Appendix X

SUMMARY OF ACTIONS TAKEN

November 14, 2018 - Wexner Medical Center Board Meeting

Voting Members Present:

Leslie H. Wexner
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:

Michael J. Gasser (ex officio)
W.G. "Jerry" Jurgensen

PUBLIC SESSION

The Wexner Medical Center Board convened for its 28th meeting on Wednesday, November 14, 2018, in the Ross Auditorium of the Richard M. Ross Heart Hospital. Board Secretary Jeff M.S. Kaplan called the meeting to order at 9:08 a.m.

EXECUTIVE SESSION

It was moved by Mrs. Wexner, and seconded by Mr. Steinour, 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, Mrs. Wexner, Ms. Krueger, Dr. Fujita, Mr. Zeiger, Dr. Porter, Mr. Steinour, Mr. Schottenstein, Ms. Hilsheimer, Dr. Drake, Dr. McPheron and Mr. Papadakis. Mr. Gasser and Mr. Jurgensen were absent.

The board entered executive session at 9:09 a.m.

PUBLIC SESSION

The Wexner Medical Center Board returned to public session at 11:54 a.m.

Item for Action

1. Approval of Minutes: No changes were requested to the August 31, 2018, meeting minutes; therefore, a formal vote was not required and the minutes were considered approved.

Items for Discussion

2. Academic Healthcare: Craig Kent, dean of the College of Medicine, discussed our role as an academic medical center. He described two of our priority missions as providing cutting-edge research that will change the lives of our patients and providing differentiated clinical care that is not available in the community for patients with complex medical problems. He then introduced Dr. John Byrd and his hematology colleagues who have developed a revolutionary, multidisciplinary approach to treating Chronic Lymphocytic Leukemia. Their goal is to eradicate the need for chemotherapy in the treatment of leukemia, and their success in this area has saved lives, enhanced quality of life for countless patients and put Ohio State on the map internationally for translational research in blood cancers.

Items for Discussion (cont'd)

3. The James Update: William Farrar, interim CEO of the James Cancer Hospital and Solove Research Institute, shared an update on The James, which has been opening new beds in the past few months. He noted that four out of seven days a week, The James is full, so bringing these additional beds online is critical to the hospital being able to provide great patient care. The James is also launching two important initiatives — first, a wellness program for its physicians that will provide active support for oncologists who suffer from symptoms of potential burnout and depression. Second, the possible establishment of a system that will better assist in the training of our physicians on how to provide the best palliative care for end-of-life patients and their families.

4. College of Medicine Report: Dr. Kent introduced two new recruits — Dr. Rama Mallampalli, chair of the Department of Internal Medicine, and Dr. Nahush Mokadam, division director for Cardiac Surgery. These two physicians shared how they plan to develop one of the top five lung transplant programs in the United States. Ohio State's lung transplant program was originally initiated in 1998, and over the course of 11 years, the team performed just 93 transplants. Due to those modest volumes, the lung transplant program voluntarily shut down. It restarted in 2013, and last week it completed its 46th lung transplant of the year. This is real, meaningful growth in a short time period. To grow the program into a signature center and destination for patients around the country, the medical center wants to recruit nationally recognized experts in different areas of chronic respiratory illness.

5. Wexner Medical Center Operations Report: David McQuaid, COO of the Wexner Medical Center, announced that the medical center and Mercy Health have signed a master affiliation agreement to create the Healthy State Alliance, which will tackle Ohio's most critical health care needs while making health care more affordable and more accessible for all. The Healthy State Alliance has identified 10 objectives, including a focus on the opioid crisis as well as increasing access to cancer treatment and transplant care. The aspiration for this alliance is that it will provide greater access to more than 2,000 clinical trials, an NCI-designated comprehensive cancer center, one of the nation's leading transplant centers, 50,000 team members and more than 600 points of care throughout the state.

6. Wexner Medical Center Financial Summary: Mark Larmore, CFO of the Wexner Medical Center, presented the financial summary for the first quarter of Fiscal Year 2019. Operating revenue, year over year, has grown 9.5 percent and controllable expenses are up 10.3 percent. The bottom line for the medical center is almost $76 million, an improvement of 13 percent over the prior year.

Items for Action

7. Resolution No. 2019-26, Approval for Acquisition of Real Property

   Synopsis: Authorization to purchase real property located at 1600 East Long Street, Columbus, Franklin County, Ohio, is proposed.

   WHEREAS The Ohio State University seeks to purchase improved real property of +/- 0.74 acres located at 1600 East Long Street, Columbus, Ohio, identified as Franklin County parcels 010-003018 and 010-023596; and

   WHEREAS the property is strategic to the Wexner Medical Center initiative for healthy communities and will complement the services provided at Outpatient East and University Hospital East and is currently zoned R-3 (Residential); and

   WHEREAS improvements on the property include an 8,933+ square-foot, one-story building, known as the former MLK Columbus Metropolitan Library:

   NOW THEREFORE

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

   BE IT 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 property and to negotiate a purchase contract containing terms and conditions deemed to be in the best interest of the university.

   (See Attachment VI for background information, page 247)

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

Items for Action (cont'd)

8. Resolution No. 2019-27, Approval to Enter Into/Increase Professional Services and Construction Contracts

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

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

	Prof. Serv. Approval Requested	Total Project Cost	
Wexner Medical Center West Campus Ambulatory Facilities	$23.0M	TBD	Auxiliary Funds

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

	Prof. Serv. Approval Requested	Construction Approval Requested	Total Project Cost	
Lincoln – 11th and 13th Floor Office Renovations	$0.6M	$4.4M	$5.0M	Auxiliary Funds
Wexner Medical Center Inpatient Hospital Garage (Infrastructure and Road Work)	$0.5M	$21.5M	TBD	University Debt Auxiliary Funds

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

	Prof. Serv. Approval Requested	Construction Approval Requested	Total Project Cost	
Health Sciences Faculty Office and Optometry Clinic Building	$1.3M	$6.3M	$35.9M	University Funds Auxiliary Funds

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

	Construction Approval Requested	Total Project Cost	
Interdisciplinary Health Sciences Center (Anatomy Lab)	$4.4M	TBD	State 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

Items for Action (cont'd)

BE IT FURTHER RESOLVED, That the President and/or Senior Vice President for Business and Finance be authorized to enter into and 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.

(See Attachment VII for background information, page 250)

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

9. Resolution No. 2019-28, Clinical Quality Management, Patient Safety and Service Plan

Synopsis: Approval of the annual review of the Clinical Quality Management, Patient Safety and Service Plan for The Ohio State University Wexner Medical Center, is proposed.

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

WHEREAS the Clinical Quality Management, Patient Safety and Service Plan outlines assessment and improvement of processes in order to deliver safe, effective, optimal patient care and services in an environment of minimal risk for patients of the hospitals and clinics at The Ohio State University Wexner Medical Center; and

WHEREAS the Clinical Quality Management, Patient Safety and Service Plan for The Ohio State University Wexner Medical Center was approved by the Leadership Council for Clinical Quality, Safety and Service on August 8, 2018, and the Quality and Professional Affairs Committee on October 30, 2018:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the Clinical Quality Management, Patient Safety and Service Plan for The Ohio State University Wexner Medical Center.

(See Attachment VIII for background information, page 258)

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

Resolutions No. 2019-26 and No. 2019-27 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 Mrs. Wexner, 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, Mrs. Wexner, Ms. Krueger, Dr. Fujita, Mr. Zeiger, Dr. Porter, Ms. Hilsheimer, Dr. Drake, Dr. McPheron and Mr. Papadakis. Mr. Gasser, Mr. Steinour, Mr. Schottenstein and Mr. Jurgensen were absent.

The board entered executive session at 1:18 p.m. and the board meeting adjourned at 2:00 p.m.

Attachment VI

The Ohio State University
Wexner Medical Center Board

November 14, 2018

APPROVAL FOR ACQUISITION OF REAL PROPERTY

1600 EAST LONG STREET
COLUMBUS, FRANKLIN COUNTY, OHIO

Synopsis: Authorization to purchase real property located at 1600 East Long Street, Columbus, Franklin County, Ohio, is proposed.

WHEREAS The Ohio State University seeks to purchase improved real property of +/- 0.74 acres located at 1600 East Long Street, Columbus, Ohio, identified as Franklin County parcels 010-003018 and 010-023596; and

WHEREAS the property is strategic to the Wexner Medical Center initiative for healthy communities and will complement the services provided at Outpatient East and University Hospital East and is currently zoned R-3 (Residential); and

WHEREAS improvements on the property include an 8,933± square-foot, one-story building, known as the former MLK Columbus Metropolitan Library:

NOW THEREFORE

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

BE IT 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 property and to negotiate a purchase contract containing terms and conditions deemed to be in the best interest of the university.

{00279422-1}

APPROVAL FOR ACQUISITION OF REAL PROPERTY
1600 EAST LONG STREET
COLUMBUS, FRANKLIN COUNTY, OHIO

Background

The Ohio State University seeks to acquire from Columbus Metropolitan Library Board of Trustees, approximately 0.74 acres of land located on 1600 East Long Street, Franklin County, Columbus, Ohio. The land will be acquired as part of a Wexner Medical Center (WMC) strategic initiative for healthy communities.

Location and Description

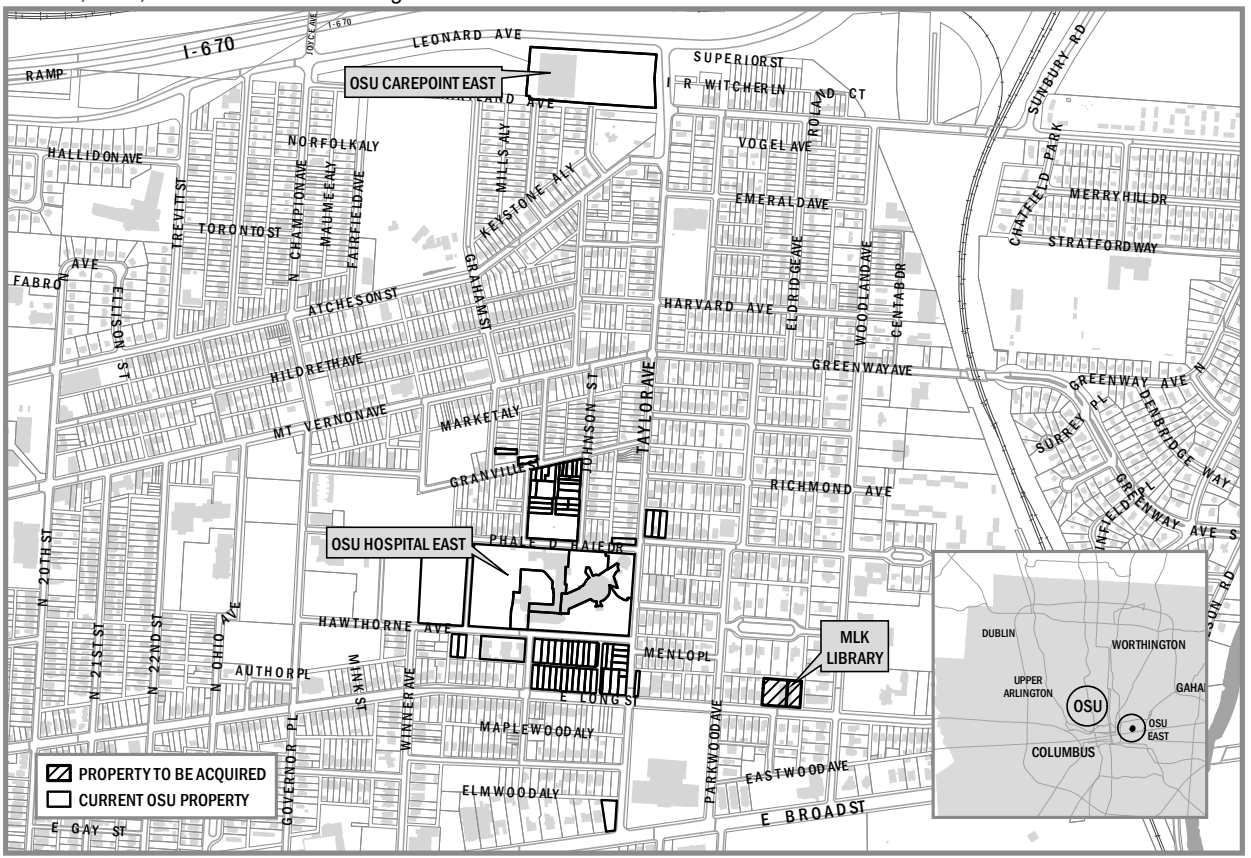
Ohio State is purchasing the property located at 1600 East Long Street, Columbus, Ohio. The site is improved with the former MLK Columbus Metropolitan Library, a single-story building of 8,933±, which was constructed in 1960 and renovated in 1992. The facility was marketed because the library is relocating to their new facility. The site is currently zoned R3 (Residential).

Purchase Rationale

The acquisition of this property is strategic to the WMC initiative for healthy communities. Specifically, the site will continue to serve as a community center with a few proposed renovations that will include a demonstration kitchen, café and meeting rooms. This non-clinical space will complement the services provided at Outpatient East and University Hospital East.

Recommendation

Planning and Real Estate, together with the Wexner Medical Center, recommends the acquisition of the +/- 0.74 acres. The property will be acquired for $245,000 subject to appropriate adjustments and prorations at closing and under terms and conditions that are deemed to be in the best interest of the university.



THE OHIO STATE UNIVERSITY

PURCHASE OF REAL PROPERTY
1600 EAST LONG STREET
COLUMBUS, FRANKLIN COUNTY, OHIO 43203
PARCELS 010-003018 & 010-023596

Prepared By: The Ohio State University
Office of Planning and Real Estate
Issue Date: October 5, 2018
The Ohio State University Board of Trustees

Attachment VII

The Ohio State University
Wexner Medical Center Board

November 14, 2018

APPROVAL TO ENTER INTO/INCREASE PROFESSIONAL SERVICES AND CONSTRUCTION CONTRACTS

APPROVAL TO ENTER INTO PROFESSIONAL SERVICES CONTRACTS
Wexner Medical Center West Campus Ambulatory Facilities

APPROVAL TO ENTER INTO PROFESSIONAL SERVICES AND CONSTRUCTION CONTRACTS
Lincoln – 11th and 13th Floor Office Renovations
Wexner Medical Center Inpatient Hospital Garage (Infrastructure and Road Work)

APPROVAL TO INCREASE PROFESSIONAL SERVICES AND CONSTRUCTION CONTRACTS
Health Sciences Faculty Office and Optometry Clinic Building

APPROVAL TO ENTER INTO CONSTRUCTION CONTRACTS
Interdisciplinary Health Sciences Center (Anatomy Lab)

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

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

	Prof. Serv. Approval Requested	Total Project Cost	
Wexner Medical Center West Campus Ambulatory Facilities	$23.0M	TBD	Auxiliary Funds

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

	Prof. Serv. Approval Requested	Construction Approval Requested	Total Project Cost	
Lincoln – 11th and 13th Floor Office Renovations	$0.6M	$4.4M	$5.0M	Auxiliary Funds
Wexner Medical Center Inpatient Hospital Garage (Infrastructure and Road Work)	$0.5M	$21.5M	TBD	University Debt Auxiliary Funds

The Ohio State University
Wexner Medical Center Board

November 14, 2018

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

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

	Prof. Serv. Approval Requested	Construction Approval Requested	Total Project Cost	
Health Sciences Faculty Office and Optometry Clinic Building	$1.3M	$6.3M	$35.9M	University Funds Auxiliary Funds

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

	Construction Approval Requested	Total Project Cost	
Interdisciplinary Health Sciences Center (Anatomy Lab)	$4.4M	TBD	State 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

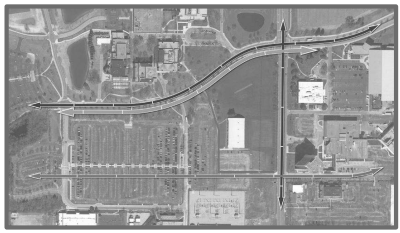
BE IT FURTHER RESOLVED, That the President and/or Senior Vice President for Business and Finance be authorized to enter into and increase professional services and construction contracts for the projects listed above in accordance with established university and State of Ohio procedures, with all actions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

Project Data Sheet for Board of Trustees Approval

WMC West Campus Ambulatory Facilities

OSU-180390 (CNI# 18000156)

Project Location: Kenny Road and Carmack Road



- **approval requested and amount**
  professional services $23.0M

- **project budget**

professional services	TBD
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 – 08/20
construction	09/20 – 12/22

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

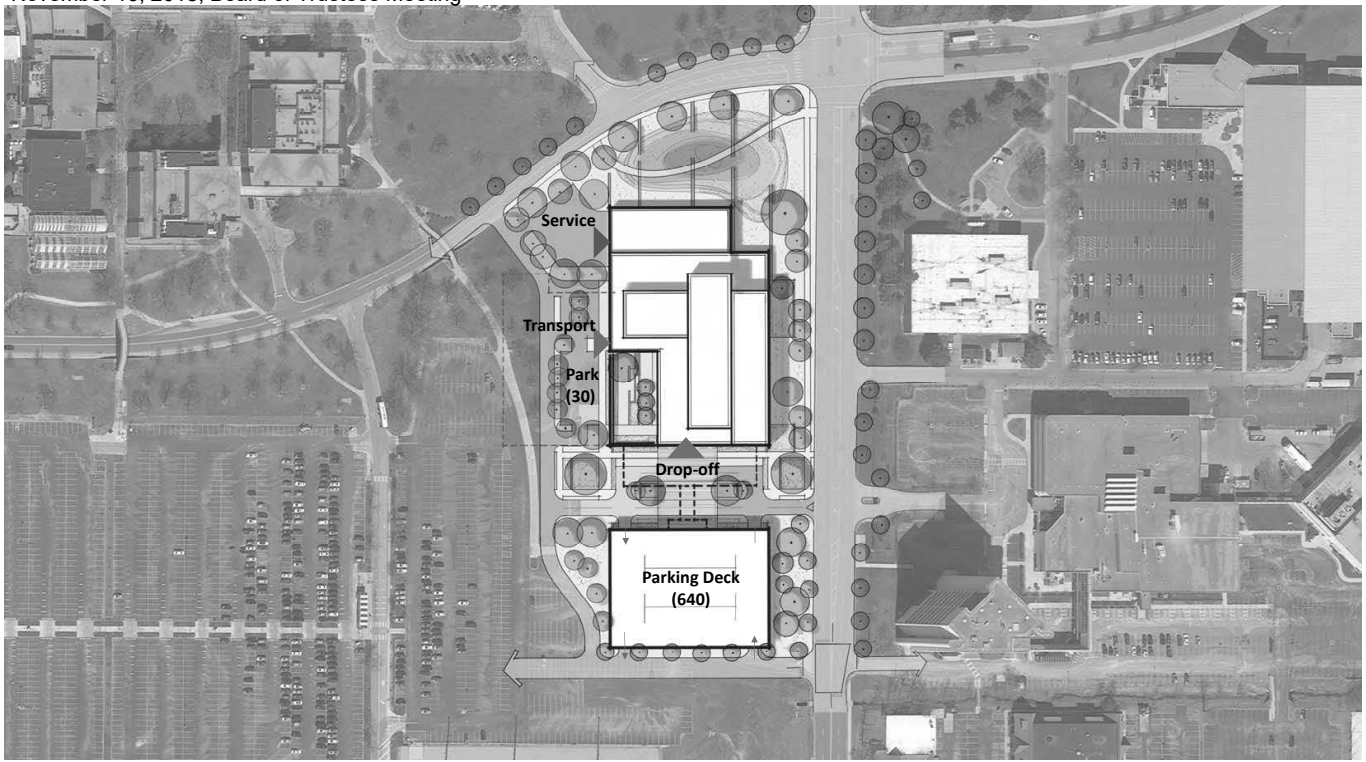
- **planning framework**
  - consistent with the strategic plans of the university and Wexner Medical Center to provide medical services within ambulatory facilities
  - a portion of design for the project is included in the FY 2019 Capital Investment Plan; the Capital Investment Plan will be amended to include design through design development
  - total project cost will be validated during design

- **project scope**
  - 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 amend the FY 2019 Capital Investment Plan
  - approval is requested to enter into professional services contracts through the design development phase

- **project team**

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



Site Plan

Project Data Sheet for Board of Trustees Approval

Lincoln – 11th and 13th Floor Office Renovations

OSU-190192 (CNI# 180000154)

Project Location: Lincoln Tower

- **approval requested and amount**

prof serv and constr w/contingency	$5.0M

- **project budget**

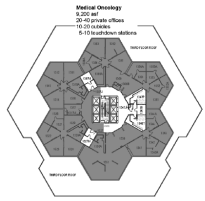
professional services	$0.6M
construction w/contingency	$4.4M
total project budget	$5.0M

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

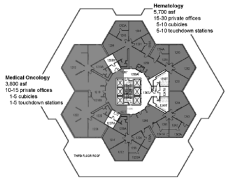
- **project schedule**

BoT prof svc/cons approval	11/18
design/bidding	12/18 – 03/19
construction	04/19 – 07/19

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



13th Floor



11th Floor

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

- **project scope**
  - the project will renovate the 11th and 13th floors for Wexner Medical Center faculty and staff offices

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

- **project team**

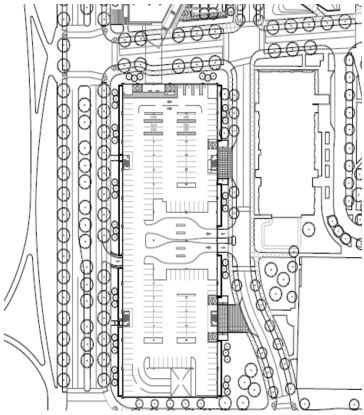
University project manager:	Lance Timmons
AE/design architect:	
General contract:	

Project Data Sheet for Board of Trustees Approval

Wexner Medical Center Inpatient Hospital Garage (Infrastructure & Road Work)

OSU-180391-1 (CNI# 18000171)

Project Location: Wexner Medical Center



- **approval requested and amount**

professional services	$0.5M
construction w/contingency	$21.5M

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

- **project schedule**

BoT professional services approval	02/18
design	06/18 – 12/18
BoT construction approval (partial)	11/18
construction	01/19 – 11/20

- **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 parking adjacent to medical facilities
  - the garage infrastructure and road work is included in the FY2019 Capital Investment Plan
  - $6.1M of professional services was included in the February 2018 approval for the Wexner Medical Center Inpatient Hospital project

- **project scope**
  - construct a 1,870-space parking garage west of McCampbell Hall and provide adjacent site utilities; garage construction will be phased
  - construct a street to connect 10th Avenue with Medical Center Drive and King Avenue

- **approval requested**
  - approval is requested to increase professional services and enter into construction contracts for site, civil, street connection and foundations

- **project team**

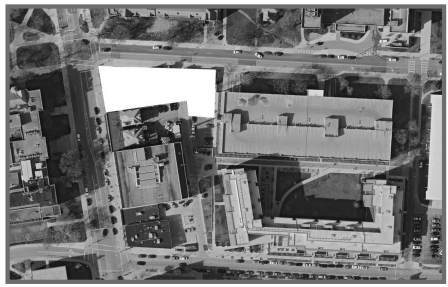
University project manager:	Kristin Poldemann
AE/design architect:	Henningson, Durham & Richardson
CM at Risk:	selected

Project Data Sheet for Board of Trustees Approval

Health Sciences Faculty Office and Optometry Clinic Building

OSU-180356 (CNI# 180000074, 18000019, 18000158)

Project Location: West 11th Ave & Neil Ave



- **approval requested and amount**

	Orig	Incr	Total
prof services	$2.9M	$1.3M	$4.2M
construction	$25.4M	$6.3M	$31.7M

- **project budget**

professional services	$4.2M
construction w/contingency	$31.7M
total project budget	$35.9M

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

- **project schedule**

BoT prof serv appr (criteria design)	11/17
design/bidding	4/18 – 5/19
BoT construction approval	11/18
construction	12/18 – 8/20

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

- **planning framework**
  - the project is included in the FY 2018 and FY 2019 Capital Investment Plans
  - the FY 2019 Capital Investment Plan will be amended to include the increase in total project cost

- **project scope**
  - demolish three existing buildings at the corner of W. 11th Ave and Neil Ave
  - construct approximately 106,000 GSF for optometry clinics, retail, faculty offices and support spaces
  - key enabling project for the Interdisciplinary Health Sciences Center
  - project scope was increased for a basement and an additional floor

- **approval requested**
  - approval is requested to amend the FY 2019 Capital Investment Plan
  - approval is requested to increase professional services and construction contracts

- **project team**

University project manager:	Evan Gardiner
Criteria architect:	Acock Associates
Design-builder:	TBD

Project Data Sheet for Board of Trustees Approval

Interdisciplinary Health Sciences Center (Anatomy Lab)

OSU-180354 (CNI# 18000021)

Project Location: Hamilton Hall

- **approval requested and amount**
  construction $4.4M

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

- **project schedule**

BoT professional services approval	11/17
design	8/18 – 11/18
construction	01/19 – 08/19

- **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 transformational research and learning environments
  - this project is included in the FY 2018 Capital Investment Plan for design; the FY 2019 Capital Investment Plan will be amended to include $4.4M for enabling construction work

- **project scope**
  - the interdisciplinary health sciences project scope includes renovating existing facilities and constructing a new building to create a collaborative campus for interprofessional education throughout the health sciences
  - anatomy lab work includes renovating 18,000 in Hamilton Hall and installing a chiller, boiler and generator

- **approval requested**
  - approval is requested to amend the FY 2019 Capital Investment Plan
  - approval is requested to enter into construction contracts

- **project team**

University project manager:	Evan Gardiner
Study/planner:	CO Architects
AE/design architect:	Acock Associates
Construction Manager:	Gilbane Building Company

Attachment VIII

The Ohio State University
Wexner Medical Center Board

November 14, 2018

CLINICAL QUALITY MANAGEMENT, PATIENT SAFETY AND SERVICE PLAN

The Ohio State University Wexner Medical Center

Synopsis: Approval of the annual review of the Clinical Quality Management, Patient Safety and Service Plan for The Ohio State University Wexner Medical Center, is proposed.

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

WHEREAS the Clinical Quality Management, Patient Safety and Service Plan outlines assessment and improvement of processes in order to deliver safe, effective, optimal patient care and services in an environment of minimal risk for patients of the hospitals and clinics at The Ohio State University Wexner Medical Center; and

WHEREAS the Clinical Quality Management, Patient Safety and Service Plan for The Ohio State University Wexner Medical Center was approved by the Leadership Council for Clinical Quality, Safety and Service on August 8, 2018, and the Quality and Professional Affairs Committee on October 30, 2018:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the Clinical Quality Management, Patient Safety and Service Plan for The Ohio State University Wexner Medical Center.

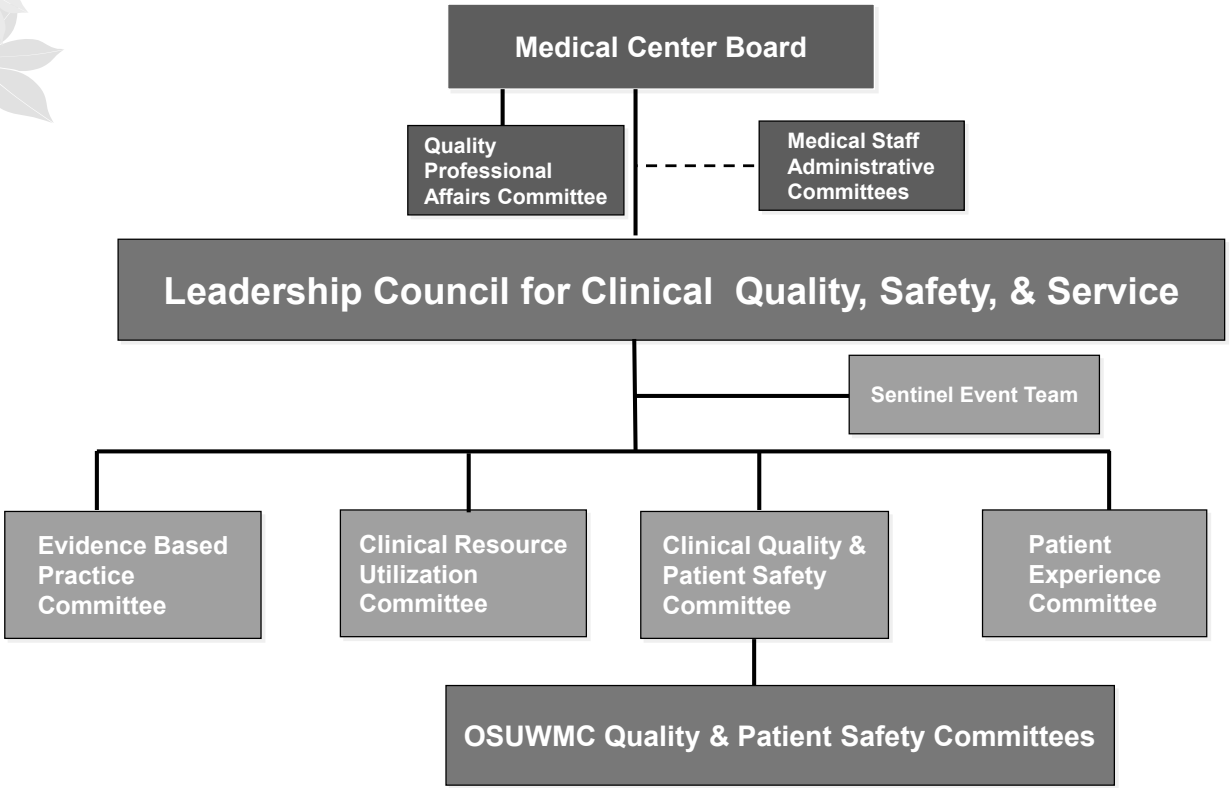
{00279422-1}


Clinical Quality, Patient Safety & Service Annual Plan – FY19
Iahn Gonsenhauser, MD MBA
November 2018
The Ohio State University
Wexner Medical Center

Overview of Plan:

- Defines Quality program
  - Purpose, Scope, Objectives
- Structure for oversight
- Approach to Quality Oversight
- Assessment methodology
- FY 2019 Priorities and goals

OSUWMC Quality Oversight



August 2018

FY 19 Goals

Metric	FY 2019 Goal	Notes
Mortality Index - Medical Center	0.79	Maintain FY 18 Target
Mortality Index - System (No James)	0.75	Maintain FY 18 Target
LOS Index	1.00	Achieve Expected LOS; Gain points on Aetna
PSI-90	0.63	13% reduction to put PSI-90 better than national median in HAC program
PSI-03 Pressure Ulcer	0.53	33% reduction to put PSI-90 better than national median in HAC program
PSI-13 Post-op Sepsis	5.54	20% reduction to put PSI-90 better than national median in HAC program
Overall 30 Day All Cause Readmission Rate	10.40%	Reduciton to potentially avoid Medicaid penalty ($1 million)
CLABSI Rate	1.20	15% Reduction to achieve 2 additional points in VBP
CAUTI Rate	0.53	25% Reduction to achieve 1 additional point in VBP
C-Diff Rate	5.30	10% Reduction to potentially achieve 1 additional point in VBP
MRSA Rate	0.46	25% Reduction to achieve 2 additional points in VBP
SSI - Colon Rate	6.01	Return to FY 17 rate
SSI - Abdominal Hysterectomy Rate	1.54	Return to FY 17 rate
Hand Hygiene Rate	95%	Maintain FY 18 Target
Sepsis Mortality	0.92	Maintain FY 18 Target
HCAHPS Overall Rating	80.5%	90th percentile nationally
CGCAHPS Recommend	92.6%	65th percentile nationally

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

LEADERSHIP COUNCIL

FOR CLINICAL QUALITY, SAFETY AND SERVICE

The Ohio State University Wexner Medical Center

Clinical Quality Management, Patient Safety & Service Plan

FY19

July 1, 2018 -June 30, 2019

Clinical Quality Management, Patient Safety & Service Plan

ATTACHMENTS

Clinical Quality Management, Patient Safety & Service Plan

Mission, Vision and Values

Our Mission:

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

Our Values:

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

Our Vision:

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

Definition

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

Program Scope

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

Program Purpose

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

Objectives

1) Continuously monitor, evaluate, and improve outcomes and sustain improved performance.

2) Recommend reliable system changes that will improve patient care and safety by assessing, identifying, and reducing risks within the organization and responding accordingly when undesirable patterns or trends in performance are identified, or when events requiring intensive analysis occur.

3) Assure optimal compliance with accreditation standards, state, federal and licensure regulations.

4) Develop, implement, and monitor adherence to evidenced-based practice guidelines and companion documents in accordance with best practice to standardize clinical care and reduce practice variation.

5) Improve patient experience and their perception of treatment, care and services by identifying, evaluating, and improving performance based on their needs, expectations, and satisfaction.

6) Improve value by providing the best quality of care at the minimum cost possible.

7) Provide a mechanism by which the governance, medical staff and health system staff members are educated in quality management principles and processes.

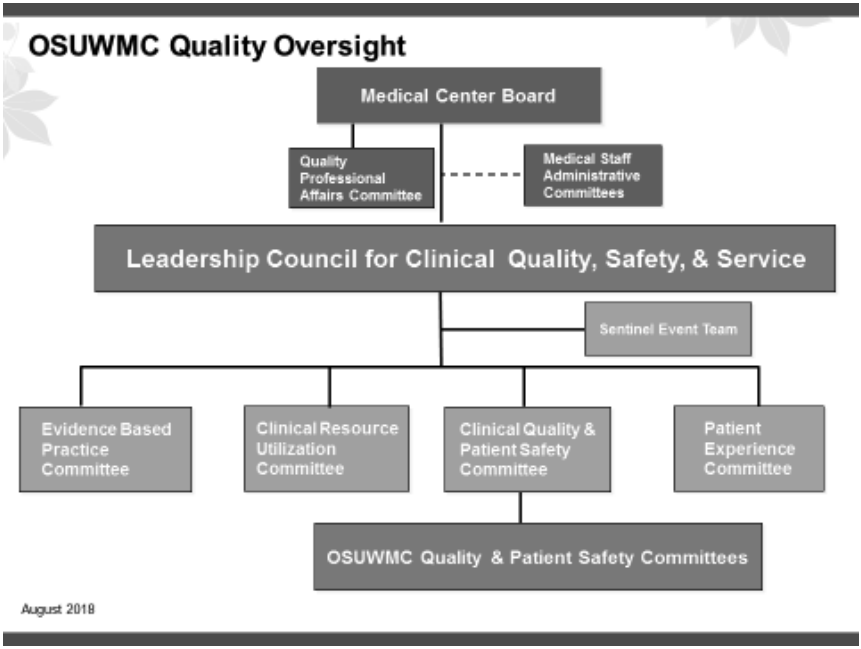
8) Provide appropriate levels of data transparency to both internal and external customers.

9) Assure processes involve an interdisciplinary teamwork approach.

10) Improve processes to prevent patient harm.

Structure for Quality Oversight

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



COMMITTEES:

Medical Center Board

The Medical Center Board is accountable to The Ohio State University Board of Trustees through the President and Executive Vice President (EVP) for Health Sciences and is responsible for overseeing the quality and safety of patient care throughout the Medical Center including the delivery of patient services, quality assessment, improvement mechanisms, and monitoring achievement of quality standards and goals.

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

Quality Professional Affairs Committee

Composition:

The committee shall consist of: no fewer than four voting members of the university Wexner medical center board, appointed annually by the chair of the university Wexner medical center board, one of

whom shall be appointed as chair of the committee. The chief executive officer of the Ohio state university health system; chief medical officer of the medical center; the director of medical affairs of the James; the medical director of credentialing for the James; the chief of the medical staff of the university hospitals; the chief of the medical staff of the James; the associate dean of graduate medical education; the chief quality and patient safety officer; the chief nurse executive for the OSU health system; and the chief nursing officer for the James shall serve as ex-officio, voting members. Such other members as appointed by the chair of the university Wexner medical center board, in consultation with the chair of the quality and professional affairs committee.

Function: The quality and professional affairs committee shall be responsible for the following specific duties:

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

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

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

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

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

(6) Reviewing and approving clinical privilege forms;

(7) Reviewing and approving membership and granting appropriate clinical privileges for the credentialing of practitioners recommended for membership and clinical privileges by the university hospitals medical staff administrative committee and the James medical staff administrative committee;

(8) Reviewing and approving membership and granting appropriate clinical privileges for the expedited credentialing of such practitioners that are eligible by satisfying minimum approved criteria as determined by the university Wexner medical center board and are recommended for membership and clinical privileges by the university hospitals medical staff administrative committee and the James medical staff administrative committee;

(9) Reviewing and approving reinstatement of clinical privileges for a practitioner after a leave of absence from clinical practice;

(10) Conducting peer review activities and recommending professional review actions to the university Wexner medical center board;

(11) Reviewing and resolving any petitions by the medical staffs for amendments to any rule, regulation or policy presented by the chief of staff on behalf of the medical staff pursuant to the medical staff

bylaws and communicating such resolutions to the university hospitals medical staff administrative committee and the James medical staff administrative committee for further dissemination to the medical staffs; and

(12) Such other responsibilities as assigned by the chair of the university Wexner medical center board.

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

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

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

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

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

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

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

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

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

Clinical Quality and Patient Safety Committee (CQPSC)

Composition:

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

Function:

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

Patient Experience Council

Composition:

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

Function:

1. Create a culture and environment that delivers an unparalleled patient experience consistent with the OSU Medical Center's mission, vision and values focusing largely on service quality.
2. Set strategic goals and priorities for improving the patient experience to be implemented by area specific patient experience councils.
3. Serve as a communication hub reporting out objectives and performance to the system.
4. Serve as a coordinating body for subcommittees working on specific aspects of the patient experience.

5. Measure and review voice of the customer information in the form of Patient and Family Experience Advisor Program and related councils, patient satisfaction data, comments, letters and related measures.
6. Monitor publicly reported and other metrics used by various payers to ensure optimal reimbursement.
7. Collaborate with other departments to reward and recognize faculty and staff for service excellence performance.

Clinical Resource Utilization Committee (CRU)

Composition:

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

Function:

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

Key areas of focus:

- Availability and appropriateness of clinical resources and services
- Billing compliance
- Denial management reporting
- Avoidable Hospital days
- VAF reports (help with utilization issues)
- LOS
- Case management issues as new software and workflows are introduced
- Readmissions
- CMS conditions of participation
- Being nimble as new CMS directives are introduced
- How do other hospitals in the system fit into the UM work plan/CMD conditions of participation

Practitioner Evaluation Committee (PEC)

Composition:

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

Function:

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

Health System Information Technology Steering (HSITS)

Composition:

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

Function:

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

Sentinel Event Team

Composition:

The OSU Health System Sentinel Event Team (SET) includes an Administrator, the Chief Quality and Patient Safety Officer, the Associate Executive Director for Quality & Patient Safety, a member of the Physician Executive Council, a member of the Nurse Executive Council, representatives from Quality and Operations Improvement and Risk Management and other areas as necessary.

Function:

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

The Sentinel Event Determination Group (SEDG)

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

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

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

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

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

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

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

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

Chief Clinical Officer (CCO)
The CCO for the Medical Center is responsible for facilitating the implementation of the overall Clinical Quality Management, Patient Safety & Service Plan at OSUWMC. The CMO is responsible for facilitating

the implementation of the recommendations approved by the various committees under the Leadership Council for Clinical Quality, Safety & Service.

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

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

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

Medical Director/Director of Medical Affairs
Each business unit Medical Director is responsible for the implementation and oversight of the Clinical Quality Management, Patient Safety & Service Plan. Each Medical Director is also responsible for reviewing the recommendations from the Clinical Quality Management, Patient Safety & Service Plan.

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

Chief Administrative Officer – Hospital Division
The OSUWMC Chief Administrative Officer is responsible to the Board for implementation of the Clinical Quality Management Patient Safety & Service Plan.

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

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

Medical Staff

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

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

House Staff Quality Forum (HQF)

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

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

Nursing Quality

The primary responsibility of the Nursing Quality Improvement and Patient Safety Department is to coordinate and facilitate nursing quality improvement, participation/collaboration with system-wide patient safety activities, the use of evidence-based practice (EBP) and research to improve both the delivery and outcomes of personalized nursing care, and the submission of outcome data to the National Database for Nursing Quality Indicators (NDNQI). The primary responsibility for the implementation and evaluation of nursing quality improvement, patient safety, and EBP resides in each department/program; however, the Nursing Quality Improvement and Patient Safety staff members also serve as internal consultants for the development and evaluation of quality improvement, patient safety, and EBP activities. The department maintains human and technical resources for team facilitation, use of performance improvement tools, data collection, statistical analysis, and reporting. The Nursing Quality Improvement and Patient Safety Department collaborates with the OSUWMC Hospital Quality and Operations Department.

Hospital Department Directors

Each department director is responsible for ensuring the standards of care and service are maintained or exceeded within their department. Department directors are responsible for implementing, monitoring, and evaluating activities in their respective areas and assisting medical staff members in developing appropriate mechanisms for data collection and evaluation. In addition, department directors may be asked to implement recommendations from the Clinical Quality Management, Patient Safety & Service Plan or participate in corrective action plans for individual employees or the department as a whole. Department directors provide input regarding committee memberships, and serve as participants on quality management committees and/or quality improvement teams.

Health System Staff

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

- Reporting events that reach the patient and those that almost reach the patient via the internal Patient Safety Reporting System
- Suggesting processes to improve quality, safety and service
- Monitoring activities and processes, such as patient complaints and patient satisfaction participating in focus groups
- Attending staff meetings
- Participating in efforts to improve quality and safety including Root Cause Analysis and Proactive Risk Assessments

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

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

Approach to Quality, Safety & Service Management

The OSU Health System approach to clinical quality management, patient safety, and service is leadership-driven and involves significant staff and physician participation. Clinical quality management patient safety and service activities within the Health System are multi-disciplinary and based on the Health System's mission, vision, values, and strategic plan. It embodies a culture of continuously

measuring, assessing, and initiating changes including education in order to improve outcomes. The Health System employs the following principles of continuous quality improvement in its approach to quality management and patient safety:

Principles

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

Safe
Timely
Effective
Efficient
Equitable
Patient-centered

These principles are:

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

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

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

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

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

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

Continuous: Measurement and improvement are ongoing.

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

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

Model

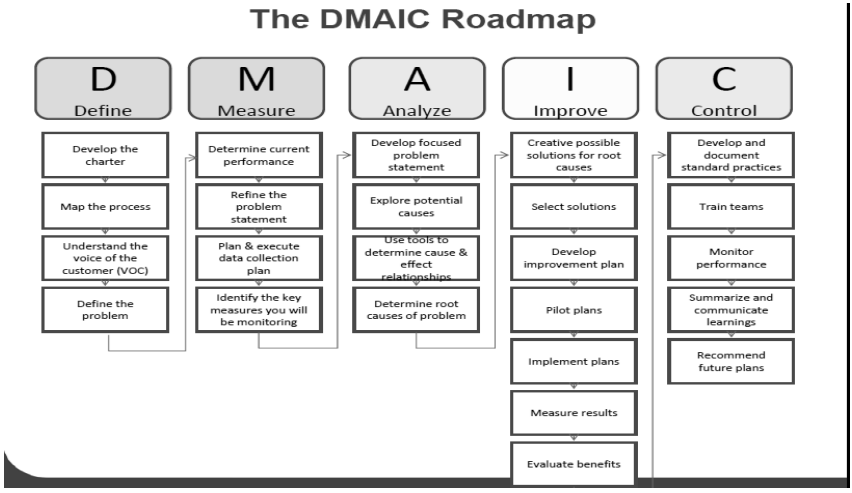
Systematic Approach/Model to Process Improvement

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

***The Process Improvement Toolkit**

Methodology
PDCA
Rapid Cycle Improvement
DMAIC
Lean Principles

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



Consistent Level of Care

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

- Policies and procedures and services provided are not payer driven.

- Application of a single standard for physician credentialing.
- Health system monitoring tools to measure like processes in areas of the Health System.
- Standardize and unify health system policies and procedures that promote high quality, safe care.

Performance Transparency

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

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

Confidentiality

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

Conflict of Interest

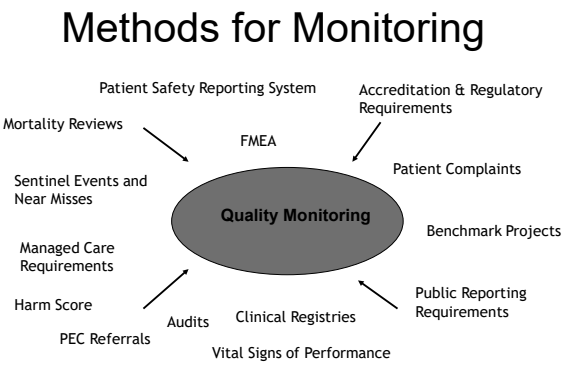
Any person, who is professionally involved in the care of a patient being reviewed, should not participate in peer review deliberations and voting. A person is professionally involved if they are responsible for patient care decision making either as a primary or consulting professional and/or have a financial interest (as determined by legal counsel) in the case under review. Persons who are professionally involved in the care under review are to refrain from participation except as requested by the appropriate administrative or medical leader. During peer review evaluations, deliberations, or

voting, the chairperson will take steps to avoid the presence of any person, including committee members, professionally involved in the care under review. The chairperson of a committee should resolve all questions concerning whether a person is professionally involved. In cases where a committee member is professionally involved, the respective chairperson may appoint a replacement member to the committee. Participants and committee members are encouraged to recognize and disclose, as appropriate, a personal interest or relationship they may have concerning any action under peer review.

Determining Priorities

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

Data Measurement and Assessment



Determination of data needs

Health system data needs are determined according to improvement priorities and surveillance needs. The Health System collects data for monitoring important processes and outcomes related to patient care and the Health System's functions. In addition, each department is responsible to identify quality

indicators specific to their area of service. The quality management committee of each area is responsible for monitoring and assessment of the data collected.

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

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

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

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

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

Quality & Safety Scorecard
The Quality and Safety Scorecard is a set of health system-wide indicators related to those events considered potentially preventable. The Quality & Safety Scorecard covers the areas such as, hospital-acquired infections, falls, patient safety indicators, mortality, length of stay, readmissions, and patient experience. The information is shared in various Quality forums with staff, clinicians, administration, and the Boards. The indicators to be included in the scorecard are reviewed each year to represent the priorities of the quality and patient safety program **[Attachment II].**

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

Patient Satisfaction Dashboard

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

Quality, Patient Safety, and Service Educational Information

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

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

Benchmark data

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

Internal Benchmarking

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

External Benchmarking

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

Design and evaluation of new processes

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

Performance Based Physician Quality & Credentialing

Performance-based credentialing ensures processes that assist to promote the delivery of quality and safe care by physicians and advanced practice licensed health care providers. Both Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) occur. Focused Professional Practice Evaluation (FPPE) is utilized on 3 occasions: initial appointment, when a Privileged Practitioner requests a new privilege, and for cause when questions arise regarding the practitioner's ability to provide safe, high quality patient care. Ongoing Professional Practice Evaluation (OPPE) is performed on an ongoing basis (every 6 months).

Profiling Process:

- Data gathering from multiple sources
- Report generation and indicator analysis
- Department chairs (division directors as well) have online access 24/7 to physician profiles for their ongoing review
    - Individual physician access to their profiles 24/7
- Discussion at Credentialing Committee
- Final Recommendation & Approval:
    - Medical Staff Administrative Committees
    - Medical Director
    - Hospital Board

Service-Specific Indicators

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

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

Purpose of Medical Staff Evaluation

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

Annual Evaluation

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

Attachment I: Priority Criteria

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

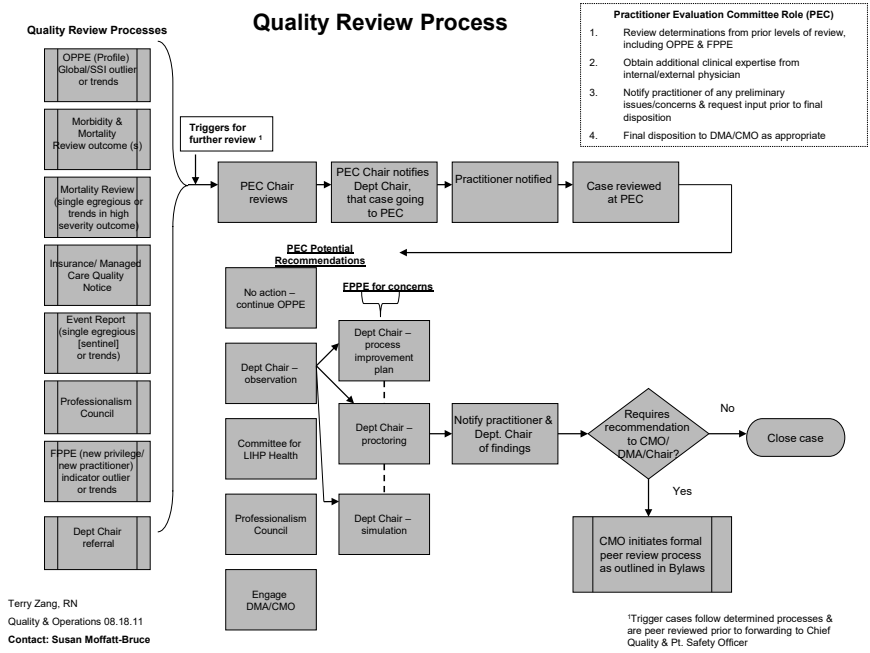
1. Ties to strategic initiatives and is consistent with hospital's mission, vision, and values
2. Reflects areas for improvement in patient safety, appropriateness, quality, and/or medical necessity of patient care (e.g., high risk, serious events, problem-prone)
3. Has considerable impact on our community's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

Attachment II: LCCQSS FY18 Priorities & Scorecard

FY 19 Goals

Metric	FY 2019 Goal	Notes
Mortality Index - Medical Center	0.79	Maintain FY 18 Target
Mortality Index - System (No James)	0.75	Maintain FY 18 Target
LOS Index	1.00	Achieve Expected LOS
PSI-90	0.63	13% reduction to put PSI-90 better than national median in HAC program
PSI-03 Pressure Ulcer	0.53	33% reduction to put PSI-90 better than national median in HAC program
PSI-13 Post-op Sepsis	5.54	20% reduction to put PSI-90 better than national median in HAC program
Overall 30 Day All Cause Readmission Rate	10.40%	Reduciton to potentially avoid Medicaid penalty ($1 million)
CLABSI Rate	1.20	15% Reduction to achieve 2 additional points in VBP
CAUTI Rate	0.53	25% Reduction to achieve 1 additional point in VBP
C-Diff Rate	5.30	10% Reduction to potentially achieve 1 additional point in VBP
MRSA Rate	0.46	25% Reduction to achieve 2 additional points in VBP
SSI - Colon Rate	6.01	Return to FY 17 rate
SSI - Abdominal Hysterectomy Rate	1.54	Return to FY 17 rate
Hand Hygiene Rate	95%	Maintain FY 18 Target
Sepsis Mortality	0.92	Maintain FY 18 Target
HCAHPS Overall Rating	80.5%	90th percentile nationally
CGCAHPS Recommend	92.6%	65th percentile nationally

Attachment IV: Physician Performance Based Profile



Profile for <name>
SERVICE: INTERNAL MEDICINE-CARDIOVASCULAR MEDICINE
Profile last viewed by Provider: Never

Status	Indicator	My Score	Peers Score	Target	SPC Alert	Current Period	6 Month Values: My Score	Peer Score	Start Month
A - Volume and Acuity									
	CMI	n/a	2.03	n/a		Q2 2013	No Data	1.97	Feb 2013
	IP Discharges	n/a	14.6	n/a		Q2 2013	No Data	14.0	Feb 2013
★ ▼	IP LOS Index (Obs_Exp Total Days)	0.83	1.06	1.00		Q1 2013	No Data	1.08	Feb 2013
▼	IP Procedures	4	42.7	n/a		Q2 2013	4	34.5	Mar 2013
▼	Observation Cases	0	1.85	n/a		Q2 2013	0	2.63	Feb 2013
▲	Outpatient Visits	189	107	n/a		Q2 2013	396	102	Feb 2013
B - Patient Care									
★ —	Autopsy Discrepancy	0	0.00	0		Q2 2013	0	1.00	Feb 2013
	Cath PCI Peri-procedure AMI	No Data	1.1%	n/a		Q2 2013	No Data	1.2%	Mar 2013
	Cath PCI Retro-peritoneal Bleed	No Data	0.3%	n/a		Q2 2013	No Data	0.2%	Mar 2013
	CM - AMI_2 Aspirin Prescribed at Discharge	n/a	91.2%	100.0%		Q4 2012	No Data	No Data	No Data
	CM - AMI_3 ACEI or ARB for LVSD	n/a	24.6%	100.0%		Q4 2012	No Data	No Data	No Data
	CM - AMI_5 Beta Blocker at Discharge	n/a	87.7%	100.0%		Q4 2012	No Data	No Data	No Data
	CM - AMI_9 Inpatient Mortality	n/a	0.0%	0.0%		Q4 2012	No Data	No Data	No Data
	CM - HF_2 Evaluation of LVS Function	n/a	95.7%	100.0%		Q4 2012	No Data	No Data	No Data
	CM - HF_3 ACEI or ARB for LVSD	n/a	46.8%	100.0%		Q4 2012	No Data	No Data	No Data
	ICD Registry CVA	No Data	0.0%	n/a		Q1 2013	No Data	0.0%	Mar 2013
★ ▼	IP Mort Index (Obs_Exp)	0.00	0.50	0.79		Q1 2013	No Data	0.47	Feb 2013
—	Mortalities Reviewed	1	0.44	n/a		Q2 2013	1	1.57	Mar 2013
★ —	Mortalities Sent for Peer Review	0	0.14	0		Q2 2013	0	1.07	Feb 2013
★ —	Mortality Peer Review #1 Score 4 or 5	0	0.00	0		Q2 2013	0	No Data	No Data
★ —	Quality Management Events - Standard of Care Not Met	0	0.04	0		Q2 2013	0	1.14	Mar 2013
—	Related ReAdmit 30 days	0.00%	3.34%	n/a		Q1 2013	No Data	3.19%	Feb 2013
	SSI CABG Procedures	No Data	0.0%	3.0%		Q2 2013	No Data	0.0%	May 2013
	SSI Pacemaker and AICD	No Data	0.0%	n/a		Q2 2013	No Data	0.0%	Apr 2013
C - Medical and Clinical Knowledge									
★ —	Formal Peer Reviews	0	0.00	0		Q2 2013	0	0.00	Feb 2013
E - Interpersonal and Communication									
★ —	Patient Complaints	0	0.02	0		Q2 2013	0	1.00	Mar 2013

Status	Indicator	My Score	Peers Score	Target	SPC Alert	Current Period	6 Month Values		
							My Score	Peer Score	Start Month
▼	Patient Satisfaction Ave Score	98.6%	91.9%	n/a		Q2 2013	99.3%	91.5%	Feb 2013
G - Practice Based Learning and Improvement									
★ —	Surgical Team Safety Checklist Variances	0	0.00	0		Q2 2013	0	0.00	Feb 2013

Profile Generated 09/04/2013 13:53:57
Next Review Due: Aug 13, 2013

	Reviewed By	Outcome	Notes
Jan 28, 2013	<name>	Maintain privileges without modification	The Provider's performance meets expectations.

SPC Alert Legend

- Most recent period is below Lower Control Limit
- Most recent period is above Upper Control Limit
- Process shift: Most recent 8 periods are all above the Center Line
- Process shift: Most recent 8 periods are all below the Center Line
- Most recent 6 periods are all increasing
- Most recent 6 periods are all decreasing

Green border: The alert is in a positive direction
Red border: The alert is in a negative direction
No border: There is no target direction for the indicator