Floor Updates	\$0.7M	\$4.3M	\$5.0M	Auxiliary Funds
WMC Regional Ambulatory Facilities – Hamilton Rd	\$11.0M	\$114.9M	\$137.9M	Auxiliary Funds

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

	Construction Approval Requested	Total Project Cost	
WMC West Campus Ambulatory Facilities	\$6.6M	TBD	Auxiliary Funds

**RECOMMEND FOR APPROVAL TO ENTER INTO/INCREASE
PROFESSIONAL SERVICES AND CONSTRUCTION CONTRACTS (CONT)**

NOW THEREFORE

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

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

Project Data Sheet for Board of Trustees Approval

WMC Regional Ambulatory Facilities - Dublin

OSU-180636-1 (CNI#18000177, 19000140)

Project Location: Dublin, Ohio

- **approval requested and amount**

professional services	\$12.0M
-----------------------	---------

- **project budget**

professional services (through DD)	\$12.0M
construction w/contingency	TBD
<hr/> total project budget	<hr/> TBD

- **project funding**
 - university debt
 - development funds
 - university funds
 - auxiliary funds (health system)
 - state funds

- **project schedule**

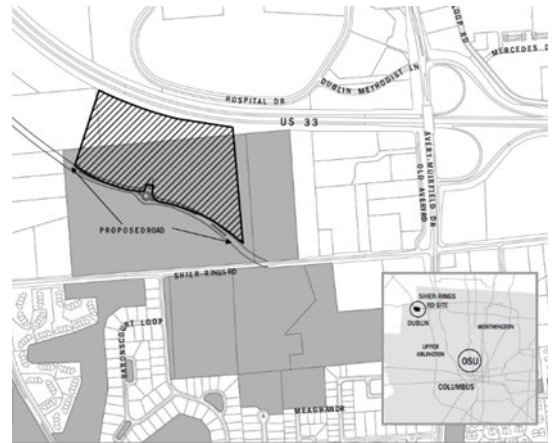
BoT professional services approval	5/19
design	6/19 – 6/20
construction	7/20 – 6/22
facility opening	9/22

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

- **planning framework**
 - consistent with the strategic plans of the university and Wexner Medical Center to provide medical services within community-based ambulatory facilities
 - the FY 2019 Capital Investment Plan includes the \$4.0M professional services; the FY 2020 Capital Investment Plan includes \$8.0M for a total of \$12.0M for design services through Design Development

- **project scope**
 - the project will design an ambulatory building that will include ambulatory surgery, endoscopy, primary care, specialty medical and surgical clinics, and related support

- **approval requested**
 - approval is requested to enter into professional services contracts for design services through Design Development



-
- **project team**

University project manager: Holly Cloud
AE/design architect:
CMR:

Project Data Sheet for Board of Trustees Approval

Morehouse Tower – 7th & 8th Floor Updates

OSU-190180 (CNI#18000154)

Project Location: Morehouse Medical Plaza - Tower

- **approval requested and amount**

prof serv/construction	\$5.0M
------------------------	--------

- **project budget**

professional services	\$0.7M
construction w/contingency	\$4.3M
<hr/>	
total project budget	\$5.0M

- **project funding**
 - university debt
 - fundraising
 - university funds
 - auxiliary funds (health system)
 - state funds

- **project schedule**

BoT approval	5/19
design/bidding	6/19 – 6/20
construction	7/20 – 2/21



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

- **planning framework**
 - this project is included in the FY 2019 Capital Investment Plan

- **project scope**
 - the project will renovate the recently vacated 7th floor for the Gastrointestinal Cancer Center, which is currently on the 8th floor. The program will include patient exam rooms, procedure room and support spaces
 - the project will also renovate the 8th floor for future patient services
 - the scope includes HVAC updates, updates for ADA restroom compliance, and interior finish upgrades

- **approval requested**
 - approval is requested to enter into professional services contracts and construction contracts

-
- **project team**

University project manager:	Kevin Koesters
AE/design architect:	

Project Data Sheet for Board of Trustees Approval

WMC Regional Ambulatory Facilities – Hamilton Road

OSU-180636 (CNI# 18000157, 19000139)

Project Location: Hamilton Road and SR 161

- **approval requested and amount**
prof serv/construction \$125.9M

- **project budget**
professional services \$20.1M
construction w/contingency \$117.8M

total project budget \$137.9M

- **project funding**
 - university debt
 - development funds
 - university funds
 - auxiliary funds (health system)
 - state funds

- **project schedule**
BoT professional services approval 4/18
design 4/18 – 5/19
BoT construction approval (site) 8/18
BoT construction approval (full project) 5/19
construction 10/18 – 5/21
facility opening 7/21

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

- **planning framework**
 - consistent with the strategic plans of the university and Wexner Medical Center to provide medical services within community-based ambulatory facilities
 - the FY 2019 Capital Investment Plan includes the remainder of professional services and a portion of construction costs; the FY 2020 Capital Investment Plan includes the remainder of construction costs

- **project scope**
 - design and construct an approximately 244,000 square foot ambulatory building that will include ambulatory surgery, endoscopy, primary care, specialty medical and surgical clinics, and related support
 - the facility will be located at Hamilton Road and SR 161 in Columbus

- **approval requested**
 - approval is requested to increase professional services and construction contracts for the remainder of design and construction



-
- **project team**
University project manager: Holly Cloud
AE/design architect: DLR Group
CMR: Daimler Group

Project Data Sheet for Board of Trustees Approval

WMC West Campus Ambulatory Facilities

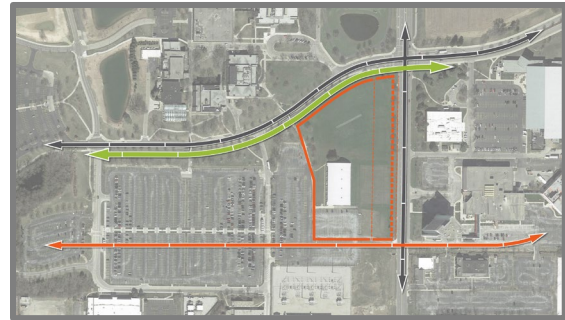
OSU-180390 (CNI# 18000175)

Project Location: Kenny Road and Carmack Road

- **approval requested and amount**
construction w/contingency \$6.6M

- **project budget**
professional services (through DD) \$23.0M
construction – enabling projects \$6.6M
construction w/contingency TBD

- total project budget TBD



- **project funding**
 - university debt
 - development funds
 - university funds
 - auxiliary funds (health system)
 - state funds

- **project schedule**
BoT professional services approval 11/18
design 12/18 – 8/20
BoT construction approval – enabling projects 5/19
construction 9/20 – 12/22
facility opening – proton 2022
facility opening – ambulatory 2023

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

- **planning framework**
 - consistent with the strategic plans of the university and Wexner Medical Center to provide high-value care with an unparalleled patient experience
 - this project was included in the FY 2019 Capital Investment Plan for design; the enabling projects are included in the FY 2020 Capital Investment Plan
 - total project cost will be validated during design

- **project scope**
 - the project will construct a new ambulatory facility on west campus
 - the ambulatory center will be approximately 395,000 square feet and will include outpatient operating rooms, an endoscopy unit, an urgent care, a pre-anesthesia center, an outpatient diagnostic imaging center, and patient and building support spaces

- **approval requested**
 - approval is requested to enter into construction contracts to construct a parking lot on Kinnear Road and for initial proton equipment procurement

-
- **project team**
University project manager: Mitch Dollery
Study/Planning AE: Perkins & Will
AE/design architect: Perkins & Will
CM at Risk: (selected)

APPROVAL OF THE FRANKLIN COUNTY HEALTH MAP PRIORITIES

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

Synopsis: Consistent with federal requirements, a community health needs assessment is conducted every three years for Franklin County, and Hospitals, public health entities and others work collaboratively to determine health status and community needs. Approval of the resulting Franklin County Health Map priorities and plan of action, is proposed.

WHEREAS the mission and strategic plan of the Wexner Medical Center is to improve health in Ohio and across the world through innovation in research, education and patient care; and

WHEREAS the Franklin County Health Map 2019 gives a comprehensive overview of our community's health status and needs; and

WHEREAS each hospital is asked to obtain approval from their respective hospital boards of the Franklin County Health Map priorities and interventions; and

WHEREAS the community priorities of 1) Mental Health and Addiction, 2) Poverty and Income, and 3) Infant Mortality, will be addressed through our Healthy Communities action plan, and are being recommended to the Wexner Medical Center Board for approval:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board approves the Franklin County Health Map priorities and plan of action for The Ohio State University Wexner Medical Center.

OHIO STATE'S STRATEGIC PLAN

TIME AND CHANGE

Enable, Empower and Inspire

Driving breakthrough healthcare solutions to improve people's lives.



HEALTHY COMMUNITIES

To create healthy communities by addressing Ohio's most pressing health needs

Strategic Plan Goals



Talent and Culture

Foster an environment to attract and develop a diverse and talented team of people committed to creating a culture of innovation and discovery



Research

Pioneer life-altering biomedical discoveries and their translation into breakthrough healthcare solutions



Education

Implement an innovative multidisciplinary education model to educate the most diverse and sought-after health professionals in the world



Healthcare Delivery

Create innovative healthcare delivery models that deliver high-value care with unparalleled patient experience and access



Healthy Communities

Create healthy communities by addressing Ohio's most pressing health needs. With partnerships throughout the state and nation, the medical center can leverage its tremendous resources to address Ohio's most pressing health needs.



Resource Stewardship

Be a responsible steward of all resources

What is the Franklin County HealthMap?

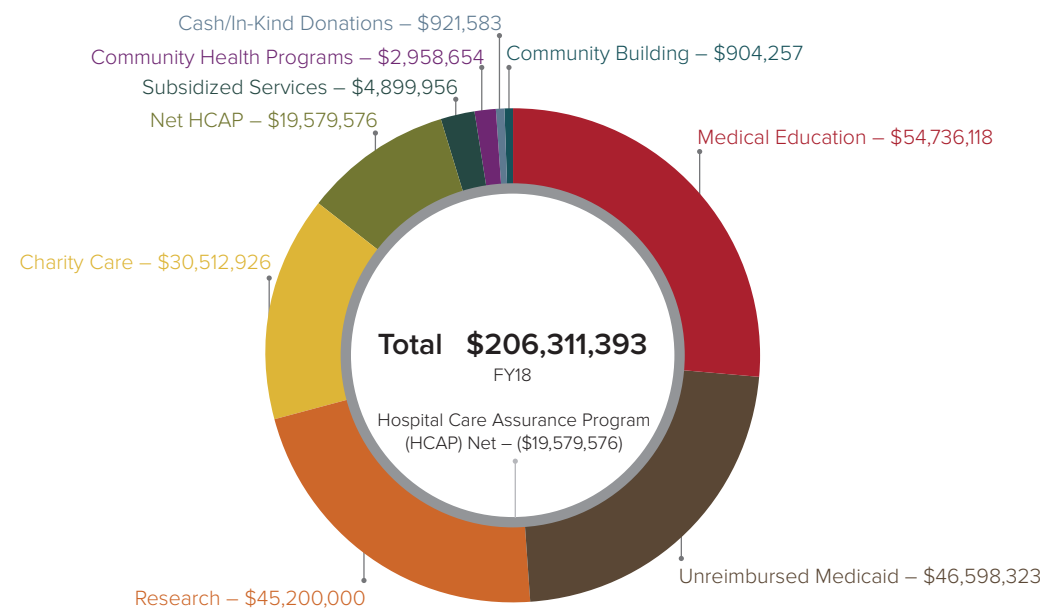


The Franklin County HealthMap 2019 serves as:

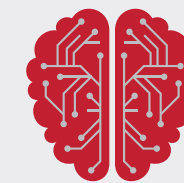
- A guide to target and prioritize limited resources.
- A vehicle to strengthen community relationships.
- A source of information that contributes to our goal of keeping people healthy.

Participating organizations include: The Ohio State University Wexner Medical Center, OhioHealth, Mount Carmel Health System, Nationwide Children's Hospital, Columbus Public Health, the Central Ohio Trauma System, the Central Ohio Area Agency on Aging, Franklin County Public Health, the Ohio Department of Health, the Ohio Disability and Health Program, PrimaryOne Health and the United Way of Central Ohio.

Reportable Community Benefit Numbers



Wexner Medical Center Action Plan



1. Mental Health and Addiction:

- Recruit an addiction fellowship leader
- Monitor prescribing of opioids system-wide
- Start Medically Assisted Treatment (MAT) for addicted patients in our emergency departments and hospitals
- Through the Healthy State Alliance, partner with Mercy Health to address opioid crises across the state
- Enhance the primary care video visits program
- Add 18 beds at Harding Hospital



2. Income/Poverty:

- Launch a mobile health unit that will include a medical provider and social worker
- Expand Community Health Day
- Develop a health equity report
- Continue to evaluate and offer targeted health services on the Near East side
- Continue to partner with many community-based organizations



3. Maternal and Infant Health:

- Launch a mobile health unit that will include an Ob/Gyn provider and social worker
- Expand enrollment in Moms2B
- Expand lactation service consults and home visits
- Recruit additional staff to support Ob/Gyn outpatient clinics
- Enhance awareness of smoking risks in pregnancy

RATIFICATION OF COMMITTEE APPOINTMENTS 2019-2020

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves that the ratification of appointments to the Quality and Professional Affairs Committee for 2019-2020 are as follows:

Quality and Professional Affairs Committee

Cheryl L. Krueger, Chair

JANET PORTER, VICE CHAIR

HAROLD L. PAZ

Bruce A. McPheron

Michael Papadakis

David P. McQuaid

Andrew M. Thomas

David E. Cohn

Jon P. Walker (term ends June 30, 2019)

MINKA SCHOFIELD (term begins July 1, 2019)

John C. Grecula

Scott A. Holliday

Iahn Gonsenhauser

JACALYN BUCK

Kristopher M. Kipp

Abigail S. Wexner (ex officio)

PATIENT CARE SERVICES CONTRACT EVALUATION

UNIVERSITY HOSPITALS

Synopsis: Approval of the annual review of patient care services contracts for The Ohio State University Hospital, Richard M. Ross Heart Hospital, Harding Hospital and University Hospital East, 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 University Hospitals patient care services contracts are evaluated annually to review scope, nature and quality of services provided to clinical departments and personnel who provide care and services for inpatient and outpatient care at The Ohio State University Hospital, Richard M. Ross Heart Hospital, Harding Hospital and University Hospital East; and

WHEREAS the annual review of these contracts was approved by University Hospitals Medical Staff Administrative Committee on December 12, 2018; and

WHEREAS the annual review of these contracts was approved by the Quality and Professional Affairs Committee on February 19, 2019:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board approves the annual review of patient care services contracts for The Ohio State University Hospital, Richard M. Ross Heart Hospital, Harding Hospital and University Hospital East as outlined in the attached UH Patient Care Contract Evaluation Summary.

University Hospitals - Patient Care Contract Evaluation Summary: 2018 Contracts

<i>Evaluation Criteria</i>	Alere – Home monitoring for patient weight, INR, and Doppler blood pressure (NEW)	American Kidney Stone Management (AKSM) – Lithotripsy technician at Outpatient Surgery Center	American Orthotics - Orthotics	American Red Cross – provides blood & blood products	AMN HealthCare Inc – All temporary staffing needs	Asist Translations / US Together / Deaf Services / Language Access Network - Translations – Interpreter Services	Bella Baby – Onsite newborn photos (NEW)	Cardinal Health – provides radionuclotides for nuclear medicine	CareLink - telephone interpretation of implantable cardiac devices by Medtronic	Champion – Environmental Services (NEW)	Comtex – cleans and disinfects soiled linen	Crothall – Environmental Services	EDM Express – Environmental Services (NEW)	ForTec Medical – Laser and Technician at Outpatient Surgery Center	Fresenius Medical Holdings, Inc. – Dialysis equipment	G Brands – Environmental Services (NEW)
Accredited / certified?	Y	N	Y	Y	Y	N	N	Y	N	N	Y	N	N	N	Y	N
If not accredited / certified, meets standards?	NA	N	Y	NA	NA	Y	NA	NA	NA	Y	NA	Y	Y	Y	Y	Y
Outstanding requirements issued by accrediting body?	N	NA	N	Y	N	N	N	N	N	N	N	N	N	N	N	N
Nature and scope of services in writing?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Contract expectations defined?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Key quality indicators monitored?	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Performance / quality data provided?	N	Y	Y	Y	Y	Y	Y	N	N	N	Y	Y	Y	N	Y	Y
Protocol for improvement efforts when needed?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Any improvements in the past year?	N	N	N	Y	Y	Y	N	N	N	NA	Y	Y	Y	Y	Y	Y
Agency:																
▪ Maintains job descriptions?	Y	Y	Y	NA	Y	Y	Y	Y	N	Y	Y	Y	NA	Y	Y	NA
▪ Assures licensure, registration, or certifications?	Y	Y	Y	NA	Y	Y	Y	Y	N	Y	Y	Y	NA	Y	Y	NA
▪ Provides orientation, initial competency assessment?	Y	Y	Y	NA	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
▪ Provides / ensures ongoing education?	Y	Y	Y	NA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
▪ Performance appraisal / competency evaluation?	Y	Y	Y	NA	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Has a Corporate Compliance Plan?	Unclear	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	NA	Y	Y	NA
Educate its staff and monitor HIPAA compliance?	Unclear	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ever sanctioned by CMS?	Unclear	N	N	N	N	N	N	N	N	N	N	N	NA	N	N	NA
Continuity plans if contract terminates?	Y	Y	Y	Y	Y	Y	N	Y	N	Y	Y	Y	Y	Y	Y	Y
Federal regulations for clinical lab met?	NA	NA	--	Y	NA	NA	NA	--	NA	NA	NA	NA	NA	NA	Y	NA

Patient Care Contract Evaluation Summary: 2018 Contracts

	Healogics – provides outpatient wound healing services including hyperbaric care at UH & UHE	HearSafe Group – N95 Fit Testing for Employees (NEW)	Infinity Orthopedics – Referrals from Spine Center for back braces and TENS units (NEW)	In Touch – web enabled acute stroke medical treatment consultation and decision support system with integrated audio-visual capabilities	Langer – Sports Med Custom Foot Orthotics	Lifeline of Ohio – tissue and organ procurement organization for donor hospitals	LOOP - Organ Procurement Organization coordinates organ and tissue donation for transplant (recipient) patients	Mayo Medical Labs – Primary reference lab for services not available at OSU Wexner Medical Center	MedCare Ambulance – transportation for hospital patients for which hospital is responsible for payment	MedFlight – Patient Transport as requested by hospital	MModal – Medical dictation equipment and edited transcription	Mobile Instruments – Repairs instruments and scopes in Central Sterile Supply (NEW)	Nationwide Children’s Echo – cardio echo tech on site with equipment to scan neonates; results read by Nationwide Childrens Hospital	Nationwide Children’s Hospital – NICU management	Nationwide Children’s Hospital – Healthy New Albany - Radiology Services (NEW)	Nuvasive – Intra-operative services for neurosurgery
Accredited / certified?	Y	Y	N	N	N	Y	Y	Y	Y	Y	N	--	Y	Y	Y	Y
If not accredited / certified, meets standards?	NA	NA	Y	NA	N	Y	Y	NA	NA	NA	Y	Y	NA	--	--	NA
Outstanding requirements issued by accrediting body?	N	N	N	N	N	N	N	N	N	N	NA	N	N	N	N	N
Nature and scope of services in writing?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Contract expectations defined?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Key quality indicators monitored?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Performance / quality data provided?	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Protocol for improvement efforts when needed?	Y	Y	--	Y	Y	Y	Y	Y	Y	Y	Y	--	Y	--	Y	Y
Any improvements in the past year?	Y	Y	--	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	--	N	N
Agency:																
▪ Maintains job descriptions?	Y	Y	Y	NA	N	Y	--	NA	Y	Y	Y	N	Y	--	Y	Y
▪ Assures licensure, registration, or certifications?	NA	Y	Y	NA	Y	Y	--	NA	Y	Y	NA		Y	--	Y	Y
▪ Provides orientation, initial competency assessment?	Y	Y	Y	NA	Y	Y	--	NA	Y	Y	Y	N	Y	--	Y	Y
▪ Provides / ensures ongoing education?	Y	Y	Y	NA	Y	Y	--	NA	Y	Y	Y	N	Y	--	Y	Y
▪ Performance appraisal / competency evaluation?	Y	Y	Y	NA	Y	Y	--	NA	Y	Y	Y	N	Y	--	Y	Y
Has a Corporate Compliance Plan?	N	--	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	--	Y	N
Educate its staff and monitor HIPAA compliance?	Y	--	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	--	Y	Y
Ever sanctioned by CMS?		N	N	N	N	N	N	N	N	N	N	--	N	--	N	N
Continuity plans if contract terminates?	Y	Y	--	Y	Y	Y	NA	Y	--	Y	Y	--	N	--	Y	Y
Federal regulations for clinical lab met?	NA	--	NA	NA	NA	NA	NA	Y	--	--	NA	Y	NA	--	NA	--

Patient Care Contract Evaluation Summary: 2018 Contracts

	Pacific Interpreters – telephone service for non-English proficient patients	PharMEDium – Compounds available sterile drugs into FDA approved sterile parenteral containers	Quest – Reference Lab Testing and United Healthcare Testing	Recover Care Inc – Repair and preventative maintenance to all hospital owned beds	Safecor Health - repackages oral solid, oral liquid and oral powder medications in unit dose or units of use packaging	SBH – Provides compounded sterile projects not commercially available, assists in compliance with USP 797 requirements for high risk compounding	Scioto Services – EVS at CarePoint East	Sound – 24/7 hospitalists coverage for UHE	Specialty Care* – Neurophysiology monitoring	The Kings – Environmental Services (NEW)	US Together / CRIS / Reliable / Deaf Services / Language Access Network– Interpreter Services (evaluated in conjunction with Assist Translations)	Versiti – Blood products (NEW)	Wright Center** – MRI overflow
Accredited / certified?	N	Y	Y	N	Y	Y	N	N	Y	N	N	Y	
If not accredited / certified, meets standards?	Y	NA	Y	Y	NA	--		NA	--	Y	Y	NA	
Outstanding requirements issued by accrediting body?	N	Y	N	N	N	N	N	NA	N	N	N	N	
Nature and scope of services in writing?	Y	Y	Y	Y	Y	Y	Y	TBD	Y	Y	Y	Y	
Contract expectations defined?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Key quality indicators monitored?	Y	--	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Performance / quality data provided?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Protocol for improvement efforts when needed?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Any improvements in the past year?	Y	Y	Y	Y	N	N	Y	Y	N	Y	Y	NA	
Agency:													
▪ Maintains job descriptions?	Y	Y	NA	Y	Y	Y	Y	Y	Y	NA	Y	Y	
▪ Assures licensure, registration, or certifications?	Y	Y	NA	Y	Y	Y	Y	Y	Y	NA	Y	Y	
▪ Provides orientation, initial competency assessment?	Y	Y	NA	Y	Y	Y	Y	Y	Y	Y	Y	Y	
▪ Provides / ensures ongoing education?	Y	Y	NA	Y	Y	Y	Y	Y	Y	Y	Y	Y	
▪ Performance appraisal / competency evaluation?	Y	Y	NA	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Has a Corporate Compliance Plan?	Y	Y	Y	N	--	Y	Y	Y	Y	NA	Y	Y	
Educate its staff and monitor HIPAA compliance?	Y	NA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Ever sanctioned by CMS?	N	N	N	N	N	N	N	N	N	NA	N	N	
Continuity plans if contract terminates?	Y	Y	Y	N	Y	Y	--	N	Y	Y	Y	Y	
Federal regulations for clinical lab met?	NA	NA	Y	NA	NA	NA	NA	NA	NA	NA	NA	Y	

* *Specialty Care* formerly called *Sentient*

***Wright Center* contract not yet signed for patient overflow.

Terminated Contracts: Healthy New Albany Community Partnership, IMS Instrument Repair, OHA staffing solutions

PATIENT CARE SERVICES CONTRACT EVALUATION

THE ARTHUR G. JAMES CANCER
HOSPITAL AND RICHARD J. SOLOVE RESEARCH INSTITUTE

Synopsis: Approval of the annual review of patient care services contracts for the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, 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 James Cancer Hospital patient care services contracts are evaluated annually to review scope, nature and quality of services provided to clinical departments and personnel who provide care and services for inpatient and outpatient care at the James Cancer Hospital; and

WHEREAS the annual review of these contracts was approved by the James Medical Staff Administrative Committee on April 13, 2018; and

WHEREAS the annual review of these contracts was approved by the Quality and Professional Affairs Committee on February 19, 2019:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board approves the annual review of patient care services contracts for the James Cancer Hospital as outlined in the attached the James Cancer Hospital Patient Care Contract Evaluation Summary.

James Cancer Hospital - Patient Care Contract Evaluation Summary: 2018 Contracts

<i>Evaluation Criteria</i>	American Kidney Stone Management (AKSM) – Lithotripsy technician at Outpatient Surgery Center	American Red Cross – provides blood & blood products	AMN HealthCare Inc – Traveling RNs, sitters, phlebotomists, surgical techs, sterile processing techs & mammo techs contract	Asist Translations / US Together / Deaf Services / Language Access Network - Translations – Interpreter Services	Nuvasive– Intra-operative services for neurosurgery (replaced Biotronics)	Cardinal Health – provides radionuclotides for nuclear medicine	CareLink - telephone interpretation of implantable cardiac devices by Medtronic	Comtex – cleans and disinfects soiled linen	Crothall – Environmental Services	ForTec Medical – Laser and Technician at Outpatient Surgery Center	Fresenius Medical Holdings, Inc.	American Orthotics – Orthotics (replaced Hanger)	Healogics – provides outpatient wound healing services including hyperbaric care at UH & UHE
<i>All questions were answered by contract manager at Wexner Medical Center. (Note: Some contracts do not have staff on-site performing hands-on patient functions and thus not all questions were applicable).</i>													
Accredited / certified?	N	Y	Y	N	Y	Y	N	Y	N	N	Y	Y	Y
If not accredited / certified, meets standards?	Y	NA	NA	Y	NA	NA	N	NA	Y	Y	NA	NA	NA
Outstanding requirements issued by accrediting body?	NA	Y	N	N	N	N	N	N	N	N	N	N	Y
Nature and scope of services in writing?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Contract expectations defined?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Key quality indicators monitored?	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y
Performance / quality data provided?	Y	Y	Y	Y	Y	N	N	Y	Y	N	Y	Y	Y
Protocol for improvement efforts when needed?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Any improvements in the past year?	Y	Y	Y	Y	N	N	N	Y	Y	Y	Y	N	Y
Agency:													
▪ Maintains job descriptions?	Y	NA	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N
▪ Assures licensure, registration, or certifications?	Y	NA	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N
▪ Provides orientation, initial competency assessment?	Y	NA	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N
▪ Provides / ensures ongoing education?	Y	NA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
▪ Performance appraisal / competency evaluation?	Y	NA	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N
Has a Corporate Compliance Plan?	Y	Y	Y	Y	Y	Y	Y	Y	NA	Y	Y	Y	Y
Educate its staff and monitor HIPAA compliance?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ever sanctioned by CMS?	N	N	N	N	N	N	N	N	N	N	N	N	N
Continuity plans if contract terminates?	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	N	Y	Y
Federal regulations for clinical lab met?	NA	Y	NA	NA	NA	NA	N	NA	NA	NA	NA	NA	Y

Patient Care Contract Evaluation Summary: 2018 Contracts

	Healthy New Albany – Community Partnership	In Touch – web enabled acute stroke medical treatment consultation and decision support system with integrated audio-visual capabilities	Langer – Sports Med Custom Foot Orthotics	Lifeline of Ohio – tissue and organ procurement organization for donor hospitals	LOOP - Organ Procurement Organization coordinates organ and tissue donation for transplant (recipient) patients	Mayo Medical Labs – primary reference lab for services not available at OSU Wexner Medical Center	MedCare Ambulance – transportation for hospital patients for which hospital is responsible for payment	MedFlight – Patient Transport as requested by hospital	MModal – Medical dictation equipment and edited transcription	Nationwide Children’s Echo – cardio echo tech on site with equipment to scan neonates; results read by Nationwide Childrens Hospital	Nationwide Children’s – NICU management	*OHA - staffing solutions program for nursing, labs, surgical techs, clerical, custodial, food services and others
Accredited / certified?	Y	N	N	Y	Y	Y	Y	N	N	Y	Y	N
If not accredited / certified, meets standards?	NA	Y	Y	Y	NA	NA	NA	Y	Y	NA	NA	Y
Outstanding requirements issued by accrediting body?	N	N	N	N	N	N	N	N	NA	N	N	N
Nature and scope of services in writing?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Contract expectations defined?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Key quality indicators monitored?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Performance / quality data provided?	N	Y	N	Y	Y	Y	Y	Y	Y	N	Y	N
Protocol for improvement efforts when needed?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Any improvements in the past year?	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y
Agency:												
▪ Maintains job descriptions?	Y	NA	N	Y	Y	NA	Y	Y	Y	Y	Y	N
▪ Assures licensure, registration, or certifications?	Y	NA	Y	Y	Y	NA	Y	Y	NA	Y	Y	Y
▪ Provides orientation, initial competency assessment?	Y	NA	Y	Y	Y	NA	Y	Y	Y	Y	Y	Y
▪ Provides / ensures ongoing education?	Y	NA	Y	Y	Y	NA	Y	Y	Y	Y	Y	N
▪ Performance appraisal / competency evaluation?	Y	NA	Y	Y	Y	NA	Y	Y	Y	Y	Y	NA
Has a Corporate Compliance Plan?	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	?
Educate its staff and monitor HIPAA compliance?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
Ever sanctioned by CMS?	N	N	N	N	N	N	N	N	N	N	N	N
Continuity plans if contract terminates?	Y	Y	Y	Y	NA	Y	Y	Y	Y	N	Y	Y
Federal regulations for clinical lab met?	NA	NA	NA	NA	NA	Y	NA	NA	NA	NA	NA	NA

Patient Care Contract Evaluation Summary: 2018 Contracts

	Pacific Interpreters – telephone service for non-English proficient patients	PharMEDium – Compounds available sterile drugs into FDA approved sterile	Quest – Reference Lab Testing and United Healthcare Testing	Recover Care Inc – Repair and preventative maintenance to all hospital owned beds	Safecor Health - repackages oral solid, oral liquid and oral powder medications in unit dose or units of use packaging with human readable and machine readable	SBH – Provides compounded sterile projects not commercially available, assists in compliance with USP 797 requirements for high risk compounding	Sentient – Neurophysiology monitoring	Sound – 24/7 hospitalists coverage for UHF	US Together / CRIS / Reliable / Deaf Services / Language Access Network–
Accredited / certified?	N	Y	Y	N	Y	Y	N	N	N
If not accredited / certified, meets standards?	Y	NA	Y	Y	NA	NA	Y	Y	Y
Outstanding requirements issued by accrediting body?	N	Y	N	N	N	N	N	N	N
Nature and scope of services in writing?	Y	Y	Y	Y	Y	Y	N	Y	Y
Contract expectations defined?	Y	Y	Y	Y	Y	Y	Y	Y	Y
Key quality indicators monitored?	Y	Y	Y	Y	Y	Y	N	Y	Y
Performance / quality data provided?	Y	Y	Y	Y	Y	Y	N	Y	Y
Protocol for improvement efforts when needed?	Y	Y	Y	Y	Y	Y	Y	Y	Y
Any improvements in the past year?	Y	Y	Y	Y	Y	N	N	Y	Y
Agency:									
▪ Maintains job descriptions?	Y	Y	NA	Y	Y	Y	Y	Y	Y
▪ Assures licensure, registration, or certifications?	Y	Y	NA	Y	Y	Y	Y	Y	Y
▪ Provides orientation, initial competency assessment?	Y	Y	NA	Y	Y	Y	Y	Y	Y
▪ Provides / ensures ongoing education?	Y	Y	NA	Y	Y	Y	Y	Y	Y
▪ Performance appraisal / competency evaluation?	Y	Y	NA	Y	Y	Y	Y	Y	Y
Has a Corporate Compliance Plan?	Y	Y	Y	Y	Y	Y	Y	Y	Y
Educate its staff and monitor HIPAA compliance?	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ever sanctioned by CMS?	N	N	N	N	N	N	N	N	N
Continuity plans if contract terminates?	Y	Y	Y	Y	Y	Y	Y	N	Y
Federal regulations for clinical lab met?	NA	Y	NA	NA	NA	NA	NA	NA	NA

***Contract being canceled for 2018**

Note: IMS contract elapsed late 2017. Replaced with Mobile Instruments. No data yet available for review.

Wright Center contract not yet signed for patient overflow.

**AMENDMENTS TO THE RULES AND REGULATIONS
OF THE MEDICAL STAFF OF UNIVERSITY HOSPITALS**

Synopsis: The amendments to the *Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals are recommended for approval.

WHEREAS the proposed amendments to the *Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals were approved by a joint University Hospitals and James Medical Staff Bylaws Committee on January 4, 2019; and

WHEREAS the proposed amendments to the *Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals were approved by the University Hospitals Medical Staff Administrative Committee on January 9, 2019; and

WHEREAS the proposed amendments to the *Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals were approved by the University Hospitals Medical Staff on January 23, 2019; and

WHEREAS the proposed amendments to the *Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals were approved by the Quality and Professional Affairs Committee on March 26, 2019:

NOW THEREFORE

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

MEDICAL STAFF RULES AND REGULATIONS
The Ohio State University Hospitals

Updated April 6, 2018



THE OHIO STATE UNIVERSITY

WEXNER MEDICAL CENTER

MEDICAL STAFF RULES AND REGULATIONS
The Ohio State University Hospitals
as of April 6, 2018

84-1 Ethical pledge.

No changes.

84-2 Admission procedures.

No changes.

84-3 Attending assignment.

No changes.

84-4 Consultations.

No changes.

84-5 Privileges for giving orders.

No changes.

84-6 Death and autopsy procedures.

No changes.

84-7 Emergency care.

No changes.

84-8 Surgical case review.

No changes.

84-9 Tissue disposition.

No changes.

84-10 Committees and policy groups.

No changes.

84-11 Medical records.

(A) Each member of the medical staff shall conform to the medical information management department policies, including the following:

(1) Medical Record contents

{00284143-1}

MEDICAL STAFF RULES AND REGULATIONS
The Ohio State University Hospitals

Updated April 6, 2018

The attending medical staff member shall be ultimately responsible for the preparation of a complete medical record of each patient. The medical record may contain information collected and maintained by members of the medical staff, limited staff, other licensed healthcare professionals, medical students or providers who participate in the care of the patient in an electronic or paper form. This record shall include the following elements as it applies to the patient encounter:

- (a) Identification and demographic data including the patient's race and ethnicity.
- (b) The patient's language and communication needs.
- (c) Emergency care provided to the patient prior to arrival, if any.
- (d) The legal status of patients receiving mental health services.
- (e) Evidence of known advance directives.
- (f) Statement of present complaint.
- (g) History and physical examination.
- (h) Any patient generated information.
- (i) Provisional diagnosis.
- (j) Documentation of informed consent when required.
- (k) Any and all orders related to the patient's care.
- (l) Special reports, as those from:
 - (i) The clinical laboratory, including examination of tissues and autopsy findings, when applicable.
 - (ii) Signed and dated reports of nuclear medicine interpretations, consultations, and procedures.
 - (iii) The radiology department.
 - (iv) Consultants.
- (m) Medical and surgical treatments.
- (n) Progress notes.
- (o) Pre-sedation or pre-anesthesia assessment and plans of care for patients receiving anesthesia.
- (p) An intra-operative anesthesia record.
- (q) Postoperative documentation records, including the patient's vital signs and level of consciousness; medications, including IV fluids, blood and blood components; any unusual events or postoperative complications; and management of such events
- (r) Postoperative documentation of the patient's discharge from the post-sedation or post-anesthesia care area by the responsible licensed independent practitioner or according to discharge criteria.

MEDICAL STAFF RULES AND REGULATIONS
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- (s) A post-anesthesia follow-up report written within forty-eight hours after surgery.
 - (t) Reassessments and revisions of the treatment plan.
 - (u) Every dose of medication administered and any adverse drug reaction.
 - (v) Every medication dispensed to an inpatient at discharge.
 - (w) Summary and final diagnosis as verified by the attending medical staff member's signature.
 - (x) Discharge disposition, condition of patient at discharge, and instructions given at that time and the plan for follow up care.
 - (y) Any referrals and communications made to external or internal providers and to community agencies.
 - (z) Any records of communication with the patient made by telephone or email or patient electronic portal.
- (2) Deadlines and sanctions.
- (a) A procedure note shall be entered in the record by the responsible attending medical staff member or the medical staff member's designee, who is appropriately credentialed by the hospital, immediately upon completion of an invasive procedure. Procedure notes must be written for any surgical or medical procedures, irrespective of their repetitive nature, which involve material risk to the patient. Notes for procedures completed in the operating rooms must be finalized in the operating room information system by the attending surgeon. For any formal operative procedures, a note shall include preoperative and postoperative diagnoses, procedure(s) performed and description of each procedure, surgeon(s), resident(s), anesthesiologist(s), surgical service, type of anesthesia (general or local), complications, estimated blood loss, any pertinent information not included on the O.R./anesthesia record, preliminary surgical findings, and specimens removed and disposition of each specimen. Where a formal operative report is appropriate, the report must be completed immediately following the procedure. The operative/procedure report must be signed by the attending medical staff member. Any operative/procedure report not completed or any procedure note for procedures completed in the operating rooms not completed in the operating room information system by ten a.m. the day following the procedure shall be deemed delinquent and the attending medical staff member responsible shall lose operating/procedure room and medical staff privileges the following day. The operating rooms and procedure rooms will not cancel cases scheduled before the suspension occurred. Effective with the suspension, the attending medical staff member will lose all privileges to schedule elective and add-on cases. The attending medical staff member will only be allowed to schedule emergency cases until all delinquent operative/procedure reports are completed. All emergency cases scheduled by suspended medical staff members are subject to the review of the medical director and will be reported to the suspended medical staff members' chief of the clinical department and the medical director by the operating room staff. Affected medical staff members shall receive telephone calls from the medical information management department indicating the delinquent operative/procedure reports.
 - (b) Progress notes must provide a pertinent chronological report of the patient's course in the hospital and reflect any change in condition, or results of treatment. In the event that the patient's condition has not changed, and no diagnostic studies have been done, a progress note must be completed by the attending medical staff member or his or her designated member of the limited medical staff or practitioner with appropriate

MEDICAL STAFF RULES AND REGULATIONS
The Ohio State University Hospitals

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privileges at least once every day.

Each medical student or other licensed health care professional progress note in the medical records should be signed or counter-signed by a member of the attending, courtesy, or limited staff.

(c) Medical staff members with more than twenty-five verbal orders that remain unsigned greater than twenty-one days after the date of the order will be subject to corrective action including administrative suspension which may include suspension of admitting and operating room scheduling privileges until the orders are signed. Medical staff members shall be notified electronically prior to suspension for unsigned verbal orders.

- (c) Birth certificates must be signed by the medical staff member who delivers the baby within one week of completion of the certificate. Fetal death certificates and death certificates must be signed and the cause of death must be recorded by the medical staff member with a permanent Ohio license within twenty-four hours of death.
- (d) Outpatient visit notes and letters to referring physicians, when appropriate, shall be completed within three days of the patient's visit.
- (e) All entries not previously defined must be signed within ten business days of completion.
- (f) Queries by clinical documentation specialists requesting clarification of a patient's diagnoses and procedures will be resolved within five business days of confirmed notification of request.
- (g) Office visit encounters shall be closed within one week of the patient's visit.

(3) Discharges

- (a) Patients may not be discharged without a written or electronically entered discharge order from the appropriately credentialed, responsible medical staff member, limited staff member, or other licensed healthcare professional.
- (b) At the time of discharge, the appropriately credentialed attending medical staff member, limited staff member, or other licensed healthcare professional is responsible for verifying the principal diagnosis, secondary diagnoses, the principal procedure, if any, and any other significant invasive procedures that were performed during the hospitalization. If a principal diagnosis has not yet been determined, then a "provisional" principal diagnosis should be used instead.
- (c) The discharge summary must be available to any facility receiving the patient before the patient arrives at the facility. Similarly, the discharge summary must be available to the care provider before the patient arrives at any outpatient care visit subsequent to discharge. The discharge summary should be available within forty-eight hours of discharge for all patients. The discharge summary should be signed by the responsible medical staff member within forty-eight hours of availability.
- (d) The discharge summary must contain the following elements:
 - i. hospital course including reason for hospitalization and significant findings upon admission;
 - ii. principal and secondary diagnoses or provisional diagnoses;
 - iii. relevant diagnostic test results;

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The Ohio State University Hospitals

Updated April 6, 2018

- iv. procedures performed and care, treatment and services provided; ivi. condition at discharge;
 - vi. medication list and medication instructions;
 - vii. plan for follow up of tests and studies for which results are pending at discharge;
 - viii. coordination and planning for follow-up testing and appointments;
 - ix. plans for follow up care and communication, and the instructions provided to the patient.
- (e) A complete summary is required on all patients who expire, regardless of length of stay.
- (f) All medical records must be completed by the attending medical staff member or, when applicable, the limited staff member or other licensed healthcare professional within twenty-one days of discharge of the patient.
- (g) Attending medical staff members shall be notified prior to suspension for all incomplete records. After notification, attending medical staff members shall have their admitting and operative scheduling privileges suspended until all records are completed. Attending medical staff members shall receive electronic notification of delinquent records. If an attempt is made by the attending medical staff member, or the attending medical staff member's designee, who is appropriately credentialed by the hospital, when applicable, to complete the record, and the record is not available, electronically for completion, the record shall not be counted against the attending medical staff member. Medical staff members who are suspended for a period of longer than one hundred twenty consecutive days are required to appear before the practitioner evaluation committee.
- (h) Records which are incomplete, more than twenty-one days after discharge or the patient's visit are defined as delinquent.
- (4) Confidentiality.
- Access to medical records is limited to use in the treatment of patients, research, and teaching. All medical staff members are required to maintain the confidentiality of medical records. Improper use or disclosure of patient information is subject to disciplinary action.
- (5) Ownership.
- Medical records of hospital-sponsored care including pathological examinations, slides, radiological films, photographic records, cardiographic records, laboratory reports, statistical evaluations, etc. are the property of the hospital and shall not be removed from the hospital's jurisdiction and safekeeping except in accordance with a court order, subpoena, or statute.
- (6) Records storage and security.
- In general, medical records shall be maintained by the hospital. Records on microfilms, paper, electronic tape recordings, magnetic media, optical disks, and such other acceptable storage techniques shall be used to maintain patient records for twenty-one years for minors and ten years for adults. In the case of readmission of the patient, all records or copies thereof from the past ten/twenty-one years shall be available for the use of the attending medical staff member or other health care providers.
- (7) Informed consent documentation.
- (a) Where informed consent is required for a special procedure (such as surgical operation), documentation that such consent has been obtained must be made in

MEDICAL STAFF RULES AND REGULATIONS
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the hospital record prior to the initiation of the procedure. Such documentation shall be in compliance with the hospitals policy and procedure manual section 03-27.

- (b) In the case of limb amputation, a limb disposition form, in duplicate, must be signed prior to the operation.

(8) Sterilization consent.

Prior to the performance of an operative procedure for the expressed purpose of sterilization of a (male or female) patient, the attending medical staff member shall be responsible for the completion of the legal forms provided by the hospital and signed by the patient. Patients who are enrolled in the Medicaid program must have their forms signed at least thirty days prior to the procedure. Informed consent must also be obtained from one of the parents or the guardian of an unmarried minor.

(9) Criteria changes.

The medical information management department shall define the criteria for record completion subject to the approval of the medical staff.

(10) Entries and authentication.

- (a) Entries in the medical record can only be made by staff recommended by the medical information management department subject to the approval of the medical staff.
- (b) All entries must be legible and complete and must be authenticated, timed and dated promptly by the person, identified by name and discipline, who is responsible for ordering, providing, or evaluating the service furnished.
- (c) The electronic signature of medical record documents requires a signing password. At the time the password is issued, the individual is required to sign a statement that she/he will be the only person using the password. This statement will be maintained in the department responsible for the electronic signature system.
- (d) Signature stamps may not be used in the medical record.

(Board approval dates: 9/6/2002, 3/5/2003, 6/4/2004, 5/6/2005, 11/4/2005, 2/2/2007, 11/2/2007, 6/6/2008, 9/18/2009, 4/8/2011, 8/31/2012, 4/6/2016, 9/2/2016, 4/6/2018)

84-12 Operating room committee.

No changes.

84-13 Pharmacy and therapeutics committee.

No changes.

84-14 Transfusion and isoimmunization committee.

No changes.

84-15 Standards of practice.

No changes.

MEDICAL STAFF RULES AND REGULATIONS
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84-16 Mechanism for changing rules and regulations.

No changes.

84-17 Adoption of the rules and regulations.

No changes.

84-18 Sanctions.

No changes.

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

Synopsis: The amendments to the *Rules and Regulations of the Medical Staff* of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute are recommended for approval.

WHEREAS the proposed amendments to the *Rules and Regulations of the Medical Staff* of the James Cancer Hospital were approved by a joint University Hospitals and James Medical Staff Bylaws Committee on January 4, 2019; and

WHEREAS the proposed amendments to the *Rules and Regulations of the Medical Staff* of the James Cancer Hospital were approved by the James Medical Staff Administrative Committee on January 18, 2019; and

WHEREAS the proposed amendments to the *Rules and Regulations of the Medical Staff* of the James Cancer Hospital were approved by the James Medical Staff on January 23, 2019; and

WHEREAS the proposed amendments to the *Rules and Regulations of the Medical Staff* of the James Cancer Hospital were approved by the Quality and Professional Affairs Committee on March 26, 2019:

NOW THEREFORE

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

Rules and Regulations of the Medical Staff of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (As of April 6, 2018)

01 Ethical pledge.

No change

02 Admission procedures.

No change

03 Attending assignment.

No change

04 Consultations.

No change

05 Order writing privileges.

No change

06 Death procedures.

No Change

07 Emergency preparedness.

No Change

08 Surgical case review (tissue committees).

No Change

09 Tissue disposition.

No Change

Rules and Regulations of the Medical Staff of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (As of April 6, 2018)

10 Medical records.

(A) Each member of the medical staff shall conform to the following medical information management department policies:

(1) Medical record contents.

(a) The attending physician is ultimately responsible for the preparation of a complete medical record for each patient. The medical record may contain information collected and maintained by members of the medical staff, limited staff, other licensed healthcare professionals, medical students or providers who participate in the care of the patient. This record shall including the following elements as it applies to the patient encounter:

(i) Identification demographic data including the patient's race and ethnicity.

(ii) The patient's language and communication needs.

(iii) Emergency care provided to the patient prior to arrival, if any.

(iv) The legal status of patients receiving mental health services.

(v) Evidence of known advance directives.

(vi) Statement of present complaint.

(vii) History and physical examination.

(viii) Any patient generated information.

(ix) Provisional diagnosis.

(x) Documentation of informed consent when required.

(xi) Any and all orders related to the patient's care.

(xii) Special reports, as those from:

(a) The clinical laboratory, including examination of tissues and autopsy findings, when applicable.

(b) Signed and dated reports of nuclear medicine interpretations, consultations, and procedures.

Rules and Regulations of the Medical Staff of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (As of April 6, 2018)

- (c) The radiology department.
 - (d) Consultants as verified by the attending medical staff member's signature.
 - (xiii) Medical and surgical treatments.
 - (xiv) Progress notes.
 - (xv) Pre-sedation or pre-anesthesia assessment and plans of care for patients receiving anesthesia.
 - (xvi) An intra-operative anesthesia record.
 - (xvii) Postoperative documentation records, the patient's vital signs and level of consciousness; medications, including IV fluids, blood and blood components; any unusual events or postoperative complications; and management of such events.
 - (xviii) Postoperative documentation of the patient's discharge from the post-sedation or post-anesthesia care area by the responsible licensed independent practitioner or according to discharge criteria.
 - (xix) A post anesthesia follow-up report written within forty-eight hours after surgery by the individual who administers the anesthesia.
 - (xx) All reassessments and any revisions of the treatment plan.
 - (xxi) Every dose of medication administered and any adverse drug reaction.
 - (xxii) Every medication dispensed to an inpatient at discharge.
 - (xxiii) Summary and final diagnosis as verified by the attending physician's signature.
 - (xxiv) Discharge disposition, condition of patient at discharge, instructions given at that time and the plan for follow up care.
 - (xxv) Any referrals and communications made to external or internal providers and to community agencies.
 - (xxvi) Any records of communication with the patient made by telephone or email or patient electronic portal.
 - (xxvii) Memorandum copy of the death certificate when applicable.
- (2) Deadlines and sanctions.

Rules and Regulations of the Medical Staff of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (As of April 6, 2018)

(a) A procedure note shall be entered in the record by the responsible attending medical staff member or the medical staff member's designee (who is appropriately credentialed) immediately upon completion of an invasive procedure. Procedure notes must be written for any surgical or medical procedures, irrespective of their repetitive nature, which involve material risk to the patient. Notes for procedures performed in the operating rooms must be finalized in the operating room information system by the attending surgeon. For any formal operative procedures, a note shall include pre-operative and post-operative diagnoses, procedure(s) performed and description of each procedure, surgeon(s), resident(s), anesthesiologist(s), surgical service, type of anesthesia (general or local), complications, estimated blood loss, any pertinent information not included on the O.R./anesthesia record, preliminary surgical findings, and specimens removed and disposition of each specimen. Where a formal operative procedure report is appropriate, the report must be completed immediately following the procedure. The operative/procedure report must be signed by the attending medical staff member. Any operative/procedure report not completed or any procedure note for procedures completed in the operating rooms not completed in the operating room information system by 10:00 a.m. the day following the procedure shall be deemed delinquent and the attending medical staff member responsible shall lose operating/procedure room and medical staff privileges the following day. The operating rooms and procedure rooms will not cancel cases scheduled before the suspension occurred. Effective with the suspension, the attending medical staff member will lose all privileges to schedule elective cases. Affected medical staff members shall receive telephone calls from the medical information management department indicating the delinquent operative/procedure reports.

(b) Progress notes must provide a pertinent chronological report of the patient's course in the hospital and reflect any change in condition or results of treatment. A progress note must be completed by the attending medical staff member or his or her designated member of the limited medical staff or practitioner with appropriate privileges at least once every day. Each medical student or other licensed health care professional progress note in the medical records should be signed or counter-signed by a member of the attending, courtesy, or limited staff.

(c) Medical staff members with more than twenty-five verbal orders that remain unsigned greater than twenty-one days after the date of the order will be subject to corrective action including administrative suspension which may include suspension of admitting and operating room scheduling privileges until the orders are signed. Medical staff members shall be notified electronically prior to suspension for unsigned verbal orders.

~~twenty five administrative~~

(~~ed~~) Birth certificates must be signed by the medical staff member who delivers the baby within one week of completion of the certificate. Fetal death certificates and death certificates must be signed and the cause of death must be recorded by the medical staff member with a permanent Ohio license within twenty-four hours of death.

(~~ec~~) Outpatient visit notes and letters to referring physicians, when appropriate, shall be completed within three days of the patient's visit.

Rules and Regulations of the Medical Staff of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (As of April 6, 2018)

(ef) All entries not previously defined must be signed within ten business days of completion.

(fg) Queries by clinical documentation specialists requesting clarification of a patient's diagnoses and procedures will be resolved within five business days of confirmed notification of request.

(gh) Office visit encounters shall be closed within one week of the patient's visit.

(3) Discharges.

(a) Patients may not be discharged without a written or electronically entered discharge order from the appropriately credentialed, responsible medical staff member, a limited staff member or other licensed healthcare professional.

(b) At the time of discharge, the appropriately credentialed attending medical staff member, limited staff member, or other licensed healthcare professional is responsible for certifying the principal diagnosis, secondary diagnosis, the principal procedure, if any, and any other significant invasive procedures that were performed during the hospitalization. If a principal diagnosis has not yet been determined, then a "provisional" principal diagnosis should be used instead.

(c) The discharge summary must be available to any facility receiving the patient before the patient arrives at the facility. Similarly, the discharge summary must be available to the care provider before the patient arrives at any outpatient care visit subsequent to discharge. The discharge summary should be available within forty-eight hours of discharge for all patients. The discharge summary should be signed by the responsible attending medical staff member within forty-eight hours of availability.

(d) The discharge summaries must contain the following elements:

- i. hospital course including reason for hospitalization and significant findings upon admission;
- ii. principal and secondary diagnoses or provisional diagnosis;
- iii. relevant diagnostic test results;
- iv. procedures performed and care, treatment and services provided;
- v. condition on discharge;
- vi. medication list and medication instructions;
- vii. plan for follow-up of tests and studies for which results are pending at discharge;

Rules and Regulations of the Medical Staff of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (As of April 6, 2018)

viii. coordination and planning for follow-up testing and physician appointments;

ix. plans for follow-up care and communication, and the instructions provided to the patient.

(e) All medical records must be completed by the attending medical staff member or, when applicable, the limited staff member or other licensed healthcare professional who is appropriately credentialed by the hospital, within twenty-one days of discharge of the patient.

(f) Attending medical staff members shall be notified prior to suspension for all incomplete records. After notification, attending medical staff members shall have their admitting and operative scheduling privileges suspended until all records are completed. Attending medical staff members shall receive electronic notification of delinquent records. If an attempt is made by the attending medical staff member, or the attending medical staff member's designee, who is appropriately credentialed by the hospital, when applicable, to complete the record, and the record is not available electronically for completion, the record shall not be counted against the attending medical staff member. Medical staff members who are suspended for a period of longer than one hundred twenty consecutive days are required to appear before the practitioner evaluation committee.

(g) Records which are incomplete greater than twenty-one days after discharge or the patient's visit are defined as delinquent.

(4) Confidentiality.

Access to medical records is limited to use in the treatment of patients, research, and teaching. All medical staff members are required to maintain the confidentiality of medical records. Improper use or disclosure of patient information is subject to disciplinary action.

(5) Ownership.

Medical records of hospital sponsored care are the property of the hospital and shall not be removed from the hospital's jurisdiction and safekeeping except in accordance with a court order, subpoena, or statute.

(6) Records storage, security, and accessibility.

All patient's records, pathological examinations, slides, radiological films, photographic records, cardiographic records, laboratory reports, statistical evaluations, etc., are the property of the CHRI and shall not be taken from the CHRI except on court order, subpoena or statute duly filed with the medical record administrator or the hospital administration. The hospital administration may, under certain conditions, arrange for copies or reproductions of the above records to be made. Such copies may be removed from the hospital after the medical record administrator or the proper administrative authority has received a written receipt thereof. In

Rules and Regulations of the Medical Staff of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (As of April 6, 2018)

the case of readmission of the patient, all previous records or copies thereof shall be available for the use of the attending medical staff member.

In general, medical records shall be maintained by the hospital. Records on microfilms, paper, electronic tape recordings, magnetic media, optical disks, and such other acceptable storage techniques shall be used to maintain patient records for twenty-one years for minors and ten years for adults. In the case of readmission of the patient, all records or copies thereof from the past ten/twenty-one years shall be available for the use of the attending medical staff member or other health care providers.

(7) Informed consent documentation.

(a) Where informed consent is required for a special procedure (such as surgical operation), documentation that such consent has been obtained must be made in the hospital record prior to the initiation of the procedure.

(b) In the case of limb amputation, a limb disposition form, in duplicate, must be signed prior to the operation.

(8) Sterilization consent.

Prior to the performance of an operative procedure for the expressed purpose of sterilization of a (male or female) patient, the attending medical staff member shall be responsible for the completion of the legal forms provided by the hospital and signed by the patient. Patients who are enrolled in the Medicaid program must have their forms signed at least thirty days prior to the procedure. Informed consent must also be obtained from one of the parents or the guardian of an unmarried minor.

(9) Criteria changes.

The medical information management department shall make recommendations for changes in the criteria for record completion with approval of the medical staff.

(10) Entries and authentication.

(a) Entries in the medical record can only be made by staff recommended by the medical information management department subject to the approval of the medical staff.

(b) All entries must be legible and complete and must be authenticated, dated and timed promptly by the person, identified by name and credentials, who is responsible for ordering, providing, or evaluating the service furnished.

(c) The electronic signature of medical record documents requires a signing password. At the time the password is issued, the individual is required to sign a statement that she/he will be the only person using the password. This statement will be maintained in the department responsible for the electronic signature.

Rules and Regulations of the Medical Staff of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (As of April 6, 2018)

(d) Signature stamps may not be used in the medical record.

(11) Abbreviations.

Abbreviations, acronyms and symbols appearing on the non-approved abbreviations list may not be used in the medical record.

(Board approval dates: 9/18/2009, 4/8/2011, 8/31/2012, 4/6/2016, 9/2/2016, 4/6/2018)

10 Committees.

No Change

11 Standards of practice.

No Change

12 Mechanism for changing rules and regulations.

No change

13 Adoption of the rules and regulations.

No Change

14 Sanctions.

No Change

PATIENT COMPLAINT AND GRIEVANCE MANAGEMENT PROCESS

OSU WEXNER MEDICAL CENTER

Synopsis: Approval of the process for managing patient complaints and grievances for University Hospital, East Hospital, Brain and Spine Hospital, Richard M. Ross Heart Hospital, Harding Hospital, Dodd Rehabilitation Hospital, Ambulatory Clinics and Services, 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 Wexner Medical Center provides patient care in a manner that promotes patient satisfaction; and

WHEREAS in order to promote patient satisfaction, the Wexner Medical Center is committed to resolving any patient complaints and grievances that may arise in a timely and effective manner; and

WHEREAS the patient complaint and grievance management process was approved by the Quality and Professional Affairs Committee on May 28, 2019:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the process for managing patient complaints and grievances as outlined in the attached policy; and

BE IT FURTHER RESOLVED, That the Wexner Medical Center Board hereby delegates the responsibility of reviewing and resolving grievances to the OSU Wexner Medical Center Grievance Committee chaired by the Chief Quality and Patient Safety Officer for the Wexner Medical Center and comprised of such other members as the committee deems necessary to review and resolve any individual grievance.

PATIENT COMPLAINT AND GRIEVANCE MANAGEMENT PROCESS

ARTHUR G. JAMES CANCER HOSPITAL AND
RICHARD J. SOLOVE RESEARCH INSTITUTE

Synopsis: Approval of the process for managing patient complaints and grievances for The Arthur G. James Cancer Hospital and Solove Research Institute (the "James Cancer Hospital"), is proposed.

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

WHEREAS the Wexner Medical Center and the James Cancer Hospital provide patient care in a manner that promotes patient satisfaction; and

WHEREAS in order to promote patient satisfaction, the Wexner Medical Center and the James Cancer Hospital are committed to resolving any patient complaints and grievances that may arise in a timely and effective manner; and

WHEREAS the patient complaint and grievance management process for the James Cancer Hospital was approved by the Quality and Professional Affairs Committee on May 28, 2019:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the process for managing patient complaints and grievances for the James Cancer Hospital as outlined in the attached policy; and

BE IT FURTHER RESOLVED, That the Wexner Medical Center Board hereby delegates the responsibility of reviewing and resolving grievances to the James Grievance Committee which shall be comprised of the Director of Medical Affairs of the James or respective designee, the Patient Experience Director for the James or respective designee and such other members as the committee deems necessary to review and resolve patient grievances.

Policy Name: **Patient Complaint and Grievance Management**
Policy Number: **03-28**

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

POLICY

The Ohio State University Wexner Medical Center is committed to promptly resolving complaints at the first level of contact whenever possible.

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

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

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

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

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

It is expected that the staff of University Hospital Hospitals (including medical staff) and the James Cancer Hospital will respond to patient concerns promptly and offer reasonable and appropriate solutions.

Definitions

Term	Definition
Staff Present	4- Includes any hospital staff present at the time of the complaint or who can quickly be at the patients location (i.e. nursing, administration, nursing supervisors, patient advocate, etc.) to resolve the patient’s complaint.

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Complaint	<ol style="list-style-type: none"> 1. A clinical care issue that is verbally conveyed by a patient or the patient’s representative to staff and generally resolved within twenty-four (24) hours. 2. A complaint regarding discrimination on the basis of race, color, national origin, sex, age, or disability, unless unable to resolve within 24 hours. 3. A complaint such as not having a qualified interpreter available for a patient, patients spouse, family, and/or partner, even if the patient does not require an interpreter. 4. Minor service complaints such as housekeeping, bedding, billing issues and food. 5. Complaints regarding property loss. 6. Privacy and HIPAA complaints, unless unable to be resolved within twenty-four (24) hours.
Grievance	<ol style="list-style-type: none"> 1. Any written complaint received from a patient or the patient’s representative regarding clinical care, whether from an inpatient, outpatient or released/discharged patient. An e-mail or facsimile (fax) will be considered to be “written”. 2. Verbal complaints about clinical care that are not resolved by staff at the time of the complaint, generally within twenty-four (24) hours, and made by a patient or the patient’s representative. 3. All verbal or written complaints regarding: <ol style="list-style-type: none"> a. Abuse, neglect, patient harm; b. Hospital compliance with CMS Hospital Conditions of Participation (CoP); and c. Medicare Beneficiary Billing complaints related to rights and limitations provided by 42CFR§489. 4. Any complaint that the patient, or their representative, requests be handled as a formal grievance. 5. Any complaint where a written response from the hospital is requested by the patient or their representative. 6. Post-discharge complaints, made by a patient or their representative, related to clinical care or services during a stay shall be considered grievances, unless the complaint would have routinely been handled by staff generally within twenty four (24) hours had the communication occurred during the stay or visit. In this instance, the communication will be considered a complaint.

Policy Details

Staff Reporting Complaints via the Hospital’s Intranet Site (OneSource)

~~2-1.~~ Whenever possible, staff members are encouraged to enter non-clinical complaints directly into the Complaint Management [DatabaseSystem](#) on the hospital’s intranet site, OneSource.

~~3-2.~~ The Complaint Management [DatabaseSystem](#) provides a mechanism for tracking and

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reporting complaint data, as well as coordinating timely follow-up.

4.3. All verbal or written complaints regarding quality of care issues, abuse, neglect or patient harm shall be entered into the Patient Safety Reporting System for appropriate investigation and follow-up.

Patients or Visitors Reporting Complaints via Telephone

1. Complaints about care delivered at University Hospital, Ross ~~Heart~~ Hospital, [Dodd Rehabilitation and Brain and Spain Hospital](#), [Ambulatory](#) or the [Specialty](#) Primary Care Network may be directed to the Patient Experience Department at 1-614-293-8944.
2. Complaints about care delivered at James Cancer Hospital may be directed to James Patient Experience at 1-614-293-8609.
3. Complaints about care delivered at [EastUniversity](#) Hospital ~~East~~ may be directed to ~~UHE~~ Patient Experience at 1-614-257-2310.
4. Complaints about care delivered at Harding Hospital may be directed to Harding Patient Experience at 1-614-688-8941.
5. After regular business hours, complaints may be escalated to the Hospital Administrative Manager or Nursing Supervisor for each location.

Procedures for Complaints

1. All clinical care complaints [handled within 24 hours](#) should be referred to the attending physician or manager for appropriate follow-up [and entered in the Complaint Management Database](#).
2. All non-clinical complaints should be referred to the appropriate department manager for follow-up.
3. Patient Experience will forward all issues regarding property loss to the Property Loss Committee and enter the issue into the Complaint Management [Database System](#).
4. Privacy and HIPAA complaints will be forwarded to the HIPAA Privacy Officer.
5. When complaints cannot be immediately resolved by the staff member to whom they were reported, the complaint should be reported to the supervisor or manager for resolution and entered into the Complaint Management [Database System](#).
6. Patient Experience staff will act as a liaison for the patient by representing their interests and facilitating communication with appropriate individuals within the Medical Center.

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Procedures Procedure for Grievances

1. When notified, Patient Experience or the appropriate manager will respond and investigate grievances regarding patients who are currently located within the hospital setting.
2. Situations that endanger (e.g. neglect or abuse) the patient should be addressed immediately by the appropriate staff member.
3. When appropriate, Risk Management may initiate a review of a grievance.
4. Patient Experience will serve as the primary liaison to the patient, and may consult Risk Management as needed.
5. If the grievance is from a written source, or reported after the patient has left the facility, ~~a Patient Experience Coordinator~~ will initiate contact with the complainant.
6. Clinical Care Grievances
 - a. Clinical care grievances should be entered in the Patient Safety Reporting System, in accordance with the Patient Safety & Event Reporting Policy.
 - b. Following initial contact with the complainant, ~~the Patient Experience Coordinator~~ will arrange a meeting between the patient, or their representative, and the attending physician to assure that the patient's concerns have been addressed and that the patient's expectations have been met.
 - c. ~~The Patient Experience Coordinator~~ will work collaboratively with the patient, or their representative, and the attending physician to resolve the grievance.
7. Non-Clinical Care Grievances
 - a. Non-clinical grievances should be entered into the Complaint Management ~~Database System~~.
 - b. Following initial contact with the ~~complainant, complaintant,~~ a Patient Experience Coordinator will facilitate communication and dialogue between the patient, or their representative, and the appropriate manager to assure that the patient's concerns have been addressed and their patient's expectations have been met.
 - c. ~~The Patient Experience Coordinator~~ will work collaboratively with the patient and manager to resolve the grievance.
8. Typically, a grievance will be considered resolved when the patient is satisfied with the actions taken on their behalf.
 - a. However, there may be situations where the Hospital has taken appropriate and reasonable actions on the patient's behalf in order to resolve the patient's grievance and the patient or the patient's representative remains unsatisfied with the Hospital's actions. In these situations, the Hospital may consider the grievance to be closed.

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- b. Patient Experience must maintain documentation of its efforts and demonstrate compliance with this policy.

Written Response to Grievances

~~4-1.~~ A written response to all grievances shall be submitted to the patient, or their representative, by the Patient Experience representative or other appropriate individual within seven (7) business days regarding the disposition of the grievance.

a. Included in the written response will be:

- i. The name of the hospital;
- ii. The steps taken on behalf of the patient to investigate and resolve the grievance;
- iii. The results of the grievance process; and
- iv. The date of completion.

b. All grievance response letters will be mailed to the patient's or patient's representative's home address unless otherwise indicated.

c. If the grievance is received via email, the response may be sent via email.

~~5-2.~~ There may be complications or circumstances, which will not allow every grievance to be resolved during the seven (7) day timeframe.

a. If a response will take longer than seven (7) business days, the patient should be contacted by Patient Experience and advised that the hospital is still working to resolve the grievance.

b. The patient or the patient's representative should be contacted a minimum of every fourteen (14) business days by Patient Experience until the grievance is responded to in writing.

—If the grievance is not resolved within 30 days, it must be reviewed by the [OSU Wexner Medical Center Grievance Committee](#) or the [James Cancer Hospital Grievance Committee](#).

~~6-3.~~ A copy of the written response shall be retained by Patient Experience.

Reporting Complaints via Patient Satisfaction Surveys

1. Information obtained from patient satisfaction surveys will not be considered a grievance, except:

a. If an identified patient writes or attaches a written complaint on the survey and requests resolution (i.e. requests an act or response), then the complaint shall be considered a grievance.

b. If an identified patient writes or attaches a written complaint on the survey and does not request resolution, then the hospital shall treat this as a grievance if the hospital would usually treat such a complaint a grievance.

2. Patient Experience will work collaboratively with the patient, or their representative, and the

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appropriate business unit to resolve the grievance when resolution has been requested by the patient.

Grievance Committees Committee

1. The Ohio State University Wexner Medical Center Board has delegated oversight of the grievance management process to the Grievance [Committees for the OSU Wexner Medical Center and the James Cancer Hospital](#) ~~Committee~~ to review and resolve the grievances of the hospital [where the patient is receiving care](#).

The OSU Wexner Medical Center

- ~~3.2.~~ The Grievance Committee is comprised of the Wexner Medical Center Chief Quality Officer, Chief Medical Officer and the hospital Chief Executive Officer or their respective designees to review and resolve the grievances the hospital receives.

- ~~3.~~ The James Cancer Hospital Grievance Committee is comprised of the James Executive Director of Patient Services, James Chief Medical Officer, Chief Nursing Officer, Director of James Quality and Patient Safety, Director of Grievance Committee functions to:

[Patient Experience](#), or their respective designees to review and resolve grievances the hospital receives.

1. The OSU Wexner Medical Center and the James Cancer Hospital Grievance Committees functions to:

- a. Facilitate grievance resolution when necessary;
- b. Review grievances quarterly to evaluate effectiveness of the resolution process;
- c. Complete an [OSU Wexner Medical Center and James Cancer Hospital](#) annual summary report for presentation to the Ohio State University Wexner Medical Center Board;
- d. Submit patterns and trends to the Quality and Patient Safety Department for possible incorporation into a hospital performance improvement plan; and
- e. Recommend operational modifications to senior hospital leadership in the event an immediate correction is necessary as a result of a patient grievance.

Resources

Related Policies

[Patients Rights and Responsibilities 03-23 v.1](#)

[Patient Safety & Event Reporting 04-05 v.1](#)

Related References

CFR §482.13 (a)(2)

Staff Reporting Resources

Policy Name: **Patient Complaint and Grievance Management**
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Staff may access the following resources on OneSource:

[Complaint Management Database](#)
[Patient Safety Reporting System](#)

Patient Reporting Resources

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

The Ohio Department of Health (ODH)

<http://www.odh.ohio.gov/contactus.aspx>

Complaints → Healthcare Facilities and Nursing Homes 246 North High Street
Columbus, Ohio 43215

Toll Free: 1-800-342-0553

TTY: 1-614-752-6490

E-Mail: HCComplaints@odh.ohio.gov

The Ohio Department of Health

Complaints – Health Care Facility Complaint Hotline

Toll Free: 1-800-669-3534

KePRO Inc.

<http://www.ohiokepro.com/aboutus/contacts.aspx>

Ohio KePRO Rock Run Center, Suite 100

5700 Lombardo Center

Seven Hills, Ohio 44131 Phone: 1-216-447-9604

E-Mail: webmaster@ohiokepro.com

The Joint Commission on Accreditation of Healthcare Organizations

<http://www.jointcommission.org>

Office of Quality Monitoring ~~The Joint Commission~~

1 Renaissance Boulevard

Oakbrook Terrace, Illinois 60181

Office of Quality Monitoring Toll Free: 1-800-~~444994~~-6610

To File a Complaint: http://www.jointcommission.org/report_a_complaint.aspx

U.S. Department of Health and Human Services- Office for Civil Rights Region V- Ohio

<http://www.hhs.gov/ocr>

Office for Civil Rights

233 N. Michigan Avenue, Suite 240

Chicago, Illinois 60601

Phone: 1-312-886-2359

TTY: 1-312-353-5693

To File a Complaint: <http://www.hhs.gov/ocr/civilrights/complaints/index.html>

Ohio Department of Mental Health & Addiction Services

<http://mha.ohio.gov/>

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Ohio Department of Mental Health 30 E. Broad Street, 8th Floor
Columbus, Ohio 43215
Phone: 1-614-466-2596 TTY: 1-614-752-9696
E-Mail: questions@mh.ohio.gov
For Information about Client Rights and Resources: <http://mha.ohio.gov/Default.aspx?tabid=157>

Disability Rights Ohio

<http://www.disabilityrightsohio.org>

50 W. Broad Street, Suite 1400
Columbus, Ohio 43215-5923
Phone: 1-614-466-7264 TTY: 1-614-728-2553

For Assistance: <http://www.disabilityrightsohio.org/get-help-now>

~~For Assistance:~~ <http://www.disabilityrightsohio.org/get-help-now>

Patient Experience

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

James [Cancer Hospital](#) Patient Experience
Phone: 1-614-293-8609 Toll Free: 1-866-993-8609
[E-Mail: James.PatientExperience@osumc.edu](mailto:James.PatientExperience@osumc.edu)

University Hospital Patient Experience
Phone: 1-614-293-~~89448977~~

East Hospital Patient Experience
Phone: 1-614-257-2310

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

Contacts

Subject	Office	Telephone	E-mail/URL
Patient Experience	University Hospital Hospitals	614-293-8944	
Patient Experience	University Hospitals -East	614-257-2310	
Patient Experience	James Cancer Hospital	614-293-8609	
Shellie Anderson	Patient Experience	614-293-3085	shellie.anderson@osumc.edu

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History (UH)

OSU Wexner Medical Center

Issued: October 14, 1991
Revised: October 5, 2017
September 10, 2014

April 5, 2019

Submitted by: Patient Experience ~~Department~~
Approved by: UH MSAC September 10, 2014
Medical Center Board September, 2014

Arthur G. James Cancer Hospital and Richard J. Solove Research Institute History (OSUCCC-James)

Issued: October 1991
Revised: ~~June 2014~~
October 5, 2017
~~June 2014~~
Submitted by: Patient Experience
Approved by: ~~OSUCCC-James~~ Cancer Hospital MSAC September 12, 2014

Policy Name: Patient Complaint and Grievance Management
Policy Number: 03-28

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

POLICY

The Ohio State University Wexner Medical Center is committed to promptly resolving complaints at the first level of contact whenever possible.

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

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

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

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

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

It is expected that the staff of University Hospital (including medical staff) and the James Cancer Hospital will respond to patient concerns promptly and offer reasonable and appropriate solutions.

Definitions

Term	Definition
Staff Present	1. Includes any hospital staff present at the time of the complaint or who can quickly be at the patients location (i.e. nursing, administration, nursing supervisors, patient advocate, etc.) to resolve the patient's complaint.
Complaint	1. A clinical care issue that is verbally conveyed by a patient or the patient's representative to staff and generally resolved within twenty-four (24) hours. 2. A complaint regarding discrimination on the basis of race, color, national origin, sex, age, or disability, unless unable to resolve within 24 hours. 3. A complaint such as not having a qualified interpreter available for a patient, patients spouse, family, and/or partner, even if the patient does not require an interpreter. 4. Minor service complaints such as housekeeping, bedding, billing issues and food. 5. Complaints regarding property loss. 6. Privacy and HIPAA complaints, unless unable to be resolved within twenty-four (24) hours.
Grievance	1. Any written complaint received from a patient or the patient's representative regarding clinical care, whether from an inpatient, outpatient or released/discharged patient. An e-mail or facsimile (fax) will be considered to be "written".

Policy Name: Patient Complaint and Grievance
Management
Policy Number: 03-28

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

2. Verbal complaints about clinical care that are not resolved by staff at the time of the complaint, generally within twenty-four (24) hours, and made by a patient or the patient's representative.
3. All verbal or written complaints regarding:
 - a. Abuse, neglect, patient harm;
 - b. Hospital compliance with CMS Hospital Conditions of Participation (CoP); and
 - c. Medicare Beneficiary Billing complaints related to rights and limitations provided by 42CFR§489.
4. Any complaint that the patient, or their representative, requests be handled as a formal grievance.
5. Any complaint where a written response from the hospital is requested by the patient or their representative.
6. Post-discharge complaints, made by a patient or their representative, related to clinical care or services during a stay shall be considered grievances, unless the complaint would have routinely been handled by staff generally within twenty four (24) hours had the communication occurred during the stay or visit. In this instance, the communication will be considered a complaint.

Policy Details

Staff Reporting Complaints via the Hospital's Intranet Site (OneSource)

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

Patients or Visitors Reporting Complaints via Telephone

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

Procedures for Complaints

1. All clinical care complaints handled within 24 hours should be referred to the attending physician or manager for appropriate follow-up and entered in the Complaint Management Database.
2. All non-clinical complaints should be referred to the appropriate department manager for follow-up.
3. Patient Experience will forward all issues regarding property loss to the Property Loss Committee and enter the issue into the Complaint Management Database.



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4. Privacy and HIPAA complaints will be forwarded to the HIPAA Privacy Officer.
5. When complaints cannot be immediately resolved by the staff member to whom they were reported, the complaint should be reported to the supervisor or manager for resolution and entered into the Complaint Management Database.
6. Patient Experience staff will act as a liaison for the patient by representing their interests and facilitating communication with appropriate individuals within the Medical Center.

Procedures for Grievances

1. When notified, Patient Experience or the appropriate manager will respond and investigate grievances regarding patients who are currently located within the hospital setting.
2. Situations that endanger (e.g. neglect or abuse) the patient should be addressed immediately by the appropriate staff member.
3. When appropriate, Risk Management may initiate a review of a grievance.
4. Patient Experience will serve as the primary liaison to the patient, and may consult Risk Management as needed.
5. If the grievance is from a written source, or reported after the patient has left the facility, Patient Experience will initiate contact with the complainant.
6. Clinical Care Grievances
 - a. Clinical care grievances should be entered in the Patient Safety Reporting System, in accordance with the [Patient Safety & Event Reporting Policy](#).
 - b. Following initial contact with the complainant, Patient Experience will arrange a meeting between the patient, or their representative, and the attending physician to assure that the patient's concerns have been addressed and that the patient's expectations have been met.
 - c. Patient Experience will work collaboratively with the patient, or their representative, and the attending physician to resolve the grievance.
7. Non-Clinical Care Grievances
 - a. Non-clinical grievances should be entered into the Complaint Management Database.
 - b. Following initial contact with the complainant, Patient Experience will facilitate communication and dialogue between the patient, or their representative, and the appropriate manager to assure that the patient's concerns have been addressed and their patient's expectations have been met.
8. Patient Experience will work collaboratively with the patient and manager to resolve the grievance.
9. Typically, a grievance will be considered resolved when the patient is satisfied with the actions taken on their behalf.
 - a. However, there may be situations where the Hospital has taken appropriate and reasonable actions on the patient's behalf in order to resolve the patient's grievance and the patient or the patient's representative remains unsatisfied with the Hospital's actions. In these situations, the Hospital may consider the grievance to be closed.
 - b. Patient Experience must maintain documentation of its efforts and demonstrate compliance with this policy.



Policy Name: Patient Complaint and Grievance
Management
Policy Number: 03-28

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

10. A written response to all grievances shall be submitted to the patient, or their representative, by the Patient Experience representative or other appropriate individual within seven (7) business days regarding the disposition of the grievance.
 - a. Included in the written response will be:
 - i. The name of the hospital;
 - ii. The steps taken on behalf of the patient to investigate and resolve the grievance;
 - iii. The results of the grievance process; and
 - iv. The date of completion.
 - b. All grievance response letters will be mailed to the patient's or patient's representative's home address unless otherwise indicated.
 - c. If the grievance is received via email, the response may be sent via email.
11. There may be complications or circumstances, which will not allow every grievance to be resolved during the seven (7) day timeframe.
 - a. If a response will take longer than seven (7) business days, the patient should be contacted by Patient Experience and advised that the hospital is still working to resolve the grievance.
 - b. The patient or the patient's representative should be contacted a minimum of every fourteen (14) business days by Patient Experience until the grievance is responded to in writing.
 - c. If the grievance is not resolved within 30 days, it must be reviewed by the OSU Wexner Medical Center Grievance Committee or the James Cancer Hospital Grievance Committee.
12. A copy of the written response shall be retained by Patient Experience.

Reporting Complaints via Patient Satisfaction Surveys

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

Grievance Committees

1. The Ohio State University Wexner Medical Center Board has delegated oversight of the grievance management process to the Grievance Committees for the OSU Wexner Medical Center and the James Cancer Hospital to review and resolve the grievances of the hospital where the patient is receiving care.
2. The OSU Wexner Medical Center Grievance Committee is comprised of the Wexner Medical Center Chief Quality Officer, Chief Medical Officer and the hospital Chief Executive Officer or their respective designees to review and resolve the grievances the hospital receives.
3. The James Cancer Hospital Grievance Committee is comprised of the James Executive Director of Patient Services, James Chief Medical Officer, Chief Nursing Officer, Director of James Quality and

Policy Name: Patient Complaint and Grievance
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Patient Safety, Director of Patient Experience, or their respective designees to review and resolve grievances the hospital receives.

4. The OSU Wexner Medical Center and the James Cancer Hospital Grievance Committees functions to:
 - a. Facilitate grievance resolution when necessary;
 - b. Review grievances quarterly to evaluate effectiveness of the resolution process;
 - c. Complete an OSU Wexner Medical Center and James Cancer Hospital annual summary report for presentation to the Ohio State University Wexner Medical Center Board;
 - d. Submit patterns and trends to the Quality and Patient Safety Department for possible incorporation into a hospital performance improvement plan; and
 - e. Recommend operational modifications to senior hospital leadership in the event an immediate correction is necessary as a result of a patient grievance.

Resources

Related Policies

[Patients Rights and Responsibilities 03-23 v.1](#)

[Patient Safety & Event Reporting 04-05 v.1](#)

Related References

CFR §482.13 (a)(2)

Staff Reporting Resources on OneSource

[Complaint Management Database](#)

[Patient Safety Reporting System](#)

Patient Reporting Resources

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

The Ohio Department of Health (ODH)

<http://www.odh.ohio.gov/contactus.aspx>

Complaints – Healthcare Facilities and Nursing Homes 246 North High Street

Columbus, Ohio 43215

Toll Free: 1-800-342-0553

E-Mail: HCComplaints@odh.ohio.gov

The Ohio Department of Health

Complaints – Health Care Facility Complaint Hotline

Toll Free: 1-800-669-3534

KePRO Inc.

<http://www.ohiokepro.com/aboutus/contacts.aspx>

Ohio KePRO Rock Run Center, Suite 100

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5700 Lombardo Center
Seven Hills, Ohio 44131 Phone: 1-216-447-9604
E-Mail: webmaster@ohiokepro.com

The Joint Commission

<http://www.jointcommission.org>

Office of Quality Monitoring

1 Renaissance Boulevard

Oakbrook Terrace, Illinois 60181

Office of Quality Monitoring Toll Free: 1-800-444-6610

To File a Complaint: http://www.jointcommission.org/report_a_complaint.aspx

U.S. Department of Health and Human Services- Office for Civil Rights Region V- Ohio

<http://www.hhs.gov/ocr>

Office for Civil Rights

233 N. Michigan Avenue, Suite 240

Chicago, Illinois 60601

Phone: 1-312-886-2359

To File a Complaint: <http://www.hhs.gov/ocr/civilrights/complaints/index.html>

Ohio Department of Mental Health & Addiction Services

<http://mha.ohio.gov/>

Ohio Department of Mental Health 30 E. Broad Street, 8th Floor

Columbus, Ohio 43215

Phone: 1-614-466-2596

E-Mail: questions@mh.ohio.gov

For Information about Client Rights and Resources: <http://mha.ohio.gov/Default.aspx?tabid=157>

Disability Rights Ohio

<http://www.disabilityrightsohio.org>

50 W. Broad Street, Suite 1400

Columbus, Ohio 43215-5923

Phone: 1-614-466-7264

For Assistance: <http://www.disabilityrightsohio.org/get-help-now>

Patient Experience

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

James Cancer Hospital Patient Experience

Phone: 1-614-293-8609 Toll Free: 1-866-993-8609

E-Mail: James.PatientExperience@osumc.edu

University Hospital Patient Experience

Policy Name: Patient Complaint and Grievance
Management
Policy Number: 03-28

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

Phone: 1-614-293-8944

East Hospital Patient Experience
Phone: 1-614-257-2310

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

Contacts

Subject	Office	Telephone	E-mail/URL
Patient Experience	University Hospital	614-293-8944	
Patient Experience	East Hospital	614-257-2310	
Patient Experience	James Cancer Hospital	614-293-8609	

History

OSU Wexner Medical Center

Issued: October 14, 1991

Revised: October 5, 2017
September 10, 2014
April 5, 2019

Submitted by: Patient Experience

Approved by: UH MSAC September 10, 2014
Medical Center Board September, 2014

Arthur G. James Cancer Hospital and Richard J. Solove Research Institute

Issued: October 1991

Revised: June 2014
October 5, 2017

Submitted by: Patient Experience

Approved by: James Cancer Hospital MSAC September 12, 2014

Patient Complaint and Grievance Committee

Meetings are held quarterly:
October 20, January 19, April 19 and July 19,
2018-2020 Time: 2PM
Location: James B030

LAST NAME	FIRST NAME	DEGREE	DEPARTMENT	PHONE
Grecula Chief of Staff	John	MD	Radiation Oncology	293-8415
Colussi	Carol	MHA, RN	Patient Safety and Quality	293-0866
Cohn	David	MD	Director of Medical Affairs	293-3873
Jones Director	Renee		Patient Experience	293-8609
Kipp CNO	Kris	MSN, RN	Hospital Administration	293-7948
Plant Risk Management	John	JD	Legal Services	293-3987
Anderson (Facilitator) Program Manager	Shellie		Patient Experience	293-3085
Larson Manager	Josh		Patient Experience	685-1565

CLINICAL QUALITY, PATIENT SAFETY AND RELIABILITY PLAN

JAMES CANCER HOSPITAL

Synopsis: Approval of the annual review of the clinical quality, patient safety and reliability plan for The Arthur G. James Cancer Hospital, is proposed.

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

WHEREAS the clinical quality, patient safety and reliability 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 James Cancer Hospital:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the Clinical Quality, Patient Safety and Reliability Plan for the James Cancer Hospital.

The James



Clinical Quality, Patient Safety, and Reliability Plan

Fiscal Year 2019

July 1, 2018 through June 30, 2019

THE OHIO STATE UNIVERSITY
James Cancer Hospital and Solove Research Institute
The Comprehensive Cancer Center
(CCC and The James)



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Quality, Patient Safety and Reliability Plan

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Quality, Patient Safety, and Reliability Plan

MISSION, VISION, AND VALUES:

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

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

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

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

Definition:

The Quality, Patient Safety and Reliability Plan of The James Cancer Hospital/Solove Research Institute and The Ohio State University Comprehensive Cancer Center and (hereinafter referred to as The James and CCC Plan or the Plan) is the organization-wide approach to systematic assessment of process design and performance improvement targeting quality of care, patient safety, and patient experience. The James and CCC Plan serves to provide direction for how clinical care and activities are to be designed to enrich patient outcomes, reduce harm, and improve value-added care and service to the cancer patient population.

Scope:

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

Purpose:

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

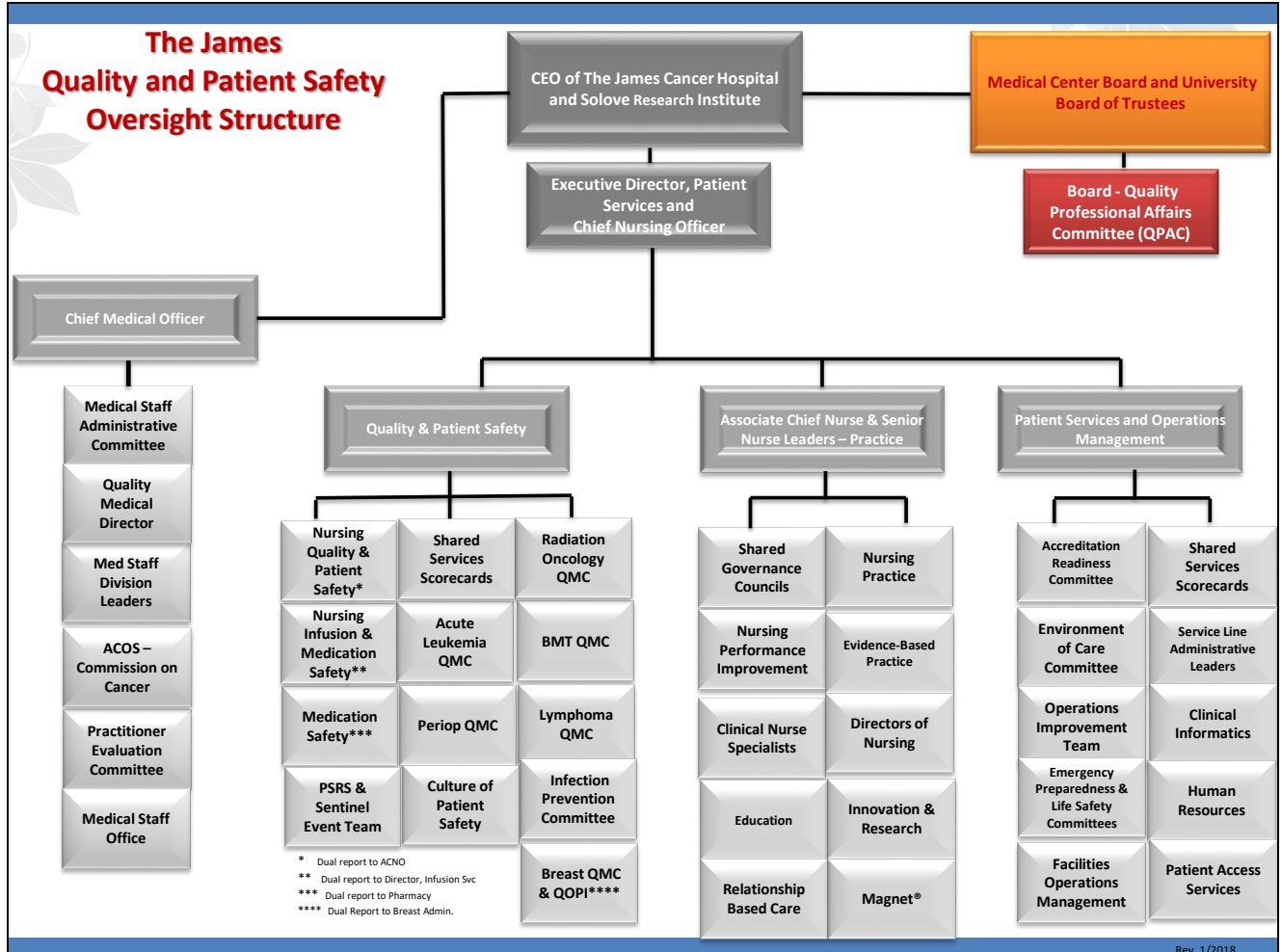
Objectives:

The central objectives of The James and CCC Plan are to:

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

Structure for Quality Oversight:

The James Quality and Patient Safety Committee serves as the primary entity within The James and CCC to develop annual goals which are consistent with goals from the Health System, but these goals are designed with specific focus for the cancer patient population and cancer research agendas.



Roles and responsibilities

Clinical quality management, patient safety and service excellence are identified as responsibilities for all faculty, staff members, and volunteers.

Governing Body

The Wexner Medical Center Board is the governing body, responsible to The Ohio State University Board of Trustees, for operation, oversight and coordination of the Wexner Medical Center and the James Cancer Hospital. The Wexner Medical Center Board is composed of up to 16 members, plus an additional group of university and medical center senior leaders who serve in ex-officio roles. The Quality & Professional Affairs Committee reports to the Wexner Medical Center Board and is responsible for, among other things, reviewing and evaluating the James Cancer Hospital and medical center's patient safety and quality improvement programs and granting clinical privileges for the credentialing of practitioners.

The Board of Trustees and its committees meet throughout the year with focused agendas and presentations.

Chief Executive Officer (CEO)

The CEO for The James is responsible for providing leadership and oversight for the overall Clinical Quality and Patient Safety Plan.

Director of Medical Affairs/Chief Medical Officer (CMO)

The Director of Medical Affairs is the Chief Medical Officer for the James Cancer Hospital and reports to the CEO of The James Cancer Hospital. The CMO provides leadership and strategic direction for the faculty, medical staff and providers, to ensure the delivery of high quality, cost-effective health care consistent with The James and CCC mission.

Quality Medical Director

The James Quality Medical Director, reports to the Chief Medical Officer and is responsible for assisting the quality department with event reviews for patient safety and quality outcomes. This physician works collaboratively with the health system quality department in determining sentinel and significant events, as well as reporting events when necessary through the peer review process.

Executive Director, Patient Services, Chief Nursing Officer (CNO)

The James Executive Director for Patient Services, Chief Nursing Officer provides leadership and oversight of the overall James Quality and Patient Safety Plan, and works collaboratively with the OSUWMC Quality Leadership Council (QLC, formerly known as LCCQSS) initiatives. The Executive Director/CNO is integral to the establishment and implementation of The James annual quality, patient safety and service goals and plan.

Associate Chief Nursing Officer (ACNO)

The James ACNO works directly within the nursing structure to provide leadership and influence over the nursing process and practices. The ACNO ensures that the overall James Quality and Patient Safety Plan is utilized to assist with the implementation of The James Nursing Quality and Patient Safety Plan annually. The ACNO has oversight of the nursing shared governance model and the nursing leadership which establishes and implements annual nursing-sensitive goals.

Medical Director

Each business unit Medical Director is responsible to review the recommendations from The James Quality and Patient Safety Plan and implement quality goals and plans and maintain oversight in their clinical areas.

Clinical Department Chief and Division Directors

Each department chairperson and/or division director is responsible to ensure the standards of care and service are maintained within their department/division. In addition, department chairpersons/division directors are to implement recommendations from The James Quality and Patient Safety Plan, and/or participate in corrective action plans for individual physicians, or the division/department as a whole.

Medical Staff

Medical staff members are responsible to achieve 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 James Quality and Patient Safety Plan. In addition members serve on quality management/patient safety committees and/or continuous quality improvement teams.

A house staff quality forum with representatives from each ACGME accredited program has dedicated one medical resident who will be the quality liaison to the overall Quality Program. This resident quality forum reports to the Health System Clinical Quality & Patient Safety committee.

Nursing Staff

The James Executive Director for Patient Services, Chief Nursing Officer, as well as the Associate Chief Nursing Officer, Director of Nursing Quality, and Directors of Nursing are responsible to implement and maintain oversight of the Nursing Quality Plan and incorporate opportunities and goals from the overall The James Quality and Patient Safety Plan as well as opportunities identified in collaboration with the QLC.

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

Hospital Management Team

Each department director and manager are responsible to ensure the standards of care and service are maintained or exceeded within their department, and are responsible to implement, monitor, and evaluate activities in their areas and assist clinical staff members in developing appropriate mechanisms for data collection and evaluation. Department directors, managers and/or assistant managers participate in corrective action plans for individual employees or the department as a whole. All department directors/managers provide input regarding committee memberships, and serve as participants on quality management/patient safety committees and/or quality improvement teams.

Managers and staff are engaged through formal and informal processes related to quality improvement and clinical patient safety efforts, including but not limited to:

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

The James and CCC Staff

All staff members are responsible to ensure the standards of care and services are maintained or exceeded within their scope of responsibility. The staff is involved through formal and informal

processes related to clinical quality improvement, patient safety and service quality efforts, including but not limited to:

- Suggesting process improvements and reporting medical/health care events and near misses.
- Participating in activities and processes to improve quality and safety at the unit level, as well as being selected to join organizational continuous quality improvement teams.
- Participating in audits, observations and peer-to-peer review and feedback.
- Participating in focus groups, task forces and/or committees.
- Attending staff meetings regularly and staying apprised of changes and improvements.

Quality Improvement and Patient Safety Department

The primary responsibility of the James Quality Improvement and Patient Safety Department is to track, trend, coordinate and facilitate clinical quality management for improved outcomes, patient safety for reduction of risk/harm to patients and service to improve services and assure that the voice of the patient is heard throughout The James. The department works in close partnership with the Quality and Operations Improvement (Q&OI) department in the Health System. While primary responsibility for the implementation and evaluation of clinical quality, patient safety and service activities resides within each department/program, the Quality Improvement and Patient Safety staff also serves as internal consultants for the development, evaluation and on-going monitoring of those activities. The Q&OI Department within the Health System as well as The James Quality Improvement & Patient Safety Departments including The James Process Engineer staff, and the Cancer Program Analytics staff, maintain human and technical resources for team facilitation, use of performance improvement tools, data collection, statistical analysis, and reporting.

Patient Experience/Guest Services Department

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

COMMITTEES:

Medical Staff Administrative Committee (MSAC)

Composition: Refer to Medical Staff Bylaws and Rules and Regulations

Function: Refer to Medical Staff Bylaws and Rules and Regulations

The organized medical staff, under the direction of the Director of Medical Affairs, implements The James Quality and Patient Safety Plan throughout the clinical departments. The MSAC reviews reports and recommendations related to clinical quality management, patient safety and service quality activities. This committee has responsibility for evaluating the quality and appropriateness of clinical performance and service quality of all individuals with clinical privileges. The MSAC reviews corrective

actions and provides authority within their realm of responsibility related to clinical quality management, patient safety and service quality activities.

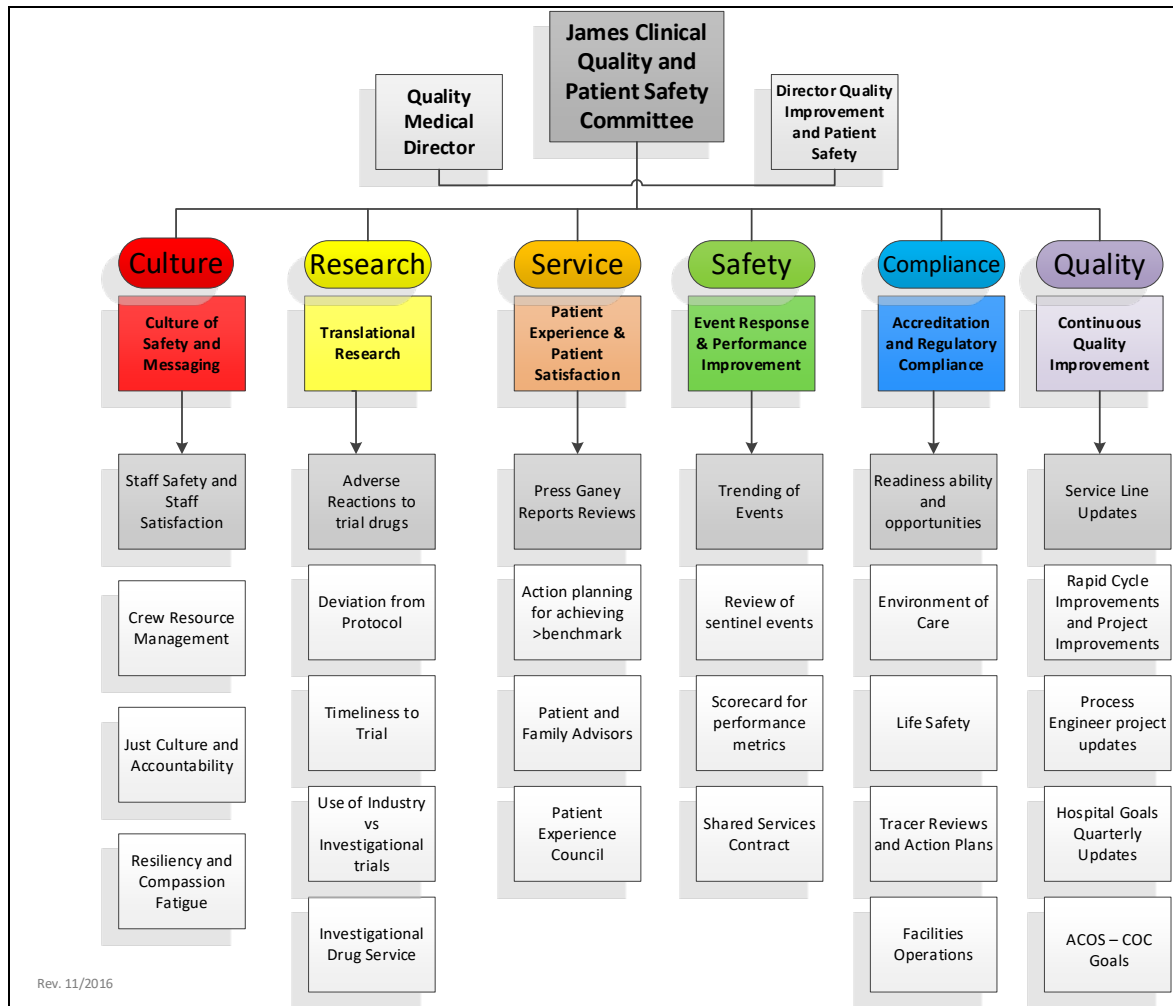
The James Quality, Patient Safety, & Reliability Committee / Commission on Cancer Committee (COC)

Composition:

The James Quality & Patient Safety/COC Committee consists of representatives from Medical Staff, Administration, Patient/Family Advisor, Advanced Practice Providers, and staff from Cancer Program Analytics, Clinical Trials, Epidemiology, Environmental Services, Clinical Informatics, Laboratory, Nursing, Organizational Culture/HR, Radiation Patient Experience, Safety, Social Work, Respiratory Therapy, Pharmacy/Medication Safety, and Risk Management. This committee reports to Executive Leadership and MSAC.

Function:

- Create a culture which promotes organizational learning and recognition of clinical quality (improving outcomes) and patient safety (reducing harm).
- Develop and sustain a culture of safety which strives to eliminate individual blame or retribution for involvement in health care errors.
- Assure compliance with patient safety-related accreditation standards.
- Proactively identify risks to patient safety and creates a call-to-action to reduce risk with a focus on process and system improvement.
- Oversee education & risk reduction strategies as they relate to Sentinel Event Alerts from TJC.
- Evaluate standards of care and evidence-based practices and provide recommendations to improve clinical care and outcomes.
- Ensure actions are taken to improve performance whenever an undesirable pattern or trend is identified.
- Receive reports from committees that have a potential impact on the quality & safety in delivering patient care such as, but not limited to, Environment of Care, BMT & Acute Leukemia, Radiation Oncology, Translational Research and Infection Prevention Committee.



Patient Experience Council

Composition:

The Patient Experience Council consists of multidisciplinary representatives from Hospital Administration, Medical Staff, Nursing, Nutrition Services, Environmental Services, Communications and the Patient Experience Department.

Function:

- Create a culture and environment to deliver exceptional patient experience consistent with the mission, vision and values focused largely on service quality.
- Measure and review voice of the customer information in the form of patient satisfaction, comments, letters and related measures. Recommend system goals and expectations for a consistent patient experience.
- Monitor publicly reported and other metrics used by various payers to ensure optimal reimbursement.
- Provides guidance and oversight on patient experience improvement efforts ensuring effective deployment and accountability throughout the system.
- Oversees the service excellence reward and recognition program. Serves as a coordinating body for subcommittees working on specific aspects of the patient experience.

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 QLC and the Wexner Medical Board, and shares information/updates with the Medical Staff Administrative Committee.

Function:

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

The James Utilization Management Committee (JUMC)

Composition:

The JUMC is co-chaired by a James Lead Physician Advisor and the Director of Patient Care Resource Management. Committee membership will include James Physician Advisors and Emergency Department Physician Advisors, physician members of the medical staff, representatives from the Patient Care Resource Management (PCRM) Department, Administration, Finance, Advance Practice Professionals, Providers, Quality and Safety, Revenue Cycle and Compliance, Nursing and Service Line Administration. Other departments in the James will be invited to join meetings as necessary when opportunities have been identified for improvement and input. JUMC members will not include any individual who has a financial interest in any hospital in the health system. No JUMC member will be included in the review process for a case when that member has direct responsibility for patient care in the case being reviewed.

Function:

The JUMC has responsibility to establish and implement of The James Utilization Management Plan. The JUMC implements procedures for reviewing the efficient utilization of care and services, including but not limited to admissions, continued stays, readmissions, over and under-utilization of services, the efficient scheduling of services, appropriate stewardship of hospital resources, access and throughput and timeliness of discharge planning. Any quality or utilization opportunities identified by the JUMC through utilization review activities are acted upon by the committee or referred to the appropriate entity for resolution. The JUMC provides education on care and utilization issues to all health care professionals and medical staff at The James.

Practitioner Evaluation Committee (PEC)

Composition:

The Practitioner Evaluation Committee (PEC) is the medical staff peer review committee that provides leadership in overseeing the peer review process. The PEC is composed of the Chair of the Clinical Quality and Patient Safety Committee, medical staff, and advanced practice providers from various

business units & clinical areas as appointed by the Chief Medical Officer (CMO) of the Medical Center and the Director of Medical Affairs at The James.

Function:

- Provide leadership for the provider clinical quality improvement processes.
- Provide clinical expertise to the practitioner peer review process by thorough and timely review of clinical care and/or patient safety issues referred to the PEC.
- Give advice to the CMO & Director of Medical Affairs at The James regarding action plans to improve the quality and safety of clinical care.
- Develop follow up plans to ensure action is successful in improving quality and patient safety.

Health System Information Systems Steering Team (HSISST)

Composition:

The HSISST is a multidisciplinary team chaired by the Chief Medical Information Officer of OSUWMC.

Function:

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

Sentinel Event Committees

Composition:

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

The Sentinel Event Determination Group (SEDG) is a sub-group of the Sentinel Event Team which is comprised of quality leaders from The James and OSUWMC, and is chaired by the Chief Quality and Patient Safety Officer and members include the Associate Chief Quality and Patient Safety Officer, Director of Risk Management, James Quality Medical Director, Directors of Quality & Patient Safety and Nursing Quality Directors of respective business units. The SEDG meets weekly to review sentinel event and significant events. Once an event is determined to be a significant or sentinel event, SEDG members assign a Root Cause Analysis (RCA) Team which includes: Executive Sponsor, RCA Workgroup Leader, RCA Workgroup Facilitator, and recommends RCA workgroup membership to the Executive Sponsor. The James Director of Quality and Patient Safety receives the input from SEDG, and collaborates with the Executive Sponsor to finalize the team membership, initiate team charters and ensure that team meetings and action plans are completed in accordance with requirements to satisfy regulatory agency compliance.

Function:

Approve & make recommendations on sentinel event determinations and teams, and action plans as received from the Sentinel Event Determination Group. Results of a sentinel event, significant event or near-miss information are not externally reported or released.

Quality & Patient Safety Sub-Committees Committees

Composition:

For the purposes of this plan, Quality & Patient Safety sub-committees refer to any standing committee or sub-committee functioning under the quality oversight structure. Membership on these committees represents 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 groups 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.

Continuous Quality Improvement Teams

Composition:

For the purposes of this plan, Continuous Quality Improvement Teams are considered as ad-hoc committees, workgroups, teams, taskforces, etc., that function under the quality oversight structure and are generally time-limited in nature. Continuous Quality Improvement teams are comprised of owners or participants in the process under study. The process may be clinical or non-clinical. Generally, the members fill the following roles: team leader, Process Engineer or facilitator, physician advisor, administrative sponsor, and technical expert.

Function:

Improve current practice or processes using traditional continuous process improvement tools such as LEAN principles and DMAIC.

Approach to Quality, Patient Safety & Service Management:

Philosophy of Patient Care Services

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

- A mission statement that outlines the synergistic relationship between patient care, research and teaching.
- Long-range strategic planning conducted by hospital leadership to determine the services to be provided.
- Establishing annual goals and objectives that are consistent with the hospital mission, and which are based on a collaborative assessment of patient/family and the community's needs.
- Provision of services that are appropriate to the meet the needs of patients.
- Ongoing evaluation of services provided through formalized processes such as: performance assessment and improvement activities, budgeting and staffing plans.
- Integration of services through the following mechanisms: continuous quality improvement teams; clinical interdisciplinary quality programs; performance assessment and improvement activities; communications through management operations meetings, nursing shared governance structure, Medical Staff Administrative Committee, administrative staff meetings; participation in OSUWMC and OSU governance structures, special forums; and leadership and employee education/development.
- Maintaining competent patient care leadership and staff by providing education and ongoing competency reviews which are focused towards identified patient care needs.

- Respect for each patient’s rights and decisions as an essential component in the planning and provision of care.
- Utilizing the Relationship Based Care principles which encompass Care of Patient, Care of Colleague and Care of Self.
- Embracing the principles of a Just Culture.
- Staff member behaviors reflect a philosophical foundation based on the values of The James Cancer Hospital and Richard J. Solove Research Institute.

Principles

The principles of providing high quality, safe care support the Institute of Medicine’s *Six Aims of Care* which are:

- **Safe:** Care should be as safe for patients in health care facilities as in their homes;
- **Effective:** The science and evidence behind health care should be applied and serve as the standard in the delivery of care;
- **Efficient:** Care and service should be cost effective, and waste should be removed from the system;
- **Timely:** Patients should experience no waits or delays in receiving care and service;
- **Patient centered:** The system of care should revolve around the patient, respect patient preferences, and put the patient in control; and
- **Equitable:** Unequal treatment should be a fact of the past; disparities in care should be eradicated.

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

1. **Care is based on continuous healing relationships.** Patients should receive care whenever they need it and in many forms, not just face-to-face visits. This implies that the health care system must be responsive at all times, and access to care should be provided over the Internet, by telephone, and by other means in addition to in-person visits.
2. **Care is customized according to patient needs and values.** The system should be designed to meet the most common types of needs, but should have the capability to respond to individual patient choices and preferences.
3. **The patient is the source of control.** Patients should be given the necessary information and opportunity to exercise the degree of control they choose over health care decisions that affect them. The system should be able to accommodate differences in patient preferences and encourage shared decision making.
4. **Knowledge is shared and information flows freely.** Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.
5. **Decision making is evidence-based.** Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.
6. **Safety is a system property.** Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.

7. **Transparency is necessary.** The system should make available to patients and their families information that enables them to make informed decisions when selecting a health plan, hospital, or clinical practice, or when choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.
8. **Needs are anticipated.** The system should anticipate patient needs, rather than simply react to events.
9. **Waste is continuously decreased.** The system should not waste resources or patient time.
10. **Cooperation among clinicians is a priority.** Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

Following these principles, The James and CCC have instituted the following guidelines as the approach to quality, safety, and service:

- **Customer Focus:** Knowledge and understanding of internal and external customer needs and expectations.
- **Leadership & Governance:** Dedication to continuous improvement instilled by leadership and the Board.
- **Education:** Ongoing development and implementation of curricula for quality, safety, and service for all faculty, staff, patients, volunteers and students.
- **Involvement:** All members have mutual respect for the dignity, knowledge, and contributions of others. Everyone is engaged in improvement of processes where they work.
- **Data-driven decision making:** Decisions for quality, safety, service are based on the knowledge derived from data.
- **Continuous Process Improvement:** Analysis of processes for design, redesign and to reduce variations are accomplished by use of an approach using science and LEAN/DMAIC. Measures and improvements are ongoing.
- **Just Culture:** Our framework of quality, safety, service is based on a culture that is open, honest, transparent, collegial, team-oriented, accountable, and non-punitive when system failures have occurred.
- **Personalized Health Care:** The incorporation of evidence-based medicine in patient-centered care which considers the patient's health status, genetics, cultural tradition, personal preferences, and values family and lifestyle situations.

Model:

Model and Systematic Approach to Continuous Quality Improvement

The James and the CCC embrace 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:

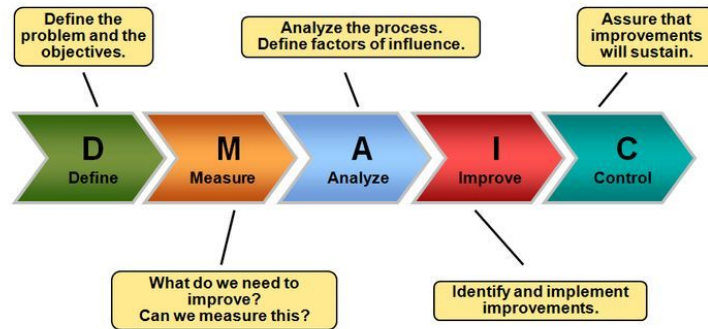
- An organizational expectation that the entire workforce is responsible for enhancing organizational performance and exemplary outcomes for our patients.
- Active involvement of multidisciplinary teams and committees focused on improving processes and,

- A broad toolkit of continuous quality improvement methodologies and expert resources that provide the appropriate level of structure and support to assure the deliverables of the project are met with long term sustainability. With the increased organizational emphasis on utilizing a metric-driven approach to reducing medical errors, eliminating rework, and enhancing efficiency and effectiveness of work, DMAIC, DMADV, and Six Sigma Green and Black Belt Lean project methods are used to help focus our efforts.

DMAIC Roadmap

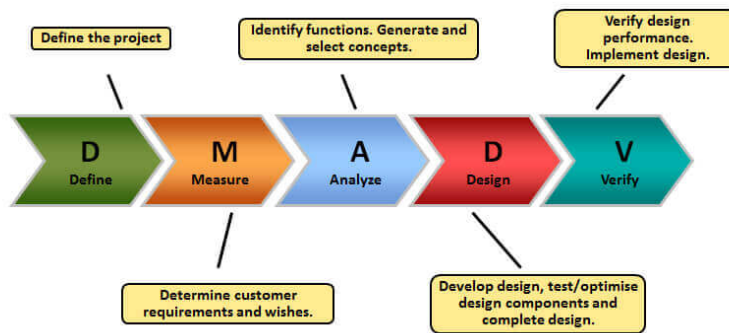


<https://www.sixsigmacamp.com/lean-thinki> 1



<https://www.sixsigmaconcept.com/six-sigm> 2

Design for Six Sigma: DMADV roadmap



<https://www.sixsigmaconcept.com/six-sigm> 3

Consistent Level of Care

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

- Policies and procedures and services provided are not payer driven and are standardized to promote high quality and safe care.
- Application of a single standard for physician credentialing.
- Use of monitoring tools to measure like processes in areas of the Health System and The James.

Performance Transparency

The James Medical and Administrative leadership have a long-standing and strong commitment to transparency of performance as it relates to clinical quality, safety and service performance.

Performance data are shared internally with faculty and staff through a variety of methods. The purpose of providing data internally is to assist faculty and staff in having real-time performance results and to use those results to drive change and improve performance when applicable. Transparency of information is provided within the limits of the Ohio law that protects attorney –client privilege, quality inquiries and reviews, as well as peer review. Current quality data is shared on The James internal intranet site.

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 individual, 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.

Priority Criteria:

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

- 1) Ties to strategic initiatives consistent with 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) Required by an external organization.
- 8) Represents significant cost/economic implications (e.g., high volume).

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 both the DMAIC and Lean Principles are instrumental.

Determining Priorities

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

Design and evaluation of new processes

New processes are designed and evaluated according to the organizational mission, vision, values and priorities, and are consistent with sound business practices.

The design or re-design of a process may be initiated by:

- Surveillance data indicating undesirable variance.
- Patients, staff, or payers perceived need to change a process.
- Information from within the organization and from other organizations about potential risks to patient safety, including the occurrence of sentinel events.
- Review and assessment of data and/or review of available literature to confirm the need.



Data Measurement and Assessment

Determination of Needs

Data needs are determined according to improvement priorities and surveillance needs. The James Cancer Program Data Analytics and the Quality and Patient Safety departments collect data for monitoring important processes and outcomes related to patient care. In addition, each department is responsible for identifying quality indicators specific to their area of service. The quality management committee of each area is responsible for monitoring and assessment of the data collected. Quality and Safety monitoring is on-going and reviewed by The James Quality and Patient Safety Committee each year.

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. The table below displays some examples of external organizations where quality, safety, and service data are reported.

Quality Data and External Reporting

Regulatory / Public Data	Payers	Registries/ Benchmarking
CMS	Anthem	STS
ODH	United Healthcare	UHC
TJC	Aetna	NSQIP
Leapfrog	Optum Health	ACOS
NHSN/CDC	MMO	NCCN
Franklin County Health	Cigna	NDNQI/Press Ganey
Red = Public Data/Reporting		



Collection of data

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

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

Assessment of data

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

Surveillance system

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

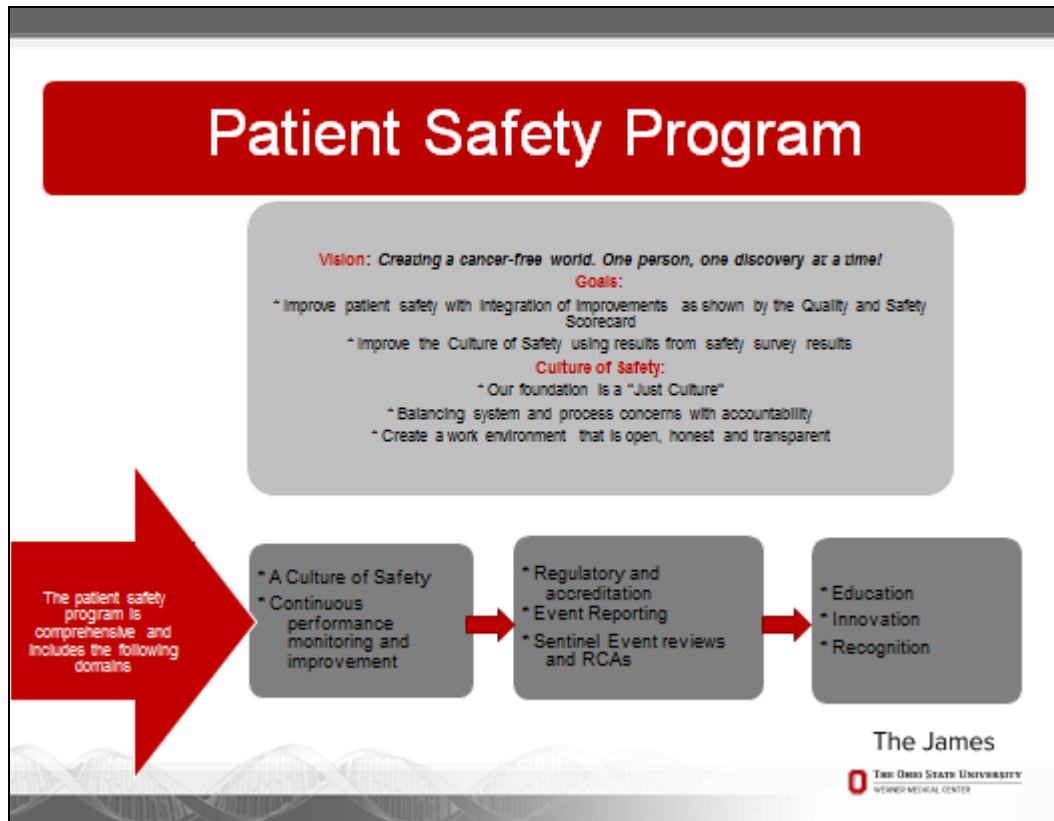
Patient Safety and Safety Scorecard

Patient Safety is the highest priority for all faculty and staff at The James. As a crucial element to caring for our patients, there is an on-going process of monitoring safety events and any untoward trends from patient care. The James Patient Safety Scorecard is a set of indicators related to those events considered potentially preventable and which cause some level of harm to the patient. The James Patient Safety Scorecard covers the areas such as never-events, sentinel events, hospital acquired infections, falls with injury, hospital-acquired pressure ulcers, medication events that reach the patient and cause harm, as well as several other categories. The information is shared in various quality forums with the medical staff, clinicians, James administration, Quality and Professional Affairs Committee and the Wexner Medical Board. The indicators to be included in the scorecard are reviewed each year to represent the priorities of the patient safety program. The Patient Safety program evaluates opportunities each

month at The James Quality and Patient Safety Committee/ ACOS/COC, as well as monthly at the Medical Staff Administrative Committee. Annually, safety goals are reviewed and adjusted as necessary by use of event trending, regulatory changes and/or needs identified from the AHRQ Culture of Patient Safety survey.

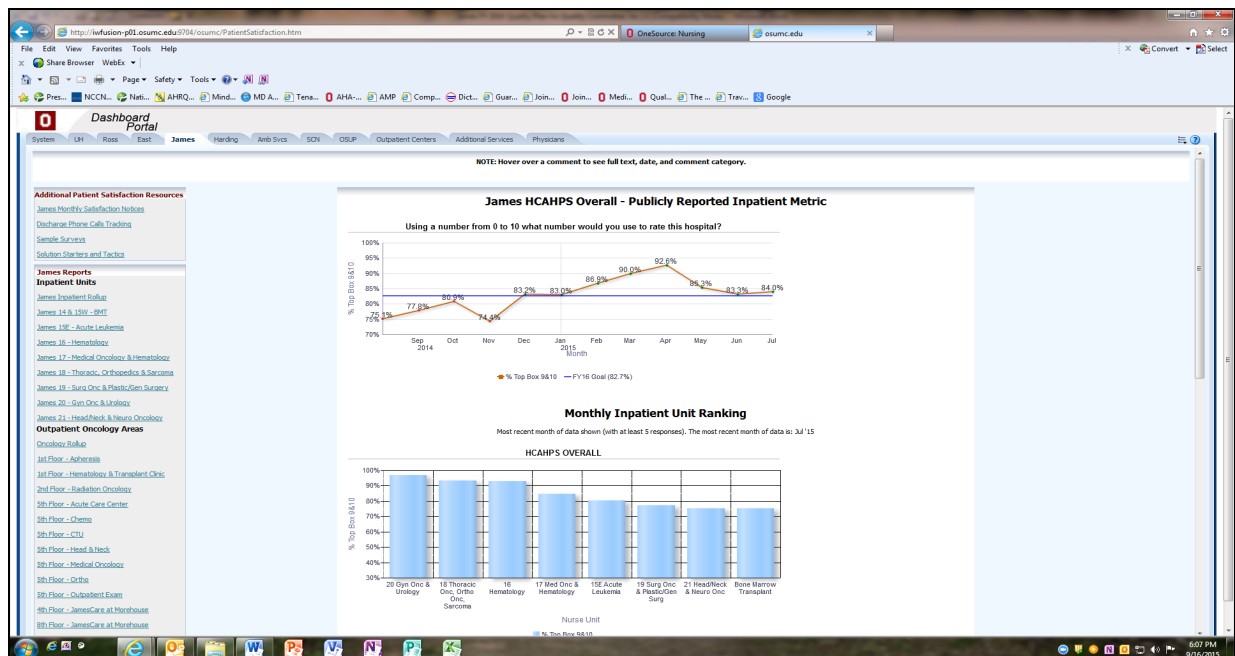
Patient Safety Scorecard

Type of Event
Retained Foreign Bodies
Wrong Site Events
Medication Events with Harm (Severity E-I)
Falls with Harm (Injury Level 2-4)
Hospital Acquired Pressure Ulcer
Central Line Blood Stream Infections
Ventilator Associated Pneumonia
Hospital Acquired Surgical Site Infections
Hospital Acquired Clostridium Difficile Infection
Total Potentially Avoidable Events



Patient Satisfaction Portal/Dashboard

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



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

- Online videos
- Quality & Patient Safety Simulcasts
- Newsletters
- Classroom forums
- Simulation training
- Computerized Based Learning Modules (e-learning/CBLs)
- Partnerships with IHI Open School
- Curriculum Development within College of Medicine
- Websites (internal OneSource and external OSUMC)
- Patient Safety/Quality Lesson’s Learned and Patient Safety Alerts

Benchmark data

Both internal and external benchmarking provides value when evaluating performance.

Internal Benchmarking

Internal benchmarking uses processes and data to compare The James performance to itself over time. Internal benchmarking provides a gauge of improvement strategies within the organization.

External Benchmarking

The James participates in various database systems and focused benchmarking projects to compare performance with that of peer institutions. The James and CCC utilize and join other comprehensive cancer centers for benchmarking such as C4QI (Comprehensive Cancer Center Consortium for Quality Improvement) and ADCC (Alliance of Dedicated Cancer Centers), National Cancer Institute (NCI). Also, The James participates in national benchmarking efforts through the following: The Vizient (formerly known as UHC/University Health Consortium), The US News Report, and the Ohio Department of Health, Press Ganey, and National Database of Nursing Quality Indicators are examples of several external organizations that provide benchmarking opportunities.

Performance Based Physician Quality & Credentialing

Performance based credentialing ensures processes that assist with promoting the delivery of quality and safe care by physicians and advanced practice licensed health care providers. Both Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) occur. Focused Professional Practice Evaluation (FPPE) is utilized on three occasions: initial appointment, when a Privileged Practitioner requests a new privilege, and for cause when questions arise regarding the practitioner's ability to provide safe, high quality patient care. Ongoing Professional Practice Evaluation (OPPE) is performed on an ongoing basis (every 6 months).

Profiling Process:

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

Service-Specific Indicators

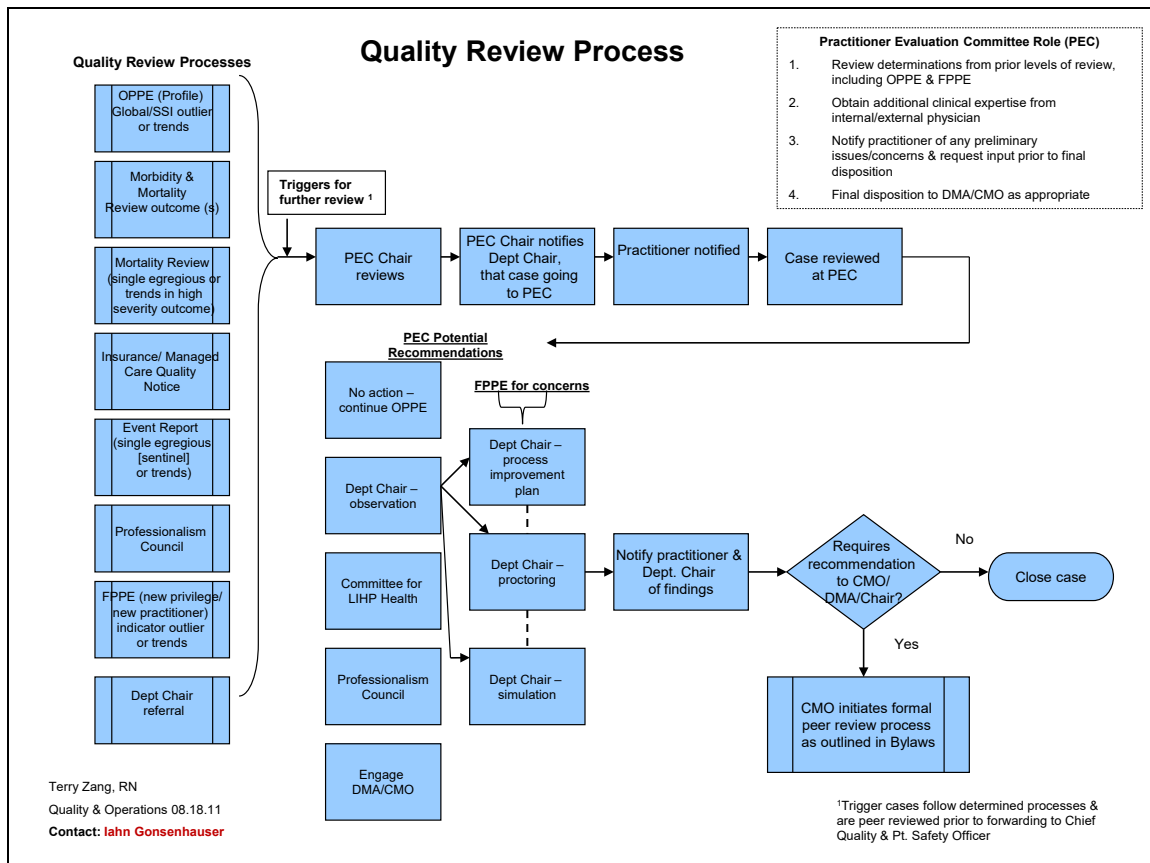
Several indicators are used to profile each physician's performance. The results are included in a physician profile, which is reviewed with the department chair as part of the credentialing process.

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

The purpose of the medical Staff Evaluation is several-fold:

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

Physician Performance Based Profile – SAMPLE



Annual Evaluation

The CCC and The James Quality, Patient Safety and Service Plan is approved by the CCC and The James Quality and Patient Safety Committee. The annual evaluation includes a review of the program activities and an evaluation of the effectiveness of the structure. Attachment 1 outlines the annual quality goals for FY19. Attachment 2 outlines the annual patient safety goals for FY19.

Attachment 1: FY 2019 James Annual Clinical Quality Goals

The James



QUALITY GOALS

JULY 1, 2018 TO JUNE 30, 2019

Clinical Improvement - Inpatient

Implement a consistent, multi-disciplinary discharge planning process

(Phase 1: Medical Units, Phase 2: Surgical Units)

Phys. Champions: Drs. Amir Mortazavi
Facilitator: Sara Stevenson/ Matt Stuckey
Analytics Support: Nick Gibson
CNS: Taletha Askew, Allison DeVilliers

Clinical Improvement - Ambulatory

Implement a consistent, multidisciplinary medication reconciliation process

Physician Champion: Dr. Sam Penza
Facilitator: Sara Stevenson
Analytics Support: Megan Reynolds
CNS: Lisa Blackburn, Kathy Burns

Clinical Research

Implement electronic tool(s) for communicating research orders and activities that is viewable by CTO and clinical staff

Physician Champion: Drs. Beth Christian & Alice Mims
Facilitator: Nanette Richardson
Analytics Support: Robert Pickard
CNS: Shelly Brown, Kim Catania, Misty Lamprecht


Clinical Improvement Inpt. & Outpt.

Develop a comprehensive, interdisciplinary, evidenced-based "End-of-Life Care" Program.

Physician Champion: Drs. Elyn Gafford & David Liebner
Facilitator: Erin Heuser, Nanette Richardson
Analytics Support: Lauren Thacker
CNS: Lynne Brophy, Amy Lindsey

Attachment 2: FY2019 James Annual Patient Safety Goals

The James

 THE OHIO STATE UNIVERSITY
COMPREHENSIVE CANCER CENTER

PATIENT SAFETY GOALS
JULY 1, 2018 TO JUNE 30, 2019

Reduce Patient Safety Events

*Focus on reduction of harm and improvement of outcomes related to
Healthcare Acquired Conditions such as :*

- Infections
- Pressure Injuries (any stage)

And Safety Indicators such as:

- Sepsis Mortality
- Overall Mortality
- Falls with injury (any level of harm)
- Sustain Hand Hygiene Compliance

**Target: To meet or exceed
National Comprehensive Cancer Center benchmarks**