THE OHIO STATE UNIVERSITY

Board of Trustees

210 Bricker Hall
190 North Oval Mall
Columbus, OH 43210-1388

Phone (614) 292-6359
Fax (614) 292-5903
trustees.osu.edu

APPENDIX IV

SUMMARY OF ACTIONS TAKEN

August 26, 2020 - Wexner Medical Center Board Meeting

Voting Members Present by Zoom Virtual Meeting:

Leslie H. Wexner
Abigail S. Wexner
Cheryl L. Krueger
Hiroyuki Fujita
John W. Zeiger
Stephen D. Steinour
Robert H. Schottenstein
Cindy Hilsheimer
Gary R. Heminger (ex officio)
Harold L. Paz (ex officio)
Bruce A. McPheron (ex officio)
Michael Papadakis (ex officio)

Members Absent:

W.G. "Jerry" Jurgensen

PUBLIC SESSION

The Wexner Medical Center Board convened for its 35th meeting on Wednesday, August 26, 2020, virtually over Zoom. Board Secretary Jessica A. Eveland called the meeting to order at 8:00 a.m.

Item for Action

1. Approval of Minutes: No changes were requested to the June 3, 2020, meeting minutes; therefore, a formal vote was not required, and the minutes were considered approved.

Items for Discussion

2. Chancellor's Report: During his report, Dr. Harold Paz shared how our role as an academic health center uniquely positions us to keep our community safe and healthy, especially during a pandemic. This has never been more evident than in the ways we are addressing COVID-19, from standing up a testing laboratory overnight, creating and distributing materials for hundreds of thousands of test kits, implementing a comprehensive testing program and serving as the reference laboratories for testing for both the Ohio Department of Health and for other hospitals in the state. He shared that more than 100 COVID-19 research projects are underway, and the Wexner Medical Center is implementing and sustaining an aggressive telehealth strategy to serve our patients. As a land-grant institution, it is a key part of our mission to share our knowledge, solutions and expertise to improve lives here in our communities and beyond. The Wexner Medical Center recently released a Safe Return to Work guidebook for employers and employees and launched a website with procedures for businesses across the nation to reopen and safely welcome their employees back amid this pandemic. In addition to its efforts around the pandemic, the Wexner Medical Center is also continuing its work to reduce health disparities and combat racism. In June, we became one of the first academic health centers in the nation to develop and put forward a comprehensive antiracism action plan. Dr. Paz shared that the medical center's Chief Diversity Officer, Dr. Leon McDougle, was recently named the 121st president of the National Medical Association. The Wexner Medical Center also remains in first place in central Ohio on *U.S. News & World Report's* "Best Hospitals" list, second place in the entire state and 37th in the nation with nine specialties ranked as high performing.

THE OHIO STATE UNIVERSITY

3. James Cancer Hospital Report: Dr. William Farrar, CEO of the James Cancer Hospital, began his report with a moment of silence for the late Dr. Dina Lev, whose husband, Dr. Raphael Pollock, serves as director of The Ohio State University Comprehensive Cancer Center. He also shared that, despite the pandemic, the James is back to pre-COVID-19 levels, with admissions, surgeries and outpatient visits climbing, and the James' patient satisfaction is at 97%, which reflects the hospital's commitment to delivering high-quality care and improving the patient experience. Additionally, the James' cancer center support grant application was approved again for five years of funding, totaling $32.7 million. Dr. Farrar also shared that this year, Pelotonia found innovative ways to continue its success, despite not being able to host its annual ride. Thanks to its personalized participation platform, Pelotonia had raised close to $7 million with more than 10,800 participants at the time of this report.

4. Wexner Medical Center Financial Report: Mark Larmore provided a FY20 Year in Review and a look ahead at the budget for FY21. For the entire health system, the year ended with an excess of revenue over expenses of approximately $280 million, which was approximately $18 million ahead of budget. Once the pandemic hit, major adjustments were made to manage and reduce expenses. Federal stimulus money helped to offset the negative impact on revenue caused by the pandemic in the last three-and-a-half months of the fiscal year. Quick transitions to telehealth, so that physicians could continue to see patients remotely, also helped significantly in the final quarter of the fiscal year. Looking ahead to FY21, the total operating revenue for the medical center is projected to be more than $4.5 billion, with a projected excess of revenue over expenses of approximately $295 million.

(See Attachment II for background information, page 112)

Items for Action

5. Resolution No. 2021-08, Approval to 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 contracts and construction contracts for the following project:

	Prof. Serv. Approval Requested	Construction Approval Requested	Total Requested	
Morehouse – Chiller and Electrical Distribution Phase 2	$0.1M	$0.6M	$0.7M	Auxiliary Funds

WHEREAS the Master Planning and Facilities Committee has reviewed the projects listed above for alignment with all applicable campus plans and guidelines; and

WHEREAS the Audit, Compliance and Finance Committee has reviewed the projects listed above for alignment with the Capital Investment Plan and other applicable financial plans:

NOW THEREFORE

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

(See Attachment III for background information, page 120)

THE OHIO STATE UNIVERSITY

Action: Upon the motion of Mrs. Wexner, seconded by Dr. Paz, the board approved the foregoing motion by majority voice vote with the following members present and voting: Mr. Wexner, Mrs. Wexner, Ms. Krueger, Dr. Fujita, Mr. Zeiger, Mr. Steinour, Mr. Schottenstein, Ms. Hilsheimer, Mr. Heminger, Dr. Paz, Dr. McPheron and Mr. Papadakis.

6. Resolution No. 2021-28, Ratification of Committee Appointments

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves that the ratification of appointments to the Quality and Professional Affairs Committee for 2020-2021 are as follows:

Quality and Professional Affairs Committee
Cheryl L. Krueger, Chair
Harold L. Paz
Bruce A. McPheron
Michael Papadakis
David P. McQuaid
Andrew M. Thomas
David E. Cohn
Elizabeth Seely
Mink Schofield
Amit Agrawal
Scott A. Holliday
Iahn Gonsenhauser
JACALYN BUCK
Kristopher M. Kipp
Abigail S. Wexner (ex officio)

7. Resolution No. 2021-29, Clinical Quality Management, Patient Safety, and Service Plan for Ohio State University Hospitals d/b/a OSU Wexner Medical Center

Synopsis: Approval of the annual review of the Clinical Quality Management, Patient Safety, and Service Plan for the hospitals at the Ohio State University Hospitals d/b/a OSU Wexner Medical Center, including: Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital, is proposed.

WHEREAS the mission of the OSU 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 for FY21 outlines assessment and improvement of processes in order to deliver safe, effective, optimal patient care and services in an environment of minimal risk for inpatients and outpatients of the Ohio State University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital; and

WHEREAS the annual review of the Clinical Quality Management, Patient Safety, and Service Plan for FY21 was approved by the Quality Leadership Council on July 10, 2020; and

WHEREAS on July 28, 2020, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the annual review of the Clinical Quality Management, Patient Safety, and Service Plan for FY21 for University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital:

NOW THEREFORE

THE OHIO STATE UNIVERSITY

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the Clinical Quality Management, Patient Safety, and Service Plan for FY21 (attached) for University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital.

(See Attachment IV for background information, page 121)

8. Resolution No. 2021-30, Clinical Quality Management, Patient Safety, and Service Plan for the Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute

Synopsis: Approval of the annual review of the Clinical Quality Management, Patient Safety, and Service Plan for FY21 for the Ohio State Comprehensive Cancer Center — James Cancer Hospital and Solove Research Institute, is proposed.

WHEREAS the mission of The James is *to eradicate cancer from individuals' lives by generating knowledge and integrating groundbreaking research with excellence in education and patient-centered care*; and

WHEREAS the Clinical Quality Management, Patient Safety, and Service Plan for FY21 outlines assessment and improvement of processes in order to deliver safe, effective, optimal patient care and services in an environment of minimal risk for inpatients and outpatients of The James; and

WHEREAS the annual review of the Clinical Quality Management, Patient Safety, and Service Plan for FY21 was approved by The James Quality, Patient Safety, and Reliability Committee on July 9, 2020; and

WHEREAS on July 28, 2020, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the annual review of the Clinical Quality Management, Patient Safety, and Service Plan for FY21 for The James:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the Clinical Quality Management, Patient Safety, and Service Plan for FY21 (attached) for The James.

(See Attachment V for background information, page 151)

9. Resolution No. 2021-31, Plan for the Scope of Patient Care Services at Ohio State University Hospitals d/b/a OSU Wexner Medical Center

Synopsis: Approval of the annual review of the plan for the scope of patient care services for the hospitals at the Ohio State University Hospitals d/b/a OSU Wexner Medical Center, including: Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and The Ohio State University Wexner Medical Center East Hospital, is proposed.

WHEREAS the mission of the Ohio State University Hospitals is to improve people’s lives through the provision of high-quality patient care; and

THE OHIO STATE UNIVERSITY

WHEREAS the plan for the scope of inpatient and outpatient care services describes the integration of clinical departments and personnel who provide care and services to patients at University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital; and

WHEREAS the annual review of the plan for the scope of patient care services was approved by the Medical Staff Administrative Committee (University Hospitals) on June 10, 2020; and

WHEREAS on July 28, 2020, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the annual review of the plan for the scope of patient care services:

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the plan for the scope of patient care services for the Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital and The Ohio State University Wexner Medical Center East Hospital, as outlined in the attached Plan for the Scope of Patient Care Services.

(See Attachment VI for background information, page 187)

10. Resolution No. 2021-32, Plan for the Scope of Patient Care Services at The Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute

Synopsis: Approval of the annual review of the plan for the scope of patient care services for the Ohio State Comprehensive Cancer Center — James Cancer Hospital and Solove Research Institute, is proposed.

WHEREAS the mission of The James is to eradicate cancer from individuals' lives by generating knowledge and integrating groundbreaking research with excellence in education and patient-centered care; and

WHEREAS The James plan for the scope of inpatient and outpatient care services describes the integration of clinical departments and personnel who provide care and services to patients at The James; and

WHEREAS the annual review of the plan for the scope of patient care services was approved by the Medical Staff Administrative Committee (The James) on May 15, 2020; and

WHEREAS on July 28, 2020, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the annual review of the plan for the scope of patient care services:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the plan for the scope of patient care services for The James as outlined in the attached Plan for the Scope of Patient Care Services.

(See Attachment VII for background information, page 200)

THE OHIO STATE UNIVERSITY

11. Resolution No. 2021-33, Direct Patient Care Services Contracts and Patient Impact Service Contracts Evaluation at Ohio State University Hospitals d/b/a OSU Wexner Medical Center

    Synopsis: Approval of the annual review of the direct patient care service contracts and patient impact service contracts for the hospitals at the Ohio State University Hospitals d/b/a OSU Wexner Medical Center, including: Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and The Ohio State University Wexner Medical Center East Hospital, is proposed.

    WHEREAS the mission of the Ohio State University Hospitals is to improve people's lives through the provision of high-quality patient care; and

    WHEREAS the Ohio State University Hospitals direct patient care services contracts and patient impact service contracts are evaluated annually to review the scope, nature, and quality of services provided to clinical departments and personnel who provide care and services for inpatient and outpatient care at University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital; and

    WHEREAS the annual review of these contracts was approved by the Medical Staff Administrative Committee (University Hospitals) on February 12, 2020; and

    WHEREAS on July 28, 2020, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the annual review of the direct patient care service contracts and patient impact service contracts for University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital:

    NOW THEREFORE

    BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the annual review of the direct patient care service contracts and patient impact service contracts for University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital as outlined in the attached University Hospitals Contracted Services Annual Evaluation Report.

    (See Attachment VIII for background information, page 220)

12. Resolution No. 2021-34, Direct Patient Care Services Contracts and Patient Impact Service Contracts Evaluations at The Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute

    Synopsis: Approval of the annual review of the direct patient care services contracts and patient impact service contracts for the Ohio State Comprehensive Cancer Center — James Cancer Hospital and Solove Research Institute, is proposed.

    WHEREAS the mission of The James is to eradicate cancer from individuals' lives by generating knowledge and integrating groundbreaking research with excellence in education and patient- centered care; and

    WHEREAS The James direct patient care services contracts and patient impact service contracts are evaluated annually to review the scope, nature, and quality of services provided to clinical departments and personnel who provide care and services for inpatient and outpatient care at The James; and

    WHEREAS the annual review of these contracts was approved by the Medical Staff Administrative Committee (The James) on January 17, 2020; and

THE OHIO STATE UNIVERSITY

WHEREAS on July 28, 2020, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the annual review of the direct patient care service contracts and patient impact service contracts for The James:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the annual review of the direct patient care service contracts and patient impact service contracts for The James as outlined in the attached The James Contracted Services Annual Evaluation Report.

(See Attachment IX for background information, page 224)

13. Resolution No. 2021-35, Infection Prevention and Control Program at Ohio State University Hospitals d/b/a OSU Wexner Medical Center

Synopsis: Approval of the appointment of leaders responsible for the Infection Prevention and Control Program for the hospitals at the Ohio State University Hospitals d/b/a OSU Wexner Medical Center, including: Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital, is proposed.

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

WHEREAS the leaders of the Infection Prevention and Control Program are responsible for managing and directing the program by: employing methods for preventing and controlling the transmission of infections through surveillance, prevention, and control of hospital-acquired infections; providing and maintaining clean and sanitary environments to avoid sources and transmission of infection; and addressing any infection control issues identified by public health authorities for the Ohio State University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital; and

WHEREAS Nora Colburn, MD and Shandra Day, MD are qualified through education, training, and experience in infection prevention and control; and

WHEREAS Andrew Thomas, MD, the Chief Medical Officer for the OSU Wexner Medical Center, and Cheryl Hoying, PhD, RN, NEA-BC, FACHE, FAONL, FAAN, the Chief Nurse Executive Officer for the OSU Wexner Medical Center, recommended that Dr. Colburn and Dr. Day serve as the leaders responsible for the Infection and Prevention Control Program for University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital by letter (attached) dated June 19, 2020; and

WHEREAS on July 28, 2020, the Quality and Professional Affairs Committee recommended the Wexner Medical Center Board approve Dr. Colburn and Dr. Day serve as the leaders responsible for the Infection and Prevention Control Program for University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves Dr. Colburn and Dr. Day as the leaders responsible for the Infection Prevention and Control Program for University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital.

(See Attachment X for background information, page 228)

THE OHIO STATE UNIVERSITY

14. Resolution No. 2021-36, Infection Prevention and Control Program at The Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute

Synopsis: Approval of the appointment of the leader responsible for the Infection Prevention and Control Program for the hospitals at the Ohio State Comprehensive Cancer Center — James Cancer Hospital and Solove Research Institute, is proposed.

WHEREAS the mission of The James is *to eradicate cancer from individuals' lives by generating knowledge and integrating groundbreaking research with excellence in education and patient-centered care*; and

WHEREAS the leader of the Infection Prevention and Control Program is responsible for managing and directing the program by: employing methods for preventing and controlling the transmission of infections through surveillance, prevention, and control of hospital-acquired infections; providing and maintaining clean and sanitary environments to avoid sources and transmission of infection; and addressing any infection control issues identified by public health authorities for The James; and

WHEREAS Christina Liscynesky, MD, is qualified through education, training, and experience in infection prevention and control; and

WHEREAS David Cohn, MD, MBA, the Chief Medical Officer for The James, and Kris Kipp, MSN, RN, the Executive Director, Patient Services, and Chief Nursing Officer for The James, recommended that Dr. Liscynesky serves as the leader responsible for the Infection and Prevention Control Program for The James by letter (attached) dated June 4, 2020; and

WHEREAS on July 28, 2020, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve Dr. Liscynesky serve as the leader responsible for the Infection and Prevention Control Program for The James:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves Dr. Liscynesky serve as the leader responsible for the Infection Prevention and Control Program at The James.

(See Attachment XI for background information, page 229)

THE OHIO STATE UNIVERSITY

15. Resolution No. 2021-37, Antimicrobial Stewardship Program at Ohio State University Hospitals d/b/a Wexner Medical Center

Synopsis: Approval of the appointment of the Medical Director responsible for the Antimicrobial Stewardship Program for the hospitals at the Ohio State University Hospitals d/b/a OSU Wexner Medical Center, including: Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital, is proposed.

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

WHEREAS the Medical Director of the Antimicrobial Stewardship Program is responsible for managing and directing the program by: coordinating all components of the hospitals responsible for antibiotic use and resistance, documenting the evidence-based use of antibiotics in all departments and services, and documenting improvements in proper antibiotic use at the Ohio State University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital; and

WHEREAS Kurt Stevenson, MD, is qualified through education, training, and experience in infectious diseases and antibiotic stewardship; and

WHEREAS Andrew Thomas, MD, the Chief Medical Officer for the OSU Wexner Medical Center, and Robert Weber, PharmD, MS, BCPS, FASHP, FNAP, the Administrator for Pharmacy Services for the OSU Wexner Medical Center, recommended that Dr. Stevenson serves as the Medical Director responsible for the Antimicrobial Stewardship Program by letter (attached) dated June 19, 2020; and

WHEREAS on July 28, 2020, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve Dr. Stevenson to serve as the Medical Director responsible for the Antimicrobial Stewardship Program for University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves Dr. Stevenson as the Medical Director responsible for the Antimicrobial Stewardship Program for University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital.

(See Attachment XII for background information, page 230)

THE OHIO STATE UNIVERSITY

16. Resolution No. 2021-38, Antimicrobial Stewardship Program at The Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute

Synopsis: Approval of the appointment of a leader responsible for the Antimicrobial Stewardship Program for the hospitals at the Ohio State Comprehensive Cancer Center — James Cancer Hospital and Solove Research Institute, is proposed.

WHEREAS the mission of The James is *to eradicate cancer from individuals' lives by generating knowledge and integrating groundbreaking research with excellence in education and patient-centered care*; and

WHEREAS the leader of Antimicrobial Stewardship Program is responsible for managing and directing the program by: coordinating all components of the hospitals responsible for antibiotic use and resistance, documenting the evidence-based use of antibiotics in all departments and services, and documenting improvements in proper antibiotic use for The James; and

WHEREAS Mark Lustberg, MD, PhD is qualified through education, training, and experience in infectious diseases and antibiotic stewardship; and

WHEREAS David Cohn, MD, MBA, the Chief Medical Officer for The James, Robert Weber, PharmD, MS, BCPS, FASHP, FNAP, the Administrator for Pharmacy Services for The James, recommended that Dr. Lustberg serves as the leader responsible for the Antimicrobial Stewardship Program by letter (attached) dated June 4, 2020; and

WHEREAS on July 28, 2020, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve Dr. Lustberg serve as the leader responsible for the Antimicrobial Stewardship Program at The James:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves Dr. Lustberg serve as the leader responsible for the Antimicrobial Stewardship Program at The James.

(See Attachment XIII for background information, page 231)

Action: Upon the motion of Dr. Paz, seconded by Ms. Krueger, the board adopted the foregoing motions by unanimous voice vote with the following members present and voting: Mr. Wexner, Mrs. Wexner, Ms. Krueger, Dr. Fujita, Mr. Zeiger, Mr. Steinour, Mr. Schottenstein, Ms. Hilsheimer, Mr. Heminger, Dr. Paz and Mr. Papadakis. Dr. McPheron was not present for this vote.

EXECUTIVE SESSION

It was moved by Mrs. Wexner, and seconded by Dr. Paz, that the board recess into executive session to consider business-sensitive trade secrets required to be kept confidential by federal and state statutes, and to discuss personnel matters involving the appointment, employment and compensation of public officials, which are required to be kept confidential under Ohio law.

A roll call vote was taken, and the board voted to go into executive session, with the following members present and voting: Mr. Wexner, Mrs. Wexner, Ms. Krueger, Dr. Fujita, Mr. Zeiger, Mr. Heminger, Mr. Schottenstein, Ms. Hilsheimer, Dr. Paz and Mr. Papadakis. Dr. McPheron and Mr. Steinour were not present for this vote.

The board entered executive session at 8:36 a.m. and reconvened in a special public session at 11:45 a.m.

Wexner Medical Center
Financial Report
Public Session

August 26, 2020

FY20 Year in Review

The Ohio State University Health System

Consolidated Statement of Operations
For the YTD ended: June 30, 2020
(in thousands)

OSUHS	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	$ 3,214,279	$ 3,354,033	$ (139,754)	-4.2%	$ 3,239,926	-0.8%
Operating Expenses						
Salaries and Benefits	1,459,997	1,449,736	(10,261)	-0.7%	1,383,491	-5.5%
Resident/Purchased Physician Services	116,598	116,331	(267)	-0.2%	112,997	-3.2%
Supplies	359,526	360,970	1,444	0.4%	355,305	-1.2%
Drugs and Pharmaceuticals	419,162	424,162	5,000	1.2%	388,591	-7.9%
Services	323,465	333,440	9,975	3.0%	311,792	-3.7%
Depreciation	171,806	173,879	2,073	1.2%	164,230	-4.6%
Interest	31,941	31,941	-	0.0%	34,981	8.7%
Shared/University Overhead	61,900	61,900	-	0.0%	60,834	-1.8%
Total Expense	2,944,396	2,952,360	7,964	0.3%	2,812,221	-4.7%
Gain (Loss) from Operations (pre MCI)	269,883	401,673	(131,790)	-32.8%	427,705	-36.9%
Medical Center Investments	(173,749)	(173,749)	-	0.0%	(150,000)	-15.8%
Income from Investments	22,272	16,439	5,833	35.5%	6,355	250.5%
Other Gains (Losses)	162,740	18,700	144,040	---	(307)	---
Excess of Revenue over Expense	$ 281,129	$ 263,063	$ 18,066	6.9%	$ 283,753	-0.9%

The OSU Wexner Medical Center

Combined Statement of Operations
For the YTD ended: June 30, 2020
(in thousands)

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Revenue	$4,326,767	$4,323,743	$ 3,024	0.1%	$4,149,612	4.3%
Operating Expenses						
Salaries and Benefits	2,268,323	2,252,956	(15,367)	-0.7%	2,099,310	-8.1%
Resident/Purchased Physician Services	116,598	116,331	(267)	-0.2%	112,997	-3.2%
Supplies	401,802	403,816	2,014	0.5%	396,723	-1.3%
Drugs and Pharmaceuticals	428,669	435,096	6,427	1.5%	399,288	-7.4%
Services	491,789	498,675	6,886	1.4%	467,915	-5.1%
Depreciation	194,906	192,525	(2,381)	-1.2%	187,557	-3.9%
Interest/Debt	42,930	42,985	55	0.1%	46,400	7.5%
Shared/University Overhead	20,189	26,761	6,572	24.6%	54,786	63.1%
Other Operating Expense	26,683	36,687	10,004	27.3%	39,320	32.1%
Medical Center Investments	3,659	22,291	18,632	83.6%	1,117	-227.6%
Total Expense	3,995,548	4,028,123	32,575	0.8%	3,805,413	-5.0%
Excess of Revenue over Expense	$ 331,217	$ 295,620	$ 35,597	12.0%	$ 344,199	-3.8%
Financial Metrics						
Integrated Margin Percentage	7.7%	6.8%	0.8%	12.0%	8.3%	-7.7%
Adjusted Admissions	127,332	130,511	(3,179)	-2.4%	127,723	-0.3%
Operating Revenue per AA	$ 25,243	$ 25,699	$ (456)	-1.8%	$ 25,367	-0.5%
Total Expense per AA	$ 23,124	$ 22,622	$ (502)	-2.2%	$ 22,018	-5.0%

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

The OSU Wexner Medical Center

Combined Balance Sheet
As of: June 30, 2020
(in thousands)

	June 2020	June 2019	Change
Cash	$ 1,770,078	$ 1,213,913	$ 556,165
Net Patient Receivables	379,121	458,277	(79,156)
Other Current Assets	544,594	483,078	61,516
Assets Limited as to Use	421,698	420,097	1,601
Property, Plant & Equipment - Net	1,758,215	1,582,773	175,442
Other Assets	462,897	464,033	(1,136)
Total Assets	$ 5,336,603	$ 4,622,171	$ 714,432
Current Liabilities	$ 768,652	$ 399,709	$ 368,943
Other Liabilities	136,546	113,432	23,114
Long-Term Debt	665,906	728,277	(62,371)
Net Assets - Unrestricted	3,081,226	2,723,090	358,136
Net Assets - Restricted	684,274	657,664	26,610
Liabilities and Net Assets	$ 5,336,603	$ 4,622,171	$ 714,432

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.

FY21 Budget Update
Combined Medical Center

The OSU Wexner Medical Center

Combined Income Statement
For the Years ended June 30

	Actual 2020	Budget 2021	% Change
OPERATING STATEMENT (in thousands)			
Total Operating Revenue	$ 4,183,500	$ 4,542,323	8.6%
Operating Expenses			
Salaries and Benefits	2,333,646	2,471,323	5.9%
Supplies and Pharmaceuticals	813,026	869,789	7.0%
Services	477,618	494,455	3.5%
Depreciation	194,906	208,527	7.0%
Interest/Debt	42,930	40,243	-6.3%
Other Operating Expense	(13,503)	150,386	-1213.7%
Medical Center Investments	3,659	13,043	256.4%
Total Expense	3,852,283	4,247,766	10.3%
Excess of Revenue over Expense	$ 331,217	$ 294,557	-11.1%

The OSU Wexner Medical Center

Combined Income Statement
For the Years ended June 30

(in thousands)	Actual 2020	Budget 2021	% Change
Health System			
Revenues	$ 3,214,279	$ 3,490,140	8.6%
Expenses	2,933,149	3,215,602	9.6%
Net	281,129	274,538	-2.3%
OSUP			
Revenues	$ 483,031	$ 537,535	11.3%
Expenses	475,364	530,558	11.6%
Net	7,667	6,977	-9.0%
COM/OHS			
Revenues	$ 486,190	$ 514,648	5.9%
Expenses	443,769	501,606	13.0%
Net	42,421	13,042	-69.3%
Total Medical Center			
Revenues	$ 4,183,500	$ 4,542,323	8.6%
Expenses	3,852,283	4,247,766	10.3%
Net	331,217	294,557	-11.1%

Attachment III

Project Data Sheet for Board of Trustees Approval

Morehouse – Chiller and Electrical Distribution Phase 2

OSU-170841 (CNI# 17000112)

Project Location: Morehouse Medical Plaza - Tower

- **approval requested and amount**

increase professional services	$0.1M
increase construction	$0.6M
total requested	$0.7M

- **project budget**

professional services	$0.4M
construction w/contingency	$4.3M
total project budget	$4.7M

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

- **project schedule**

design/bidding	01/17 – 12/19
construction	12/19 – 03/21
BoT approval	08/20
facility opening	04/21

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

- **planning framework**
  - this project is included in the FY 2018 Capital Investment Plan

- **project scope**
  - multi-phased project to enhance infrastructure and address aging building systems in support of clinic operations
  - this phase of the project will provide necessary chilled and hot water piping, pumps and mechanical room additions to the tower
  - the cost of the project originally did not require Board of Trustees approval. A revised approach to the mechanical room construction, due to existing building materials, resulted in a revised total project cost that requires Board of Trustee approval

- **approval requested**
  - approval is requested to increase professional services and construction contracts

- **project team**

University project manager:	Alexandra Radabaugh
AE/design architect:	CBLH
CM at Risk:	Regency

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

QUALITY LEADERSHIP COUNCIL

The Ohio State University Wexner Medical Center Clinical Quality Management, Patient Safety, & Service Plan

FY 2021

July 1, 2020 - June 30, 2021

Clinical Quality Management, Patient Safety, & Service Plan

ATTACHMENTS

The Ohio State University Wexner Medical Center

Clinical Quality Management, Patient Safety, and Service Plan

MISSION, VISION, AND VALUES:

Mission: To improve health in Ohio and across the world through innovation in research, education and patient care

Vision: By pushing the boundaries of discovery and knowledge, we will solve significant health problems and deliver unparalleled care

Values: Inclusiveness, Determination, Empathy, Sincerity, Ownership, and Innovation

- Inclusiveness
- Determination
- Empathy
- Sincerity
- Ownership
- Innovation

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. The Plan was developed in accordance with The Joint Commission (TJC) accreditation standards and the Center for Medicare & Medicaid Services (CMS) Conditions of Participation outlining a Quality Assurance and Performance Improvement (QAPI) program.

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. The plan includes quality, patient safety, and service goals for process improvement related to functions and processes that involve care in any clinical setting.

As part of the QAPI process, the organization provides oversight for contracted services. Each contract is categorized into one of four categories based on the goods or services provided: Professional Service, Supplies, Direct Patient Care, or directly relevant to a Condition of Participation. Once categorized, the appropriate evaluation for that contracted service category is utilized to evaluate the quality and performance improvement that has occurred or needs to occur. This evaluation is

reviewed annually by the Medical Staff Administrative Committee (MSAC) and then forwarded to the Quality and Professional Affairs Committee of the Governing Body **(Contract Evaluation Template Attachment I).**

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.

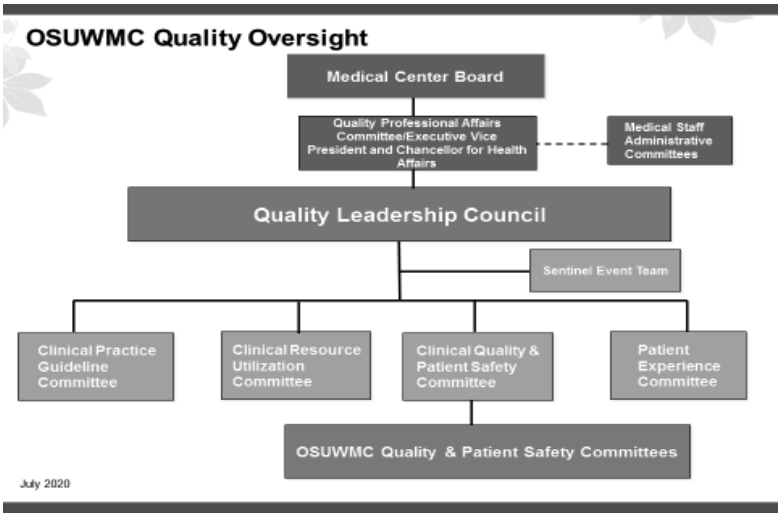
8) Provide appropriate levels of data transparency to both internal and external customers.

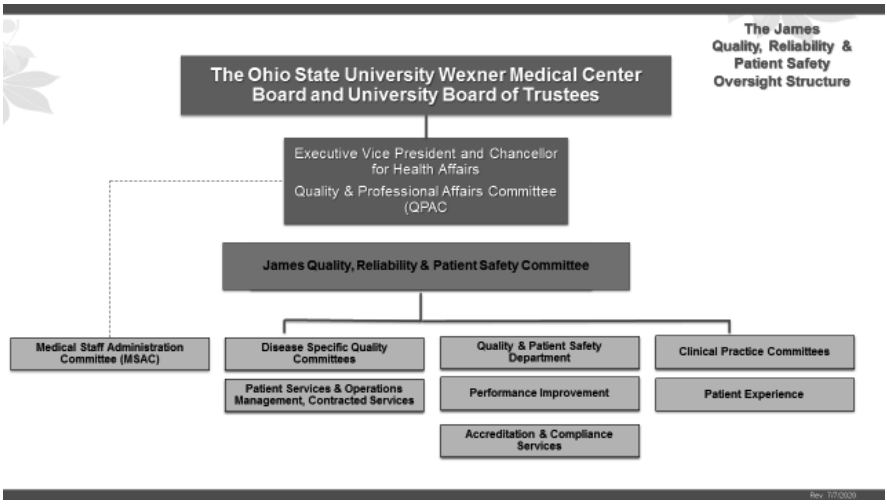
9) Assure processes involve an interdisciplinary teamwork approach.

10) Improve processes to prevent patient harm.

Structure for Quality Oversight:

The Quality Leadership Council serves as the single, multidisciplinary quality and safety oversight committee for the OSUWMC. The Quality 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.

Quality Leadership Council (QLC):
Composition: Refer to Medical Staff Bylaws and Rules and Regulations
Function: Refer to Medical Staff Bylaws and Rules and Regulations

The QLC is responsible for designing and implementing systems and initiatives to enhance clinical care, outcomes and the patient experience throughout the integrated health care delivery system. The QLC 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.

Clinical Practice Guideline Committee (CPGC)

Composition:

The CPGC 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 CPGC reports to QLC and shares pertinent information with the Medical Staff Administrative Committees. The CPGC provides guidance and support to all committees under the QLC 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 QLC 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 QLC 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 QLC, Health System Committee, and shares pertinent information with the Medical Staff Administrative Committees.

Function:

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

Key areas of focus:

- Availability and appropriateness of clinical resources and services

- 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. Advises 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 Administrative Director for Quality & Patient Safety, a member of the Physician Executive Council, a member of the Nurse Executive Council, representatives from Quality and Operations Improvement and Risk Management and other areas as necessary.

Function:

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.

Executive Vice President and Chancellor for Health Affairs

The Chancellor leads all seven health science colleges and the $3.7-billion Wexner Medical Center Enterprise which includes seven hospitals, a nationally ranked college of medicine, 20-plus research institutes, multiple ambulatory sites, an accountable care organization and a health plan. Additionally, the Chancellor serves as the Chief Executive Officer for Wexner Medical Center. The Chancellor serves in an ex-officio role for the Wexner Board of Trustees, as well as being the Chairman for the Quality and Professional Affairs committee which is a Board committee.

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.

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 Clinical Quality, Patient 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:

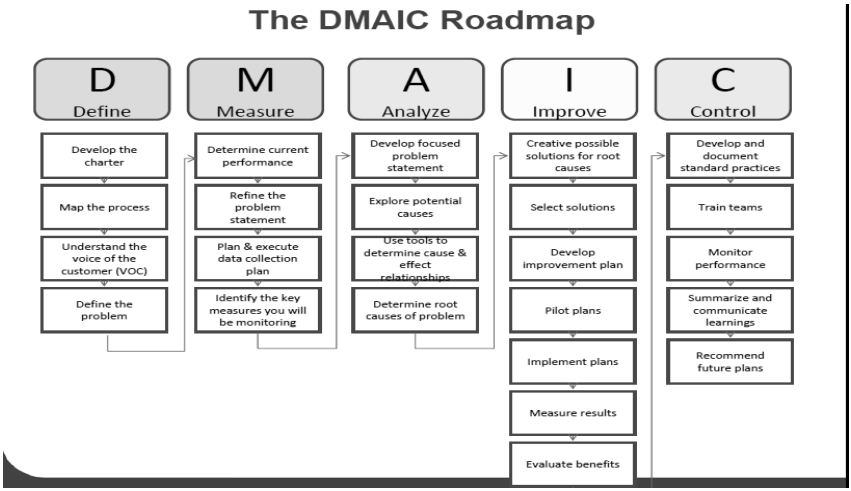
Systematic Approach/Model to Process Improvement

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.

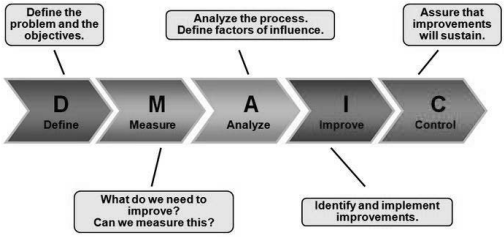
***The Process Improvement Toolkit**

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.



DMAIC Roadmap



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:

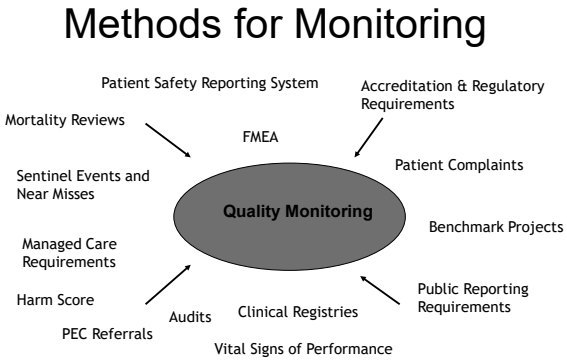
Any person, who is professionally involved in the care of a patient being reviewed, should not participate in peer review deliberations and voting. A person is professionally involved if they are responsible for patient care decision making either as a primary or consulting professional and/or have a 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 QLC 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. An annual report is given to the Compliance Committee to ensure all regulatory requirements are met.

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. Where appropriate, OSUWMC has adopted the philosophy of setting multi-year aspirational targets. Annual targets are set as steps to achieve the aspirational goal.

Surveillance 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 III].**

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

Patient Satisfaction Dashboard
The Patient Satisfaction dashboard is a set of 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
OSUWMC participates in various database systems, clinical registries and focused benchmarking projects to compare performance with that of peer institutions. Vizient, The US News & World 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 OSUWMC's ambition, 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.

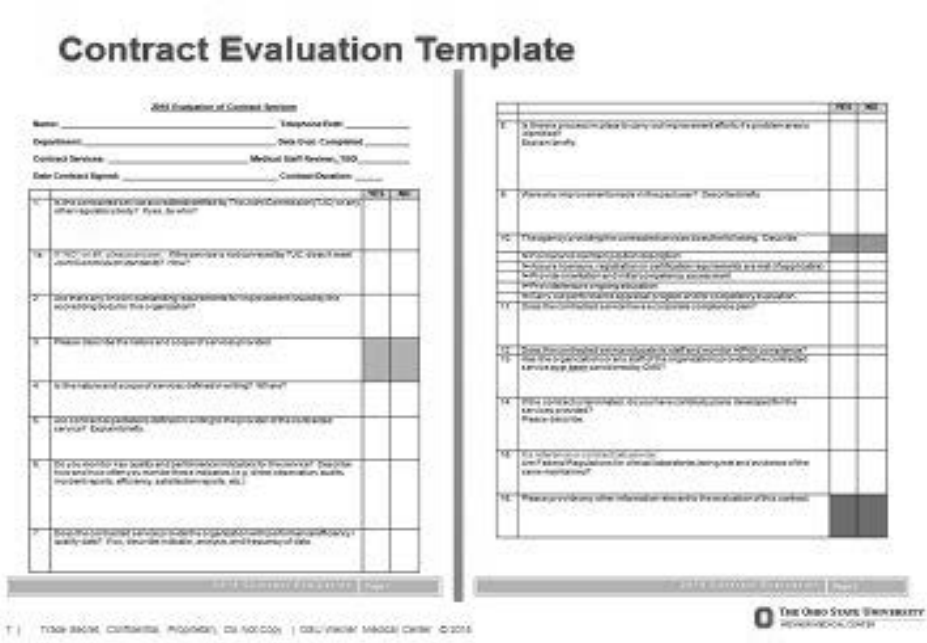
Purpose of Medical Staff Evaluation

- 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 Approval and Continuous Evaluation

The Clinical Quality Management, Patient Safety & Service Plan is approved by the QLC, the Medical Staff Administrative Committees, and the Medical Center Board on an annual basis. The annual evaluation includes a review of the program activities and an evaluation of the effectiveness of the structure. The progress and priorities are continuously evaluated throughout the year through monitoring outcomes, processes, and trends found in clinical reviews.

Attachment I: Contract Evaluation Template



Attachment II: Priority Criteria

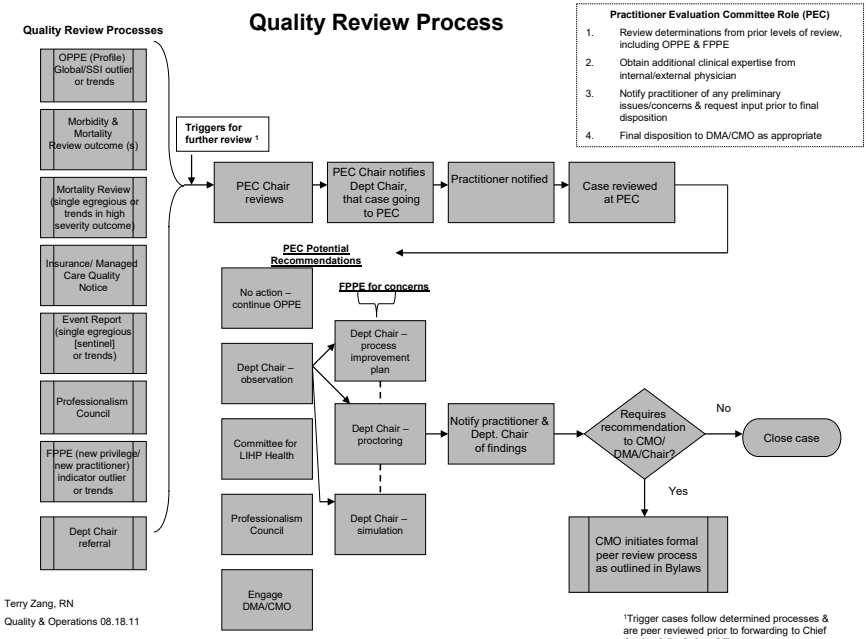
The following criteria are used to prioritize clinical value enhancement initiatives to ensure the appropriate allocation of resources.

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 III: QLC FY21 Priorities & Scorecard

Metric	FY 2020 Goal	Aspirational Goal	FY 2021 (Year 2) Goal
CAUTI	0.74	0.63	Keep FY 20 Goal (0.74)
CLABSI	0.89	0.66	Keep FY 20 Goal (0.89)
CDI	5.23	4.19	Keep FY 20 Goal (5.23)
SSI – COLO	4.94	3.49	Keep FY 20 Goal (4.94)
SSI – HYST	1.82	1.38	Keep FY 20 Goal (1.82)
MRSA	0.95	0.75	Keep FY 20 Goal (0.95)
PSI03 - Pressure Ulcer	0.81	0.29	Top Quartile (0.41)
PSI10 – Post-Op AKI	2.96	2.21	Keep FY 20 Goal (2.96)
PSI12 - Perioperative PE/DVT	3.54	3.05	5% Improvement 3.25
PSI13 - Post-op Sepsis	6.20	3.73	Keep FY 20 Goal (6.20)
Mortality Index (Medical Center)	0.79	0.69	Top Quartile (0.75)
Mortality Index (No James)	0.79	0.69	Top Quartile (0.75)
Overall Readmission Rate (No James)	10.80%	9.30%	3% Improvement (9.5%)
LOS Index (No James)	1.04	0.99	Keep FY 20 Goal (1.04)
HCAHPS Overall (Medical Center)	79.00%	90th percentile	85th Percentile (79.2%)
HCAHPS Overall (No James)	75.00%	90th percentile	Keep FY 20 Goal (75.0%)
CG-CAHPS Willingness to Recommend	92.30%	90th percentile	61st Percentile (92.8%)
Ambulatory HVF Composite	18 Points	20 points	19 points

Attachment IV: Quality Review Process & 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	1.06	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 MI	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	24.9%	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 29, 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**

The James

THE OHIO STATE UNIVERSITY
COMPREHENSIVE CANCER CENTER

The James Quality, Patient Safety, and Reliability Committee

The Arthur G. James Cancer Hospital and Richard J. Solove Research Institute
The Comprehensive Cancer Center
(The James and CCC)

Clinical Quality Management, Patient Safety, & Service Plan

FY 2021

July 1, 2020 through June 30, 2021

NIH NATIONAL CANCER INSTITUTE

Commission on Cancer® | Alliance of Dedicated Cancer Centers | NCCN National Comprehensive Cancer Network® | Magnet Recognized – American Nurses Credentialing Center

The James Clinical Quality, Patient Safety and Service Plan

The James Cancer Hospital & Solove Research Institute

Clinical Quality, Patient Safety, and Service 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, with patient service both directly and indirectly providing the foundation for teaching and research programs. This three-part mission and 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 Clinical Quality, Patient Safety and Services Plan (hereinafter The Plan) of The James Cancer Hospital/Solove Research Institute is our organization-wide approach to systematic assessment of process design and performance improvement targeting **quality** of care, patient safety, and patient experience/service. The 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. The Plan was developed in accordance with The Joint Commission (TJC) accreditation standards and the Center for Medicare & Medicaid Services (CMS) Conditions of Participation outlining a Quality Assurance and Performance Improvement (QAPI) program.

Scope:

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

As part of the QAPI process, the organization provides oversight for contracted services. Each contract is categorized into one of four categories based on the goods or services provided: professional service, supplies,

direct patient care, or directly relevant to a condition of participation. Once categorized, the appropriate evaluation for that contracted service category is utilized to evaluate the quality and performance improvement that has occurred or needs to occur. This evaluation is reviewed annually by the Medical Staff Administrative Committee (MSAC) and then forwarded to the Quality and Professional Affairs Committee of the Governing Body (See Attachment 1 Contract Evaluation Template Attachment).

Purpose:

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

Objectives:

The central objectives of The James Quality, Patient Safety and Service Plan are to:

1. Provide guidance for monitoring and evaluation of effort(s) in clinical care in order to sustain high performance and improved outcomes for all patients.
2. 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.
3. Assure overall compliance which meets or exceeds accreditation standards, state, federal and licensure regulations.
4. Provide information for adherence to evidence-based practice guidelines to standardize clinical care and reduce practice variation.
5. Improve patient satisfaction and perception of treatment, care and services by continuously identifying, evaluating, and improving performance based on needs, expectations, and satisfaction results.
6. Enhance the patient experience by providing safe and high-quality care at the best value.
7. Provide education to the governance, faculty and staff regarding quality management principles and processes for improving systems.
8. Provide appropriate levels of data transparency.
9. Assure quality and patient safety processes are developed with an approach of always involving trans-disciplinary teamwork.

Structure for Quality Oversight:

The James Quality, Patient Safety and Reliability Committee serves as the primary entity within The James to develop annual goals which are consistent with goals from the Health System. However, these goals are designed to target a specific focus for the cancer patient population and cancer research agendas. (See Figure 1).

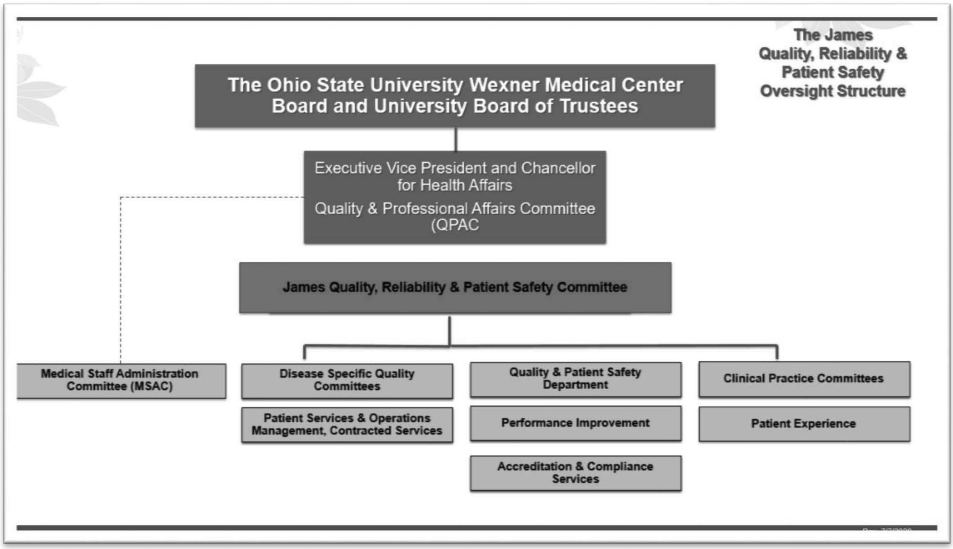


Figure 1 The James Quality, Patient Safety, & Reliability Oversight Structure

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 both for the Wexner Medical Center and The James including the delivery of patient services, quality assessment, improvement mechanisms, and monitoring achievement of quality standards and goals.

The 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 James 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; the Chief Medical Officers of the medical center and 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 James;

(2) Overseeing all patient care activity that is a part of The James, including, but not limited to, the hospital, clinics, ambulatory care facilities, and physicians' office facilities;

(3) Monitoring quality assurance performance in accordance with the standards set by The James;

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

(5) Reviewing and recommending to The 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 Board;

(11) Reviewing and resolving any petitions by the medical staff for amendments to any rule, regulation or policy presented by the Chief of Staff for The James on behalf of the medical staff pursuant to the medical staff bylaws and communicating such resolutions to The James Medical Staff Administrative Committee for further dissemination to the medical staff; and

(12) Such other responsibilities as assigned by the chair of the Board.

The James Medical Staff Administrative Committee (MSAC)

Composition: Refer to Medical Staff Bylaws and Rules and Regulations
Function: Refer to Medical Staff Bylaws and Rules and Regulations

The organized medical staff, under the direction of the Director of Medical Affairs/Chief Medical Officer, implements The Plan throughout the clinical departments. The 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 and the Commission on Cancer Sub-Committee (CoC) (See Figure 2)

Composition:
The James Quality, Patient Safety and Reliability Committee and American College of Surgeons – Commission on Cancer (CoC) Sub-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 Safety, Respiratory Therapy, Pharmacy/Medication Safety, Patient Experience, Social Work and Risk Management. This Committee reports to Executive Leadership and MSAC.
For the purposes of The Plan, Quality, Patient Safety and Reliability 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, as well as members from The James Quality, Patient Safety, and Reliability Committee. 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

1. Create a culture which promotes organizational learning and recognition of clinical quality (improving outcomes) and patient safety (reducing harm).
2. Develop and sustain a culture of safety which strives to eliminate individual blame or retribution for involvement in health care errors.
3. Assure compliance with patient safety-related accreditation standards.
4. Proactively identify risks to patient safety and creates a call-to-action to reduce risk with a focus on process and system improvement.
5. Oversee education & risk reduction strategies as they relate to Sentinel Event Alerts from TJC.
6. Evaluate standards of care and evidence-based practices and provide recommendations to improve clinical care and outcomes.
7. Ensure actions are taken to improve performance whenever an undesirable pattern or trend is identified.
8. 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.

9. Receive reports from Shared Services as they represent the metrics for quality and safety of care for the cancer patient population. (See Figure 3)
10. Maintain follow-up on Shared Services action plans as necessary for improving metrics for quality and safety of care for the cancer patient population.

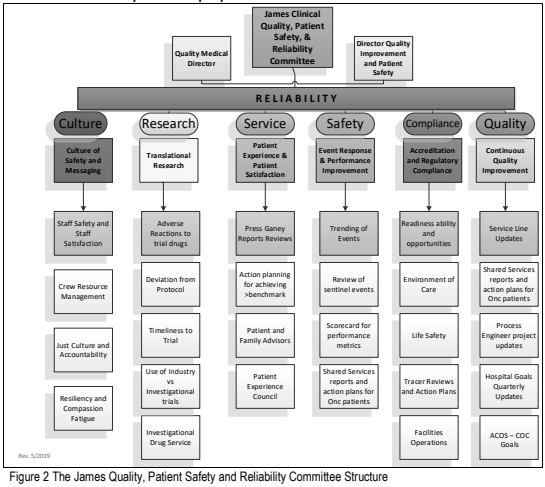


Figure 2 The James Quality, Patient Safety and Reliability Committee Structure

Clinical Practice Guideline Committee (CPGC)

Composition:

The CPGC 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 CPGC reports to QLC and shares pertinent information with the Medical Staff Administrative Committees. The CPGC provides guidance and support to all committees under The James Quality, Patient Safety and Reliability Committee 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.

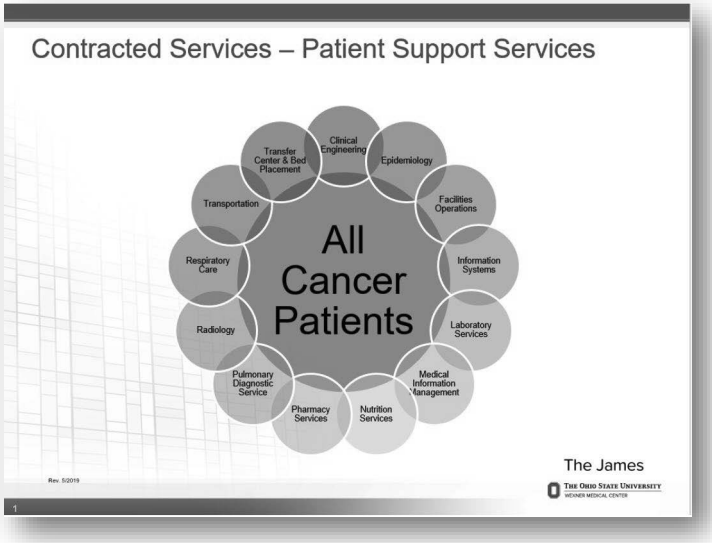


Figure 3 Contracted Services - Patient Support Services

The James 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. The Patient Experience Council has a liaison member connected to The James Quality, Patient Safety and Reliability committee.

Function:

1. Create a culture and environment to deliver exceptional patient experience consistent with the mission, vision and values focused largely on service quality.
2. 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.
3. Monitor publicly reported and other metrics used by various payers to ensure optimal reimbursement.
4. Provides guidance and oversight on patient experience improvement efforts ensuring effective deployment and accountability throughout the system.
5. Oversees the service excellence reward and recognition program.
6. Serves as a coordinating body for subcommittees working on specific aspects of the patient experience.

The James Utilization Management Committee (JUMC)

Composition:
The James Utilization Management Committee is co-chaired by a James Lead Physician Advisor and the Director of Patient Care Resource Management. Committee membership includes 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. The Director of Utilization Management is also a member of The James Quality, Patient Safety and Reliability committee.

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

Practitioner Evaluation Committee (PEC)

Composition:
The Practitioner Evaluation Committee (PEC) is the medical staff peer review committee that provides leadership in overseeing the peer review process. The PEC is composed of the Chair of the Clinical Quality and Patient Safety Committee, medical staff, and advanced practice providers from various business units & clinical areas as appointed by the Chief Medical Officer (CMO) of the Health System and of The James.

Function:
1. Provide leadership for the provider clinical quality improvement processes.
2. 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.
3. Give advice to the Director of Medical Affairs/CMO at The James regarding action plans to improve the quality and safety of clinical care.
4. Provide input to the Director for Advanced Practice Providers when an APP Peer Review is completed.
5. Develop follow up plans to ensure action is successful in improving quality and patient safety.

Health System Information Technology Steering Team (HSITS)

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 Committee

Composition:
The Sentinel Event Team includes membership from both The James and the OSUWMC. Membership from The James includes: the Executive Director Medical Affairs/Chief Medical Officer, the Quality Medical Director for The James, the Associate Medical Director of Perioperative Quality, and the Director of Quality & Patient Safety and Nursing Quality Director. Members from the Medical Center include: an Administrator, Chief Medical Officer, Chief Quality Officer, Associate Chief Quality and Patient Safety Officer, Associate Executive Director of Quality & Safety, a member of the Physician 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 Health System Chief Quality Officer. The SEDG membership includes the CQO, Associate CQO, 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, and RCA Workgroup Facilitator. The James Director of Quality and Patient Safety serves as the executive sponsor for the RCA, and receives the input from SEDG, collaborates with facilitators and physician leaders 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 compliance.

Function:
Make and approve recommendations on sentinel event determinations and teams, and action plans as received from the Sentinel Event Determination Group. Results of a sentinel event, significant event or near-miss information are considered confidential according to Ohio Revised Code Section 2305.25, and are not externally reported or released.

.

The James 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 experts.

Function:
Improve current practice or processes using traditional continuous process improvement tools such as rapid cycle improvements, LEAN principles and DMAIC/DMADV.

Roles and responsibilities

Quality management, patient safety, process improvements, 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 sixteen voting members, plus an additional group of university and medical center senior leaders who serve in ex-officio roles. The Quality & Professional Affairs Committee (QPAC) reports to the Wexner Medical Center Board and is responsible for, among other things, reviewing and evaluating at least annually The James Clinical Quality, Patient Safety, and Reliability Plan, along with goals and process improvements made for improved patient safety and quality programs, as well as granting clinical privileges for the credentialing of practitioners. The Board of Trustees and its committees meet throughout the year with focused agendas and presentations.

Executive Vice President and Chancellor for Health Affairs

The Chancellor leads all seven health science colleges and the $3.7-billion Wexner Medical Center Enterprise which includes seven hospitals, a nationally ranked college of medicine, 20-plus research institutes, multiple ambulatory sites, an accountable care organization and a health plan. Additionally, the Chancellor serves as the Chief Executive Officer for Wexner Medical Center. The Chancellor serves in an ex-officio role for the Wexner Board of Trustees, as well as being the Chairman for the Quality and Professional Affairs committee which is a Board committee.

Chief Executive Officer (CEO)

The CEO for The James reports to the Executive Vice President and Chancellor for Health Affairs and is responsible for providing leadership and oversight for the overall functions within The James. The CEO has authority of the Clinical Quality and Patient Safety Plan and works with all employees and medical staff to ensure safe care is delivered to our patients to achieve quality outcomes for each encounter.

Director of Medical Affairs/Chief Medical Officer (CMO)

The Director of Medical Affairs is the Chief Medical Officer for The James Cancer Hospital and provides leadership and strategic direction for the faculty, medical staff and other providers to ensure the delivery of high quality, cost-effective health care consistent with The James mission. The CMO has oversight of the medical staff responsibilities for progress towards goals and process improvements. The CMO is a member of The James Medical Staff Administrative Committee (MSAC), and is the medical director for provider credentialing within The James.

Quality Medical Director

The James Quality Medical Director reports to the Chief Medical Officer and is responsible for assisting the Quality Department with medical review for all patient safety and quality outcomes. This physician also works collaboratively with the health system Quality Department in determining sentinel and significant events, as well as reporting events when necessary through the peer review process. The Quality Medical Director serves as the co-chair to the Quality, Patient Safety and Reliability Committee and is a member of The James Medical Staff Administrative Committee (MSAC).

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

The James Executive Director for Clinical Services, Chief Nursing Officer provides leadership and oversight of The 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 Plan, organization-wide quality goals, and performance improvement achievements.

Associate Chief Nursing Officer (ACNO)

The James ACNO(s) report to the Executive Director of Clinical Services and CNO and provide senior leadership within the nursing organizational structure to influence nursing process and practices. The ACNO ensures that the overall James Quality, Patient Safety and Reliability Plan is utilized to assist with the development and implementation of The James Nursing Quality and Patient Safety Plan annually, as well as initiating the Nursing Strategic Plan. The ACNO has oversight of the nursing shared governance model and the nursing leadership which establishes and implements annual nursing-sensitive goals.

Director of Quality Improvement and Patient Safety and Nursing Quality

The Director for Quality Improvement and Patient Safety and Nursing Quality works directly with the executive leaders as well as the directors and managers of all areas in order to evaluate, plan and, improve patient safety and quality outcomes. The director reports to the Executive Director of Clinical Services and CNO and is responsible for the annual output of the annual The Plan. In addition, the Director has leadership oversight of the quality improvement goals, patient safety improvements, and works with the facilitators and team(s) charged for implementation of annual hospital level goals. The director serves as a co-chairperson for The James Quality, Patient Safety and Reliability committee.

Service Line Medical Director

Each service line Medical Director is responsible to review the recommendations from The Plan and implement quality goals and plans, along with maintaining 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 Plan and 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 Plan. In addition members serve on quality management/patient safety committees and/or continuous quality improvement teams throughout the year

Nursing Staff and Nursing Quality and Patient Safety Department

The James Executive Director for Patient Services, Chief Nursing Officer, as well as the Associate Chief Nursing Officer(s), 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 Plan as well as opportunities identified in collaboration with the OSUWMC-QLC Committee.

Nursing directors and managers are to implement recommendations and participate in 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 (CNS) 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.

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 Director and Management Teams

Each associate executive director, all service line administrators, department directors and managers are responsible to ensure the standards of care and service are maintained or exceeded within their department(s), 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 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 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.

The James Quality Improvement and Patient Safety Department

The primary responsibilities of The James Quality Improvement and Patient Safety Department is:

- Track and trend quality events as well as Sentinel Events.
- Coordinate and facilitate clinical quality management for improved outcomes.
- Monitor patient safety incidents and work with the management teams for elimination or reduction of risk/harm to patients.
- Improve patient care services by assuring the voice of the patient is heard throughout The James.
- Assist managers with evaluations of situations by use of the Just Culture algorithm and training.

While primary responsibility for the implementation and evaluation of clinical quality, patient safety, and service activities reside within each department/program, The James Quality and Patient Safety staff also serve as internal consultants for the development, evaluation and on-going monitoring of those activities. The James Quality Improvement & Patient Safety Departments including The James Operations Improvement 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.

The James Patient Experience/Guest Services Department

The primary responsibility of The James Patient Experience and Guest Services Department is to coordinate and facilitate a service oriented approach to providing healthcare. This is accomplished through both strategic

program developments 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. This 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 James Patient Experience and Guest Services 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.

Approach to Clinical Quality, Patient Safety & Reliability Management:

Philosophy of Patient Care Services

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

- A mission statement that outlines the relationship between patient care, research and teaching.
- Long-range, strategic planning conducted by leadership to determine the services to be provided.
- Establishing annual goals and objectives 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 appropriate to meet the needs of patients.
- Ongoing evaluation of services provided such as performance assessment and improvement activities, budgeting, and staffing plans.
- Integration of services through the following: continuous quality improvement teams; clinical interdisciplinary quality programs; performance assessment and improvement activities; communications through management operations meetings, nursing shared governance structure, Medical Staff Administrative Committee, administrative staff meetings; participation in OSUWMC and OSU governance structures and 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, Care of Self and Care of the Community.
- Embracing the principles of a Just Culture and honoring a Culture of Safety for all team members, faculty and staff.

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.
- ***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, however, it 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 has instituted the following guidelines as the approach to quality, safety, and reliability services:

- **Customer Focus:** Knowledge and understanding of internal and external customer needs and expectations.
- **Leadership & Governance:** Dedication to continuous improvement instilled by leadership and the Board.
- **Education:** Ongoing development and implementation of curricula for quality, safety, and reliability for all faculty, staff, volunteers, and students.
- **Involvement:** All team members must have mutual respect for the dignity, knowledge, and contributions of others. Everyone is engaged in improvement of processes where they work.
- **Data-driven decision making:** Decisions for quality, safety, and reliability are based on the knowledge derived from data.
- **Continuous Process Improvement:** Analysis of processes for design, redesign and to reduce variations are accomplished by use of an approach using science and LEAN/DMAIC. Measures and improvements are ongoing.

- **Just Culture:** Our framework of quality, safety, and reliability services are based on a culture that is open, honest, transparent, collegial, team-oriented, accountable, and non-punitive when system failures have occurred.
- **Personalized Health Care:** 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:

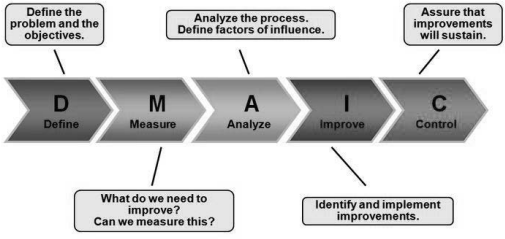
Model and Systematic Approach to Continuous Quality Improvement

The James Cancer Hospital 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:

- An organizational expectation the entire workforce is engaged and responsible for enhancing organizational performance and exemplary outcomes for our patients.
- Active involvement of multidisciplinary teams and committees focused on improving processes.
- 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 (See Fig 5), DMADV (See Fig 6), and Green and Lean (See Fig 4) project methods are used to focus our efforts.

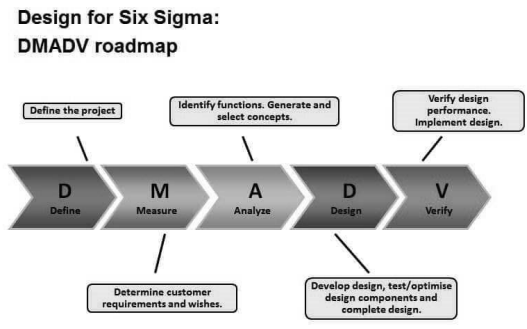
https://www.sixsigmacamp.com/lean-thinki 1

Figure 4 LEAN



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

Figure 5 DMAIC



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

Figure 6 DMADV

Consistent Level of Care

Certain elements of The 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.
- Cancer care delivery is based upon nationally recognized standards of care from the National Comprehensive Cancer Network (NCCN).
- 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. Cancer Program Analytics has worked with many departments to build and enhance quality and safety dashboards, as well as display of other important metrics to build on the equation of value for our patients.

Confidentiality

Confidentiality is essential to the quality management and patient safety process. All records and proceedings are confidential and are to be marked as such. Written reports, data, and meeting minutes are to be maintained in secure files. Access to these records is limited to appropriate administrative personnel and others as deemed

appropriate by legal counsel. As a condition of staff privilege and peer review, it is agreed that no record, document, or proceeding of this program is to be presented in any hearing, claim for damages, or any legal cause of action. This information is to be treated for all legal purposes as privileged information. This is in keeping with the Ohio Revised Code 121.22 (G)-(5) and Ohio Revised Code 2305.251.

Conflict of Interest

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 a 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 the hospital's mission, vision, and values.
2) Reflects areas for improvement in patient safety, appropriateness, quality, and/or medical necessity of patient care (e.g., high risk, serious events, problem-prone).
3) Has 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).

Determining Priorities

The James has a process in place to identify and direct resources toward quality management, patient safety, and service excellence activities. The prioritization criteria are reevaluated annually according to the mission and strategic plan. The leaders set performance improvement priorities and reevaluate annually in response to unusual or urgent events. Whenever possible, NCI, ADCC or other appropriate cancer specific benchmarks are utilized to compare performance metrics for The James, 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 and/or by evidence-based practices.

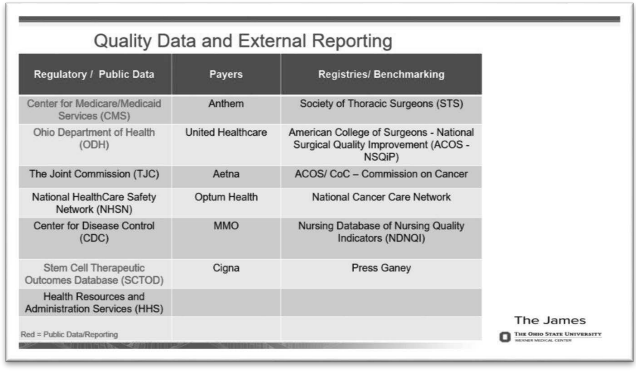
Data Measurement and Assessment

Determination of Needs

Data needs are determined according to improvement priorities and surveillance needs. The James 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 ongoing 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. (See Figure 7)



Quality Data and External Reporting

Regulatory / Public Data	Payers	Registries/ Benchmarking
Center for Medicare/Medicaid Services (CMS)	Anthem	Society of Thoracic Surgeons (STS)
Ohio Department of Health (ODH)	United Healthcare	American College of Surgeons - National Surgical Quality Improvement (ACOS - NSQiP)
The Joint Commission (TJC)	Aetna	ACOS/ CoC – Commission on Cancer
National HealthCare Safety Network (NHSN)	Optum Health	National Cancer Care Network
Center for Disease Control (CDC)	MMO	Nursing Database of Nursing Quality Indicators (NDNQI)
Stem Cell Therapeutic Outcomes Database (SCTOD)	Cigna	Press Ganey
Health Resources and Administration Services (HHS)		

Red = Public Data/Reporting

Figure 7 External 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 and Monitoring 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. (See Fig 8)

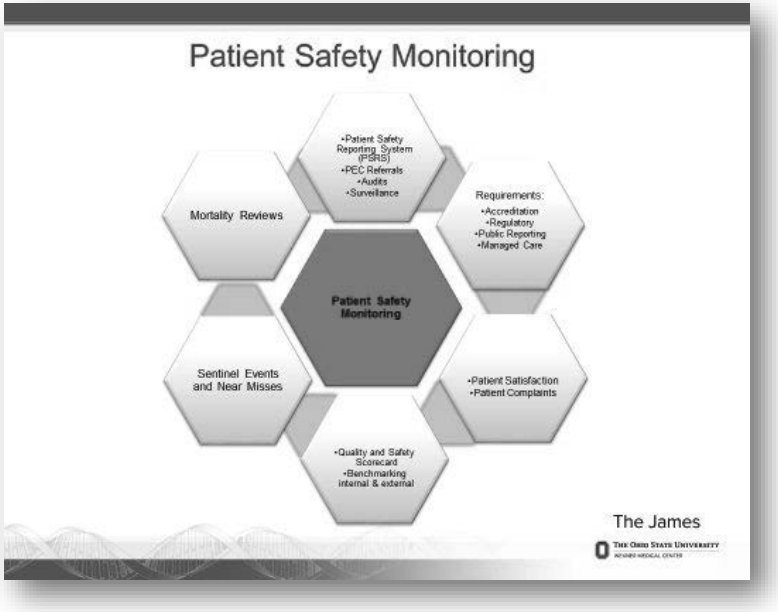


Figure 8 Quality & Patient Safety Monitoring

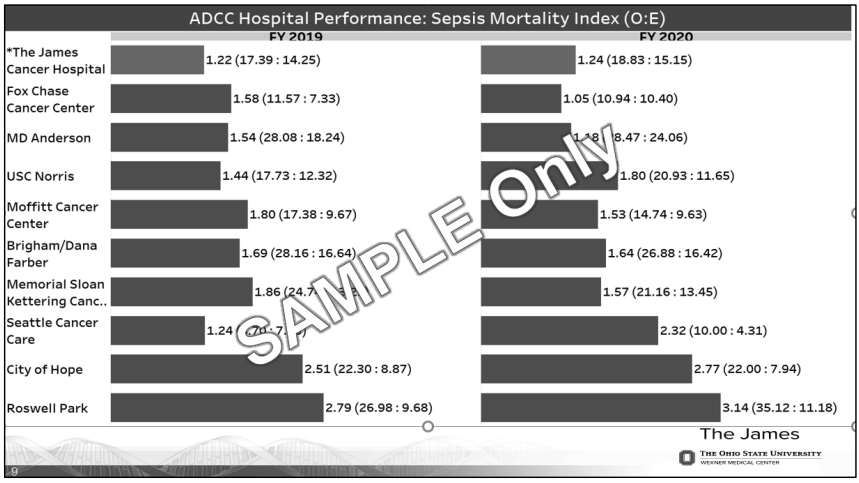
The James Quality and Patient Safety Scorecard

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 Quality and Safety Scorecard (hereinafter The Scorecard) is a set of indicators related to those events considered potentially preventable and which cause some level of harm to the patient. The Scorecard (see Figure 9) covers the areas such as sentinel events, mortality, and mortality related to sepsis, 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 and senior staff, the Chancellor, and the Quality and Professional Affairs Committee (QPAC) at the Wexner Medical Board. The indicators to be included in the scorecard are reviewed each year to represent the priorities of the Quality and Patient Safety program. The Patient Safety program (see Fig. 10) evaluates opportunities each quarter at The James Quality, Patient Safety and Reliability Committee, as well as at the Medical Staff Administrative Committee. Annually, safety goals are reviewed and adjusted as necessary by use of event trending, regulatory changes, needs identified from the culture of safety surveys and/or national cancer benchmarks.

James Quality & Patient Safety Scorecard



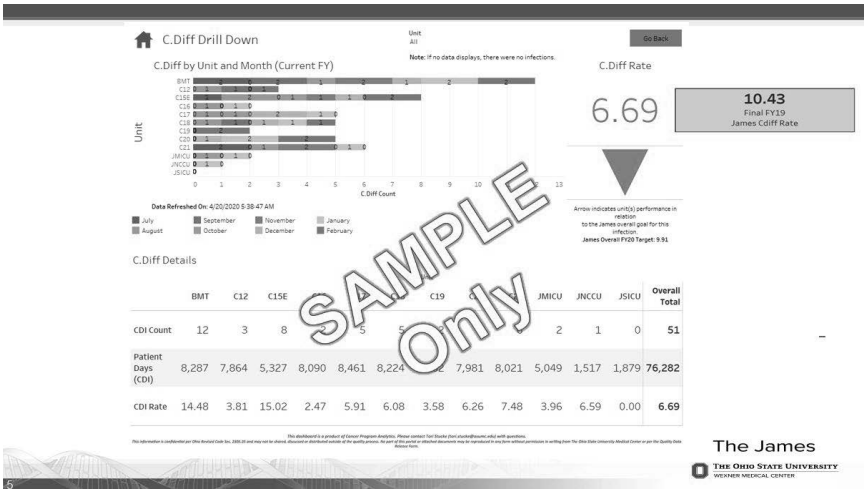
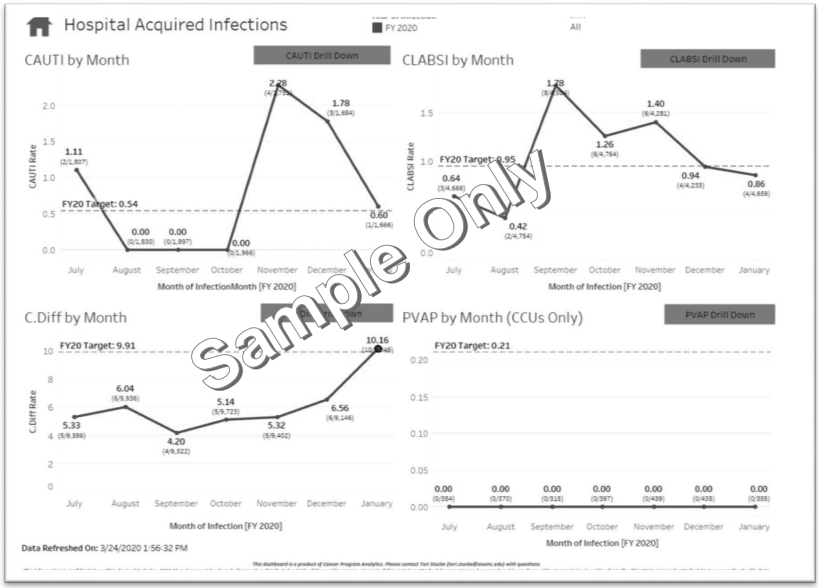


Figure 9 Quality & Patient Safety Scorecard example

Additionally, each month The James Nursing Leader Forum, Nurse Managers and other leaders along with Shared Governance Council leaders review the Nursing Quality and Patient Safety Scorecard. This report is also shared with The James Quality, Patient Safety, and Reliability Committee membership.



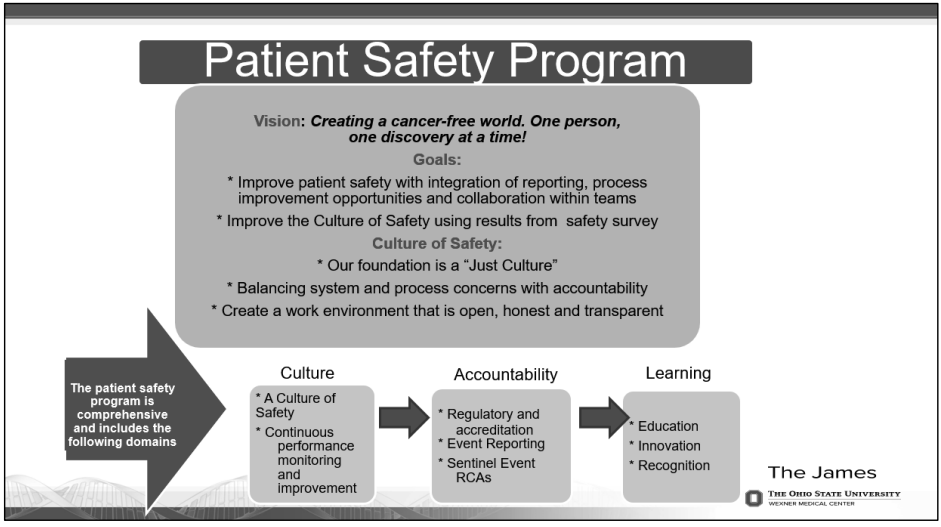


Figure 10 Patient Safety Program

The James Patient Satisfaction Portal/Dashboard

The Patient Satisfaction dashboard (See Fig 11) 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, and members of clinical and patient experience teams, Administration, including the Board. Performances on any of these indicators serve as annual goals for leaders.

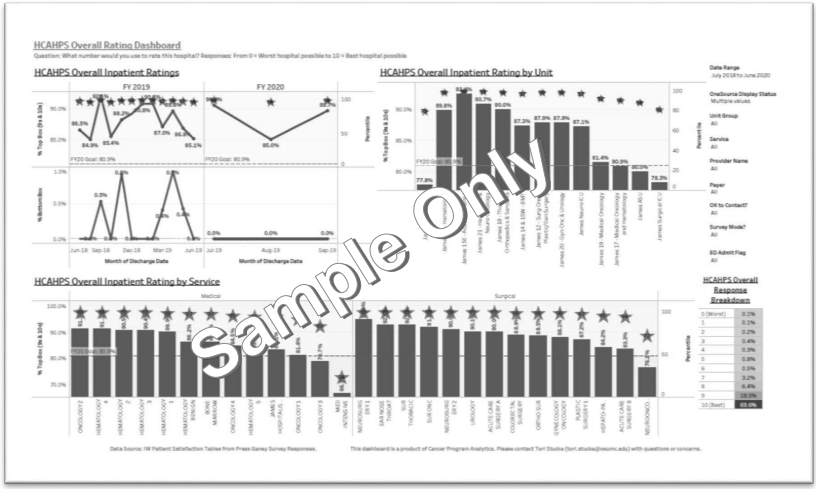


Figure 10 11 Patient Satisfaction Portal

Quality, Patient Safety & Reliability Staff Education

Education is identified as a key principle for providing safe, high quality care, and excellent service for our patients. There is ongoing 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)
- Curriculum Development within College of Medicine
- Websites (internal OneSource and external OSUMC)
- Patient Safety/Quality Lesson's Learned and Patient Safety Alerts

The James 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 and 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 cancer hospital peer institutions. The James Cancer Hospital utilizes and joins 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: Vizient, The US News Report, and the Ohio Department of Health, Press Ganey, and National Database of Nursing Quality Indicators.

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.

Provider Performance Based Process

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	2.83	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 29, 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

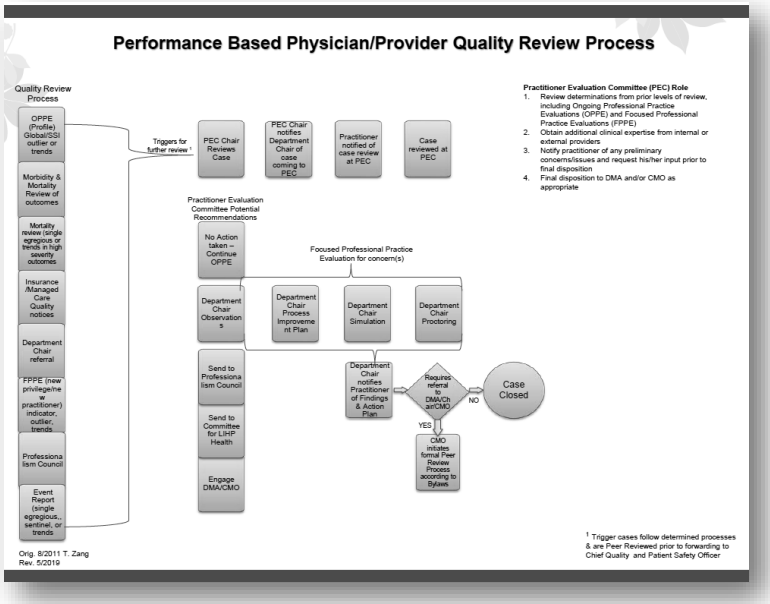
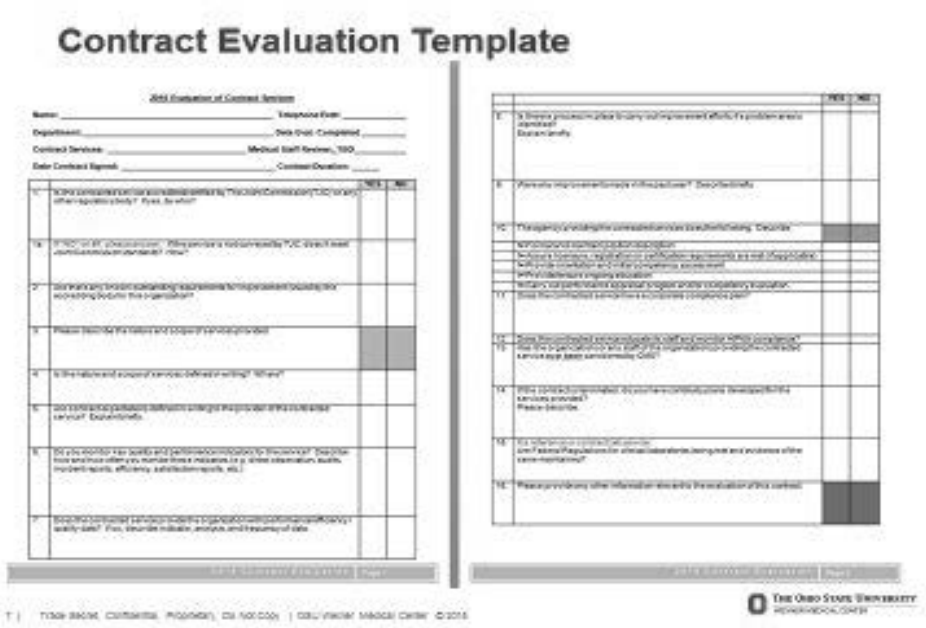


Figure12 Process for Provider Evaluations

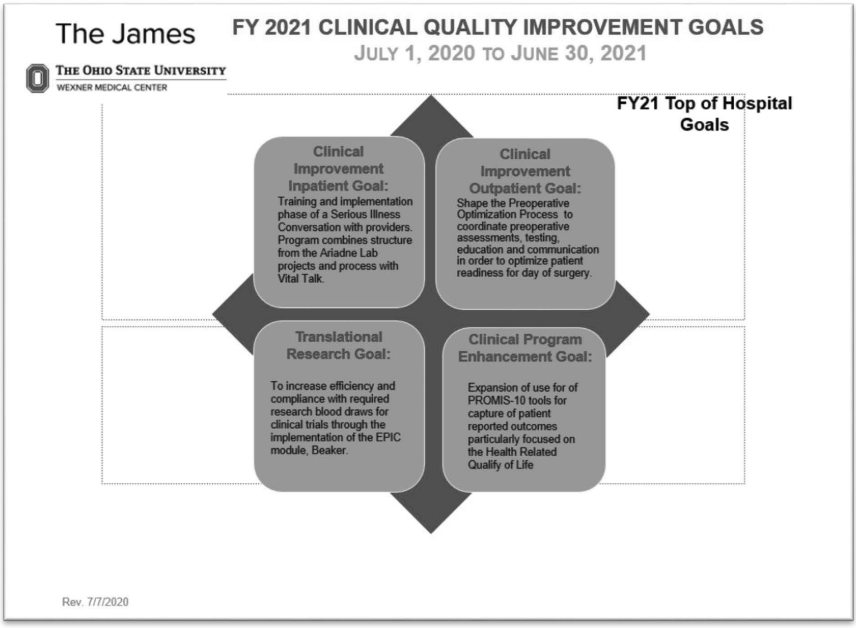
Annual Approval and Evaluation

The James Clinical Quality, Patient Safety and Service Plan is approved annually by The James Quality, Patient Safety and Reliability Committee, and forwarded to QPAC and the Board. The annual evaluation includes a review of the program activities and an evaluation of the effectiveness of the structure. Attachment 2 outlines the annual quality goals for FY21. Attachment 3 outlines the annual patient safety goals for FY21.

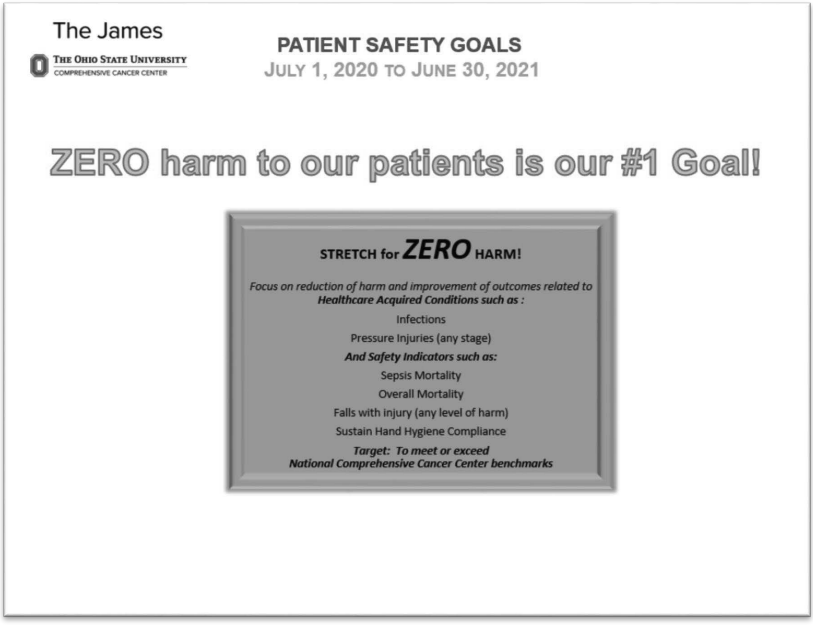
Attachment I: Contract Evaluation Template



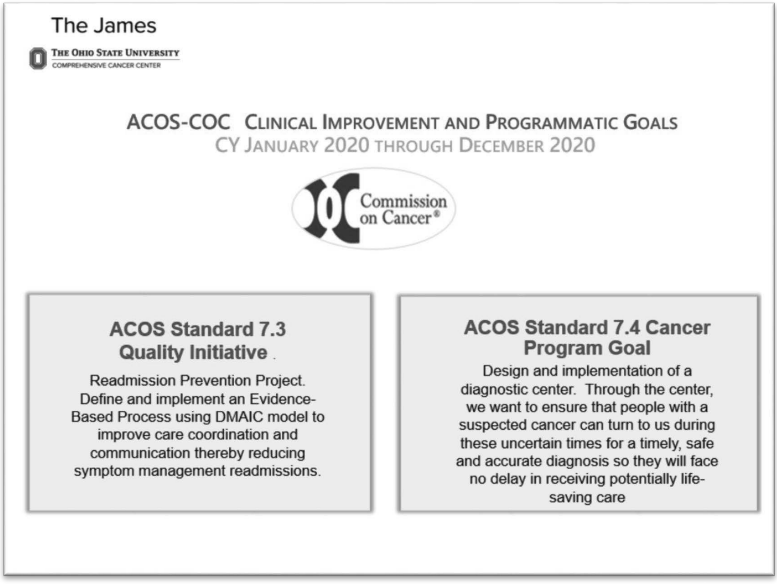
Attachment 2: FY2020 James Annual Patient Quality Goals



Attachment 3: FY2020 James Annual Patient Safety Goals



Attachment 4: CY 2020 Commission on Cancer Goals



Attachment VI

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Approvals:
MSAC- June 10, 2020
QPAC-
Wexner Medical Center Board -

TITLE: THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER (INCLUDING UNIVERSITY HOSPITAL, RICHARD M. ROSS HEART HOSPITAL, BRAIN AND SPINE HOSPITAL, DODD REHABILIATION HOSPITAL, HARDING HOSPITAL, AND EAST HOSPITAL) PLAN FOR PATIENT CARE SERVICES

University Hospital, Richard M. Ross Heart Hospital, Brain and Spine Hospital, Dodd Rehabilitation Hospital, Harding Hospital, and East Hospital (hereafter referred to as the Hospitals) plan for patient care services describes the integration of departments and personnel who provide care and services to patients based on the Hospitals' mission, vision, shared values and goals. The plan encompasses both inpatient and outpatient services of the Hospitals.

OHIO STATE UNIVERSTY WEXNER MEDICAL CENTER (OSUWMC) MISSION, VISION AND VALUES

Mission Statement:
To improve health in Ohio and across the world through innovation in research, education and patient care.

Vision Statement:
By pushing the boundaries of discovery and knowledge, we will solve significant problems and deliver unparalleled care.

Values:
Inclusiveness, Determination, Empathy, Sincerity, Ownership and Innovation

The mission, vision and values statements, developed by our staff members, physicians, governing body members and administration team members, complements and reflects the unique role the hospitals fulfill within The Ohio State University.

PHILOSOPHY OF PATIENT CARE SERVICES

In collaboration with the community, the Hospitals will provide innovative, personalized, and patient-focused care through:

a) A mission statement that outlines the synergistic relationship between patient care, research, and education;
b) Long-range strategic planning with hospital leadership to determine the services to be provided; including, but not limited to essential services as well as special areas of concentration (Cancer, Heart, Neurosciences, Transplant, Diabetes, Musculoskeletal, Digestive Diseases, and Critical Care);
c) Establishing annual goals and objectives that are consistent with the hospital mission, which are based on a collaborative assessment of needs;
d) Planning and design conducted by hospital leadership, which involves the potential communities to be served;
e) Provision of services that are appropriate to the scope and level required by the patients to be served based on assessment of need;
f) Ongoing evaluation of services provided through formalized processes; e.g., performance assessment and improvement activities, budgeting and staffing plans;
g) Integration of services through the following mechanisms: continuous quality improvement teams; clinical interdisciplinary quality programs; performance assessment and improvement activities; communications through management team meetings, administrative staff meetings, special forums, and leadership and employee education/development;

h) Maintaining competent patient care leadership and staff by providing education designed to meet identified needs;
i) Respect for each patient's rights and decisions as an essential component in the planning and provision of care; and,
j) Staff member behaviors reflect a philosophical foundation based on the values of The Ohio State University Wexner Medical Center.

THE HOSPITAL LEADERSHIP

The Hospital leadership is defined as the governing board, chancellor for health affairs, administrative staff, physicians and nurses in appointed or elected leadership positions. The Hospital leadership is responsible for providing a framework for planning health care services provided by the organization based on the hospital's mission and for developing and implementing an effective planning process that allows for defining timely and clear goals.

The planning process includes a collaborative assessment of our customer and community needs, defining a long range strategic plan, developing operational plans, establishing annual operating budgets and monitoring compliance, establishing annual capital budgets, monitoring and establishing resource allocation and policies, and ongoing evaluation of the plans' implementation and success. The planning process addresses both patient care functions (patient rights, patient assessment, patient care, patient and family education, coordination of care, and discharge planning) and organizational support functions (information management, human resource management, infection control, quality and safety, the environment of care, and the improvement of organizational performance).

The Hospital leadership works collaboratively with all operational and clinical managers and leaders to ensure integration in the planning, evaluation and communication processes within and between departments to enhance patient care services and support. This occurs informally on a daily basis and formally via interdisciplinary leadership meetings. The leadership involves department heads in evaluating, planning and recommending annual budget expenses and capital objectives, based on the expected resource needs of their departments. Department leaders are held accountable for managing and justifying their budgets and resource utilization. This includes, but is not limited to identifying, investigating and budgeting for new technologies and resources which are expected to improve the delivery of patient care and services.

Other leadership responsibilities include:

a) Communication of the organization's mission, goals, objectives and strategic plans across the organization;
b) Ensuring appropriate and competent direction, management and leadership of all services and/or departments;
c) Collaborating with community leaders and organizations to ensure services are designed to be appropriate for the scope and level of care required by the patients and communities served;
d) Supporting the patient's continuum of care by integrating systems and services to improve efficiencies and care from the patient's viewpoint;
e) Ensuring staffing resources are available to appropriately and effectively meet the needs of the patients served and to provide a comparable level of care to patients in all areas where patient care is provided;
f) Ensuring the provision of a uniform standard of patient care throughout the organization;
g) Providing appropriate job enrichment, employee development and continuing education opportunities which serve to promote retention of staff and to foster excellence in care delivery and support services;

h) Establishing standards of care that all patients can expect and which can be monitored through the hospital's quality assurance and performance improvement process;
i) Approving the organizational plan to prioritize areas for improvement, developing mechanisms to provide appropriate follow up actions and/or reprioritizing in response to untoward and unexpected events;
j) Implementing an effective and continuous program to improve patient safety;
k) Appointing appropriate committees, task forces, and other forums to ensure interdepartmental collaboration on issues of mutual concerns and requiring interdisciplinary input; and,
l) Supporting patient rights and ethical considerations.

ROLE OF THE CHIEF NURSE EXECUTIVE and PATIENT CARE SERVICES OFFICER –

The Chief Nurse Executive and Patient Care Services Officer is responsible for the practice of nursing at the OSU Wexner Medical Center by ensuring consistency in the standard of nursing practice across the clinical settings. As a member of the OSUWMC executive team, the Nurse Executive supports and facilitates an interdisciplinary team approach to the overall delivery of care to patients, families, and the community. This includes creating an environment in which collaboration is valued and excellence in clinical care, education, and research is promoted and achieved. The Nurse Executive leads quality, safety, and innovation initiatives in partnership with the Chief Quality and Patient Safety Officer. The Nurse Executive ensures the vision, strategic direction, and the advancement of the profession of Nursing at OSU Wexner Medical Center.

The Chief Nurse Executive and Patient Care Services Officer ensures the continued advancement of the nursing profession throughout the health system. Responsibly includes development of the nursing strategic plan in collaboration with health system executives to improve practice, education and research. The role includes responsibility for nursing performance improvement, program management, business operations, budgets, resource utilization and maintenance of the professional contract with the Ohio State University Nursing Organization (OSUNO).

ROLE OF THE CHIEF NURSING OFFICER

The Chief Nurse Officer (CNO) is responsible for the practice of nursing by ensuring consistency in the standard of nursing practice across the clinical settings. As a member of the OSUWMC nurse executive team, the CNO supports and facilitates an interdisciplinary team approach to the overall delivery of care to patients, families, and the community. The CNO leads quality, safety, and innovation initiatives in partnership with the Hospital Executive Directors.

The CNO is responsible for driving the nursing strategic plan to deliver excellent patient care. The role will include responsibility for nursing performance improvement, program management, business operations, budgets, resource utilization, and financial stewardship. The CNO ensures the vision, strategic direction, and the advancement of the profession of Nursing at OSUWMC under the direction of the Chief Nurse Executive.

ROLE OF THE ASSOCIATE CHIEF NURSING OFFICER

The Associate Chief Nursing Officer (ACNO) of each hospital is a member of the Nursing Executive Leadership team under the direction of the Chief Nursing Executive and Patient Care Services Officer, the Chief Nursing Officer and CEO/Executive Director of the business entities. The ACNO has the authority and responsibility for directing the activities related to the provision of nursing care in those departments defined as providing nursing care to patients.

The ACNO is responsible to plan, develop, implement, and oversee programs and projects designed to evaluate and improve clinical quality, safety, resource utilization and operations in all areas staffed by nurses. The role includes implementation of patient care services strategies to support efficiency, clinical effectiveness, clinical operations and quality improvement with interdisciplinary team members. The ACNO works with teams to develop projects, programs and implement system changes that promote care coordination across the health care continuum.

The Chief Nursing Executive and Patient Care Services Officer, CNO and ACNOs ensure the following functions are addressed:

a) Evaluating patient care programs, policies, and procedures describing how patients' nursing care needs are assessed, evaluated and met throughout the organization;
b) Developing and implementing the Plan for the Provision of Patient Care;
c) Participating with leaders from the governing body, management, medical staff and clinical areas in organizational decision-making, strategic planning and in planning and conducting performance improvement activities throughout the organization;
d) Implementing an effective, ongoing program to assess, measure and improve the quality of nursing care delivered to patients; developing, approving, and implementing standards of nursing practice, standards of patient care, and patient care policies and procedures that include current research/ literature findings that are evidence based;
e) Participating with organizational leaders to ensure that resources are allocated to provide a sufficient number of qualified nursing staff to provide patient care;
f) Ensuring that nursing services are available to patients on a continuous, timely basis; and
g) Reviewing and/or revising the Plan for the Provision of Patient Care Services on an annual basis.

DEFINITION OF PATIENT SERVICES, PATIENT CARE AND PATIENT SUPPORT

Patient Services are limited to those departments that have direct contact with patients. Patient services occur through organized and systematic throughput processes designed to ensure the delivery of appropriate, safe, effective and timely care and treatment. The patient throughput process includes those activities designed to coordinate patient care before admission, during the admission process, in the hospital, before discharge and at discharge. This process includes:

- ***Access in***: emergency process, admission decision, transfer or admission process, registration and information gathering, placement;
- ***Treatment and evaluation:*** full scope of services; and,
- ***Access out:*** discharge decision, patient/family teaching and counseling, arrangements for continuing care and discharge.

Patient Care encompasses the recognition of disease and health, patient teaching, patient advocacy, spirituality and research. The full scope of patient care is provided by professionals who are charged with the additional functions of patient assessment and planning patient care based on findings from the assessment. Providing patient services and the delivery of patient care requires specialized knowledge, judgment, and skill derived from the principles of biological, chemical, physical, behavioral, psychosocial and medical sciences. As such, patient care and services are planned, coordinated, provided, delegated, and supervised by professional health care providers who recognize the unique physical, emotional and spiritual (body, mind and spirit) needs of each person. Under the auspices of the Hospitals, medical staff, registered nurses and allied health care professionals function collaboratively as part of an interdisciplinary, personalized patient-focused care team to achieve positive patient outcomes.

Competency for patient caregivers is determined in orientation and at least annually through performance evaluations and other department specific assessment processes. Credentialed providers direct all medical aspects of patient care as delineated through the clinical privileging process and in accordance with the Medical Staff By-Laws. Registered nurses support the medical aspect of care by directing, coordinating, and providing nursing care consistent with statutory requirements and according to the organization's approved Nursing Standards of Practice and hospital-wide Policies and Procedures. Allied health care professionals provide patient care and services in keeping with their licensure requirements and in collaboration with physicians and registered nurses. Unlicensed staff may provide aspects of patient care or services at the direction of and under the supervision of licensed professionals.

Nursing Care (nursing practice) is defined as competently providing all aspects of the nursing process in accordance with Chapter 4723 of the Ohio Revised Code (ORC), which is the law regulating the Practice of Nursing in Ohio. The law gives the Ohio Board of Nursing the authority to establish and enforce the requirements for licensure of nurses in Ohio. This law also defines the practice of both registered nurses and licensed practical nurses. All of the activities listed in the definitions, including the supervision of nursing care, constitute the practice of nursing and therefore require the nurse to have a current valid license to practice nursing in Ohio.

Patient Support is provided by a variety of individuals and departments which might not have direct contact with patients, but which support the integration and continuity of care provided throughout the continuum of care by the hands-on care providers.

SCOPE OF SERVICES / STAFFING PLANS

Each patient care service department has a defined scope of service approved by the hospital's administration and medical staff, as appropriate. The scope of service includes:

- the types and age ranges of patients served;
- methods used to assess and meet patient care needs (includes services most frequently provided such as procedures, services, etc.);
- the scope and complexity of patient care needs (such as most frequent diagnosis);
- support services provided directly or through referral contact;
- the extent to which the level of care or service meets patient need (hours of operation if other than 24 hours a day/7days a week and method used for ensuring hours of operation meet the needs of the patients to be served with regard to availability and timeliness);
- the availability of necessary staff (staffing plans) and;
- recognized standards or practice guidelines, when available (the complex or high level technical skills that might be expected of the care providers).

Additional operational details and staffing plans may also be found in department policies, procedures and operational/performance improvement plans.

Staffing plans for patient care service departments are developed based on the level and scope of care provided, the frequency of the care to be provided, and a determination of the level of staff that can most appropriately (competently and confidently) provide the type of care needed. Nursing units are staffed to accommodate a projected average daily patient census. Unit management (including nurse manager and/or charge nurse) reviews patient demands to plan for adequate staffing. Staffing can be increased or decreased to meet patient needs. When the number of patients is high or the need is great, float staff assist in providing care. When staff availability is projected to be low due to leaves of absence, the unit manager and director may request temporary agency nurses. The Ohio State University Wexner Medical Center follows the Staffing Guidelines set by the American Nurses Association. In addition, we utilize staffing

recommendations from various specialty nursing organizations, including: ENA, ANCC, AACN, AORN, ASPN, NDNQI, and others.

The Administrative Team, in conjunction with the budget and performance measurement process, reviews all patient care areas staffing and monitors ongoing regulatory requirements. Each department staffing plan is formally reviewed during the budget cycle and takes into consideration workload measures, utilization review, employee turnover, performance assessment, improvement activities, and changes in customer needs/expectations. A variety of workload measurement tools may be utilized to help assess the effectiveness of staffing plans.

STANDARDS OF CARE

Patients of the Hospitals can expect that:

1) Staff will do the correct procedures, treatments, interventions, and care following the policies, procedures, and protocols that have been established. Efficacy and appropriateness of procedures, treatment, interventions and care provided will be demonstrated based on patient assessments/reassessments, standard practice, and with respect for patient's rights and confidentiality.
2) Staff will provide a uniform standard of care and services throughout the organization.
3) Staff will design, implement and evaluate systems and services for care delivery (assessments, procedures, treatments, interventions) which are consistent with a personalized health care focus and which will be delivered:
    a. With compassion, courtesy, respect and dignity for each individual without bias;
    b. In a manner that best meets the individualized needs of the patient;
    c. Coordinated through interdisciplinary collaboration, to ensure continuity and seamless delivery of care to the greatest extent possible; and,
    d. In a manner that maximizes the efficient use of financial and human resources, streamlines processes, decentralizes services, enhances communication, supports technological advancements and maintains patient safety.

Patient Assessment:
Individual patient care requirements are determined by assessments (and reassessments) performed by qualified health professionals. Each service within the organization providing patient care has defined the scope of assessment provided. This assessment (and reassessment) of patient care needs continues throughout the patient's contact with the hospital.

Coordination of Care:
Patients are identified who require discharge planning to facilitate continuity of medical care and/or other care to meet identified needs. Discharge planning is timely, is addressed at minimum during initial assessment as well as during discharge planning processes and can be initiated by any member of the interdisciplinary team. Patient Care Resource Managers or Case Managers coordinate patient care between multiple delivery sites and multiple caregivers; collaborate with physicians and other members of the care team to assure appropriate treatment plan and discharge care.

STANDARDS OF COMPETENT PERFORMANCE/STAFF EDUCATION

All employees receive an orientation consistent with the scope of responsibilities defined by their job description and the patient population to whom they are assigned to provide care. Ongoing education (such as in-services) is provided within each department. In addition, the Educational Development and Resource

Department provides annual mandatory education and provides appropriate staff education associated with performance improvement initiatives and regulatory requirements. Performance appraisals are conducted at least annually between employees and managers to review areas of strength and to identify skills and expectations that require further development.

CARE DELIVERY MODEL

The care delivery model is guided by the following goals:

- The patient and family will experience the benefits of the AACN Synergy model for patient care. This model is driven by the core concept that the patient and family needs influence the competencies and characteristics of the nursing care provided. The benefits include enhanced quality of care, improved service, appropriate length of hospitalization and minimized cost.
- Hospital employees will demonstrate values and behaviors consistent with the OSUWMC Buckeye Spirit set of core values. The philosophical foundation reflects a culture of inclusiveness, sincerity, determination, ownership, empathy and innovation.
- Effective communication will impact patient care by ensuring timeliness of services, utilizing staff resources appropriately, and maximizing the patient's involvement in his/her own plan of care.
- Configuring departmental and physician services to accommodate the care needs of the patient in a timely manner will maximize quality of patient care and patient satisfaction.
- The Synergy professional nursing practice model is a framework which reflects our underlying philosophy and vision of providing care to patients based on their unique needs and characteristics. Aspects of the professional model support:
  (1) matching nurses with specific skills to patients with specific needs to ensure "safe passage" to achieve the optimal outcome of their hospital stay;
  (2) the ability of the nurse to establish and maintain a therapeutic relationship with their patients;
  (3) the presence of an interdisciplinary team approach to patient care delivery. The knowledge and expertise of all caregivers is utilized to restore a patient to the optimal level of wellness based on the patient's definition;
  (4) physicians, nurses, pharmacists, respiratory therapists, case managers, dietitians and many other disciplines collaborate and provide input to patient care.
- The patient and family will be involved in establishing the plan of care to ensure services that accommodate their needs, goals and requests.
- Streamlining the documentation process will enhance patient care.

PATIENT RIGHTS AND ORGANIZATIONAL ETHICS

Patient Rights
In order to promote effective and compassionate care, the Hospitals' systems, policies, and programs are designed to reflect an overall concern and commitment to each person's dignity. All Hospital employees, physicians and staff have an ethical obligation to respect and support the rights of every patient in all interactions. It is the responsibility of all employees, physicians and staff of the Hospitals to support the efforts of the health care team, while ensuring that the patient's rights are respected. Each patient (and/or family member as appropriate) is provided a list of patient rights and responsibilities upon admission and copies of this list are posted in conspicuous places throughout the Hospitals.

Organizational Ethics
The Hospitals have an ethics policy established in recognition of the organization's responsibility to patients, staff, physicians and the community served. General principles that guide behavior are:

- Services and capabilities offered meet identified patient and community needs and are fairly and accurately represented to the public.
- Adherence to a uniform standard of care throughout the organization, providing services only to those patients for whom we can safely care for within this organization. The Hospitals do not

discriminate based age, ancestry, color, disability, gender identity or expression, genetic information, military status, national origin, race, religion, sex, gender, sexual orientation, pregnancy, or veteran status or ability to pay.
- Patients will be billed only for care and services provided.

Biomedical Ethics
A biomedical ethical issue arises when there is uncertainty or disagreement regarding medical decisions, involving moral, social, or economic situations that impact human life. A mechanism is in place to provide consultation in the area of biomedical ethics in order to:
- improve patient care and ensure patient safety;
- clarify any uncertainties regarding medical decisions;
- explore the values and principles underlying disagreements;
- facilitate communication between the attending physician, the patient, members of the treatment team and the patient's family (as appropriate); and,
- mediate and resolve disagreements.

INTEGRATION OF PATIENT CARE, ANCILLARY AND SUPPORT SERVICES

The importance of a collaborative interdisciplinary team approach, which takes into account the unique knowledge, judgment and skills of a variety of disciplines in achieving desired patient outcomes, serves as a foundation for integration. See Appendix A for a listing of ancillary and support services.

Open lines of communication exist between all departments providing patient care, patient services and support services within the hospitals, and as appropriate with community agencies to ensure efficient, effective and continuous patient care. Functional relationships between departments are evidenced by cross-departmental Performance Improvement initiatives as well as the development of policies, procedures, protocols, and clinical pathways and algorithms.

To facilitate effective interdepartmental relationships, problem solving is encouraged at the level closest to the problem at hand. Staff is receptive to addressing one another's issues and concerns and work to achieve mutually acceptable solutions. Supervisors and managers have the responsibility and authority to mutually solve problems and seek solutions within their spans of control; positive interdepartmental communications are strongly encouraged. Employees from departments providing patient care services maintain open communication channels and forums with one another, as well as with service support departments to ensure continuity of patient care, maintenance of a safe patient environment and positive outcomes.

CONSULTATIONS AND REFERRALS FOR PATIENT SERVICES

The Hospitals provide services as identified in the Plan for Providing Patient Care to meet the needs of our community. Patients whose assessed needs require services not offered are transferred to the member hospitals of The Ohio State University Wexner Medical Center in a timely manner after stabilization, or another quality facility (e.g., Nationwide Children's Hospital). Safe transportation is provided by air or ground ambulance with staff and equipment appropriate to the required level of care. Physician consultation occurs prior to transfer to ensure continuity of care. Referrals for outpatient care occur based on patient need.

INFORMATION MANAGEMENT PLAN

The overall goal for information management is to support the mission of The Ohio State University Wexner Medical Center. Specific information management goals related to patient care include:

- Develop and maintain an integrated information and communication network linking research, academic and clinical activities.
- Develop computer-based patient records with integrated clinical management and decision support.
- Support administrative and business functions with information technologies that enable improved quality of services, cost effectiveness, and flexibility.
- Build an information infrastructure that supports the continuous improvement initiatives of the organization.
- Ensure the integrity and security of the Hospital's information resources and protect patient confidentiality.

PATIENT CARE ORGANIZATIONAL IMPROVEMENT ACTIVITIES

All departments are responsible for following the Hospitals' Quality Assurance and Performance Improvement plan.

PLAN REVIEW

The Hospital Plan for Providing Patient Care will be reviewed regularly by the Hospitals' leadership to ensure the plan is adequate, current and that the Hospitals are in compliance with the plan. Interim adjustments to the overall plan are made to accommodate changes in patient population, redesign of the care delivery systems or processes that affect the delivery, level or amount of patient care required.

Appendix A: Scope of Services: Patient Ancillary and Support Services

Other hospital services that support the comfort and safety of patients are coordinated and provided in a manner that ensures direct patient care and services are maintained in an uninterrupted, efficient, and continuous manner. These support and ancillary services will be fully integrated with the patient care departments of the Hospitals:

DEPARTMENT	SERVICE
BEHAVIORAL EMERGENCY RESPONSE TEAM (BERT)	Expert team that provides innovative and quality care to patients with complex behavioral symptoms while working collaboratively with staff through consultation, education, and early intervention
CAPACITY MANAGEMENT AND THE TRANSFER CENTER	Monitors and supports all admissions, discharges, and transfers across OSUWMC. Ensures timely, safe, and individualized access to all patients and families through collaboration with the healthcare team.
CARDIAC PROCEDURAL	Cardiac procedural areas include both cardiac catheterization and electrophysiology. Procedures may be diagnostic or interventional.
CARDIOVASCULAR IMAGING SERVICES	Diagnostic and therapeutic procedures in cardiac MR/CT, Nuclear Medicine, Echocardiography, Vascular Imaging Stress Test. Cardiovascular Imaging Services can be provided at inpatient, outpatient, and emergency locations.
CASE MANAGEMENT	As part of the health care team, provides personalized care coordination and resource management with patients and families.
CHAPLAINCY AND CLINICAL PASTORAL EDUCATION	Assists patients, their families and hospital personnel in meeting spiritual needs through professional pastoral and spiritual care and education.
CLINICAL ENGINEERING	Routine equipment evaluation, maintenance, and repair of electronic equipment owned or used by the hospital; evaluation of patient owned equipment.
CLINICAL LABORATORY	Responsible for pre-analytic, analytic and post-analytic functions on clinical specimens in order to obtain information about the health of a patient as pertaining to the diagnosis, treatment, and prevention of disease; assisting care providers with clinical information related to patient care, education, and research.
COMMUNICATIONS AND MARKETING	Responsible for developing strategies and programs to promote the organization's overall image and specific products and services to targeted internal and external audiences. Handles all media relations, advertising, internal communications, special events and publications.
DECEDENT AFFAIRS	Provide support to families of patients who died & assist them with completing required disposition decisions. Ensure notification of the CMS designated Organ Procurement Agency (OPO) – Lifeline of Ohio (Lifeline). Promote & facilitate organ/eye/tissue donation by serving as the OSU hospital Lifeline Liaison. Analyze data provided by Lifeline regarding organ/tissue/eye donation.
DIAGNOSTIC TRANSPORTATION	Provision of on-site transportation services for patients requiring diagnostic, operative or other ancillary services.
DIALYSIS	Dialysis is provided for inpatients of the medical center within a dedicated unit unless the patient cannot be moved. In those instances, bedside dialysis will be administered.
EARLY RESPONSE TEAM (ERT)	Provides timely diagnostic and therapeutic intervention before there is a cardiac or respiratory arrest or an unplanned transfer to the Intensive Care Unit. Consists of a Critical Care RN and Respiratory Therapist who are trained to help patient care staff when there are signs that a patient's health is declining.
EDUCATIONAL DEVELOPMENT	Provides and promotes ongoing development and training experiences to all member of the OSU Wexner Medical Center community; provides staff enrichment programs,

DEPARTMENT	SERVICE
& RESOURCES	organizational development, leadership development, orientation and training, skills training, continuing education, competency assessment and development, literacy programs and student affiliations.
ENDOSCOPY	Provides services to patients requiring a nonsurgical review of their digestive tract.
ENVIRONMENTAL SERVICES	Provides quality monitoring for routine housekeeping in patient rooms. Routine housekeeping of nursing unit environment. Additional services upon request: extermination, wall cleaning, etc.
EPIDEMIOLOGY	Enhance the quality of patient care and the work environment by minimizing the risk of acquiring infection within the hospital setting.
FACILITIES OPERATIONS	Provide oversight, maintenance and repair of the building's life safety, fire safety, and utility systems. Provide preventative, repair and routine maintenance in all areas of all buildings serving patients, guests, and staff. This would include items such as electrical, heating and ventilation, plumbing, and other such items. Also providing maintenance and repair to basic building components such as walls, floors, roofs, and building envelope. Additional services available upon request.
FISCAL SERVICES	Works with departments/units to prepare capital and operational budgets. Monitors and reports on financial performance monthly.
HUMAN RESOURCES	Serves as a liaison for managers regarding all Human Resources information and services; assists departments with restructuring efforts; provides proactive strategies for managing planned change within the Health System; assists with Employee/Labor Relations issues; assists with performance management process; develops compensation strategies; develops hiring strategies and coordinates process for placements; provides strategies to facilitate sensitivity to issues of cultural diversity; provides HR information to employees, and establishes equity for payroll.
INFORMATION SYSTEMS	Work as a team assisting departments to explore, deploy and integrate reliable, state of the art Information Systems technology solutions to manage change.
MATERIALS MANAGEMENT	Routinely stocks supplies in patient care areas, distributes linen. Sterile Central Supply, Storeroom - upon request, distributes supplies/equipment not stocked on units.
MEDICAL INFORMATION MANAGEMENT	Maintains patient records serving the needs of the patient, provider, institution, and various third parties to health care.
NUTRITION SERVICES	Provides nutrition care and food service for Medical Center patients, staff, students, and visitors. Clinical nutrition assessment, care plan development, and consultation are available in both inpatient and outpatient settings. The Department provides food service to inpatients and selected outpatient settings in addition to operating a variety of retail café locations and acts as a liaison for vending and sub-contracted food services providers. Serve as dietetic education preceptors.
PATIENT ACCESS SERVICES	Coordinates registration/admissions with nursing management.
PATIENT EXPERIENCE	Develops programs for support of patient relations and customer service, and includes front-line services such as information desks.
PATIENT FINANCIAL SERVICES	Provides financial assistance upon request from patient/family. Also responsible for posting payments from patients and insurance companies among others to a patient's bill for services.
PERIOPERATIVE SERVICES	Perioperative Services include preoperative, intraoperative and postoperative care.
PHARMACY	Provides comprehensive pharmaceutical care through operational and clinical services. Responsible for medication distribution via central and satellite pharmacies, as well as 797 compliant IV compounding room and automated

DEPARTMENT	SERVICE
	dispensing cabinets. Some of the many clinical services include pharmacokinetic monitoring, renal and hepatic dose adjustments, and patient educational Specialist pharmacists also round with patient care teams to optimize medication regimens and serve as the team's primary medication information resource.
QUALITY AND OPERATIONS IMPROVEMENT	Provides an integrated quality management program and facilitates continuous quality improvement efforts throughout the medical center.
RADIOLOGIC SERVICES	Diagnostic and therapeutic procedures in MR, CT, X-ray, Fluoroscopy, Interventional Radiology, Ultrasonograpy. Radiologic Services can be provided at inpatient, outpatient, and emergency locations.
RESPIRATORY THERAPY	Provide all types of respiratory therapeutic interventions and diagnostic testing, by physician order, mainly to critically ill adults and neonates, requiring some type of ventilator support, bronchodilator therapy, or pulmonary hygiene, due to chronic lung disease, multiple trauma, pneumonia, surgical intervention, or prematurity. Provides pulmonary function testing and diagnostic inpatient and outpatient testing to assess the functional status of the respiratory system. Bronchoscopy and other diagnostic/interventional pulmonology procedures are performed to diagnose and/or treat abnormalities that exist in the airways, lung parenchyma or pleural space.
REHABILITATION SERVICES	Physical therapists, occupational therapists, speech and language pathologists, and recreational therapists evaluate and develop a plan of care and provide treatment based on the physician's referral. The professional works with each patient/family/caregiver, along with the interdisciplinary medical team, to identify and provide the appropriate therapy/treatment and education needed for the established discharge plan and facilitates safe and timely movement through the continuum of care.
RISK MANAGEMENT	Protect resources of the hospital by performing the duties of loss prevention and claims management. Programs include: Risk Identification, Risk Analysis, Risk Control, Risk Financing, Claims Management and Medical-Legal Consultation.
SAFETY	Handles issues associated with licensing and regulations, such as EPA and fire regulations.
SECURITY	Provides a safe and secure environment for patients, visitors, and staff members by responding to all emergencies such as workplace violence, fires, bomb threats, visitor/staff/patient falls, Code Blues (cardiac arrests) in public places, internal and external disasters, armed aggressors, or any other incident that needs an emergency response.
SOCIAL WORK SERVICES	Social Work services are provided to patients/families to meet their medically related social and emotional needs as they impact on their medical condition, treatment, recovery and safe transition from one care environment to another. Social workers provide psychosocial assessment and intervention, crisis intervention, financial counseling, discharge planning, health education, provision of material resources and linkage with community agencies. Consults can be requested by members of the treatment team, patients or family members.
VOLUNTEER SERVICES	Volunteer Services credential and place volunteers to fill departmental requests. Volunteers serve in wayfinding, host visitors in waiting areas, serve as patient / family advisors, and assist staff. Volunteer Services manage the patient mail & flower room, cultural support volunteer program, and the pet visitation program. Volunteer Services serve as a liaison for the Service Board auxiliary which annually grants money to department-initiated projects than enhance the patient and family experience.
WOUND CARE	Wound Care includes diagnosis and management for skin impairments.

Attachment VII

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

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

PLAN FOR THE SCOPE OF PATIENT CARE SERVICES

Prepared by: **ADMINISTRATION**

The Arthur G. James Cancer Hospital and Richard J. Solove Research Institute's plan for providing patient care services describes herein the integration of departments and personnel who provide comprehensive care and services to patients with a cancer diagnosis and their families based on the hospital's mission, vision, shared values and goal. The plan encompasses both inpatient and outpatient services of the hospital.

THE HOSPITAL MISSION, VISION, AND VALUES:

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

Vision: Create a cancer-free world, one person, and 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.

At The James, no cancer is routine. Our researchers and oncologists study the unique genetic makeup of each patient's cancer, understand what drives it to develop and then deliver the most advanced and targeted treatment for the individual patient. The James' patient-centered care is enhanced by our teaching and research programs. Our mission, and our staff are dedicated to its fulfillment and success, distinguishes The Arthur G. James Cancer Hospital and Richard J. Solove Research Institute as one of the nation's premier cancer treatment centers.

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Philosophy of Patient Care Services

The Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, in collaboration with the community, provides innovative and patient-focused multi-disciplinary sub-specialized cancer care through:

- Maintaining a mission which outlines the synergistic relationship between patient care, research, and teaching;
- Developing a long-range strategic plan with input from hospital leaders to determine the services and levels of care to be provided;
- Establishing annual goals and objectives that are consistent with the hospital mission, the strategic plan, and which are based on a collaborative assessment of patient/family and the community's needs;
- Planning and designing from the hospital leadership, involving the communities to be served;
- Providing individualized care and services appropriate to the scope and level required by each patient based on assessment of need;
- Evaluating ongoing services provided through formalized processes; such as performance assessment and improvement activities, budgeting and staffing plans;
- Integrating services through the following mechanisms: continuous quality improvement teams; clinical interdisciplinary quality programs; performance assessment and improvement activities; communications through management operations meetings, Division of Nursing governance structure, Medical Staff Administrative Committee, administrative staff meetings, participation in OSUWMC and Ohio State governance structures, special forums, and leadership and employee education/development;
- Maintaining competent patient care leadership and staff by providing education designed to meet identified needs;
- Respecting each patient's rights and their decisions as an essential component in the planning and provision of care; and
- Assuring that every staff member demonstrates behaviors which reflect a philosophical foundation based on the values of The James Cancer Hospital and Richard J. Solove Research Institute

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Hospital Leadership

The hospital leadership is defined as the governing board, the Chancellor, administrative staff, physicians, nurses, clinical, and operational leaders in appointed or elected leadership positions. The hospital leadership team is responsible for providing a framework to plan health care services that are to be provided by the organization based on the hospital's mission. Leadership responsibilities include developing and implementing a planning process that allows for defining timely and clear goals.

The planning process includes an assessment of our customer and community needs. This process begins with:

- Developing a long range strategic plan;
- Developing operational plans;
- Establishing annual operating and capital budgets, monitoring compliance;
- Establishing resource allocations and policies, and;
- Ongoing evaluation of each plan's implementation and success.

The planning process addresses both patient care functions (patient rights, patient assessment, patient care, patient safety, patient and family education, coordination of care, and discharge planning) and organizational support functions (information management, human resource management, infection control, quality, the environmentof care, and the improvement of organization performance).

The hospital leadership works collaboratively with all operational and clinical leaders to ensure there is integration of the planning, evaluation and communication processes both within and between departments in order to enhance patient care services and support. This occurs informally on a daily basis and formally via multi-disciplinary leadership meetings. The leadership team works with each department manager to evaluate, plan and recommend annual budget expenses and capital objectives, based on the expected resource needs of their department. Department leaders are accountable for managing and justifying their budgets and resource utilization. This includes, but is not limited to identifying, investigating and budgeting for new technologies and resources that are expected to improve the delivery of patient care and services.

Other leadership responsibilities include:

- Communicating the organization's mission, vision, goals, objectives and strategic plans across the organization;
- Ensuring appropriate and competent management and leadership of all services

and/or departments;

- Collaborating with community leaders and organizations to ensure services are designed to be appropriate for the scope and level of care required by thepatients and communities served;
- Supporting the continuum of care by integrating systems and services to improve efficiencies and care from the patient's viewpoint;
- Ensuring staff resources are available and competent to effectively meet the needs of the patients served and to provide a comparable level of care to patients in all areas where patient care is provided;
- Ensuring the provision of a uniform standard of patient care throughoutthe continuum of care;
- Providing appropriate job enrichment, employee development and continuing education opportunities that serve to promote retention of staff and to foster excellence in care delivery and support services;
- Establishing standards of care that all patients can expect and which can be monitored through the hospital's performance assessment and improvement plan;
- Approving the organizational plan to prioritize areas for improvement, developing mechanisms to provide appropriate follow up actions and/or reprioritizing in response to untoward and unexpected events;
- Implementing an effective and continuous program to improve patient safety;
- Appointing appropriate committees, task forces, and other forums to ensure interdepartmental collaboration on issues of mutual concerns and requiring interdisciplinary input; and,
- Supporting patient rights and ethical considerations.

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Role of the Executive Director, Clinical Services and Chief Nursing Officer

The Executive Director, Clinical Services and Chief Nursing Officer is a member of the Executive Leadership Team who has the requisite authority and responsibility for directing the activities related to the provision of care services in those departments defined as providing care to patients.

The Executive Director, Clinical Services and Chief Nursing Officer ensures the following functions are addressed:

- Evaluating patient care programs, policies, and procedures which describe how patients' care needs are assessed, evaluated, and met throughout theorganization;
- Implementing the Plan for the Provision of Patient Care;
- Participating with leaders from the governing body, medical staff and clinical areas in organizational decision-making, strategic planning and in planning and conducting performance improvement activities through the organization;
- Implementing an effective, ongoing program to assess, measure and improve the quality of care and safe outcomes of care provided for patients;
- Implementing standards of nursing practice, standards of patient care, and patient care policies and procedures that include current research and evidence based practice;
- Participating with organizational leaders to ensure that resources are allocated to provide sufficient number of qualified staff to provide patient care;
- Ensuring that services are available to patients on a continuous, timely basis; and
- Reviewing the Plan for the Providing Patient Care Services on an annual basis.

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Definition of Patient Services, Patient Care, Nursing Care, and Patient Support

Patient Services

Defined as those departments and care providers that have direct contact with patients. These services occur through organized and systematic through-put processes designed to ensure the delivery of appropriate, safe, effective and timely care and treatment. The patient through-put process includes those activities designed to coordinate patient care before admission, during the admission process, in the hospital, before discharge and at discharge. This process includes

- Access in: emergency process, admission decision, transfer or admission process, registration and information gathering, placement;
- Treatment and evaluation: full scope of services; and
- Access out: discharge decision, patient/family education and counseling, arrangements for continuing care and discharge.

Patient Care:

Encompasses the recognition of disease and health, and patient education which allows the patient to participate in their care, their own advocacy, and spirituality. The full scope of patient care is provided by professionals who perform the functions of assessing and planning patient care based on information gathered from the assessment as well as past medical history, social history and other pertinent findings. Patient care and services are planned, coordinated, provided, delegated and supervised by professional health care providers who recognize the unique physical, emotional and spiritual (body, mind and spirit) needs of each person. Under the auspices of the hospital, medical staff, registered nurses and allied health care professionals function collaboratively as part of an interdisciplinary, patient-focused care team in order to achieve positive patient outcomes and personalized care.

Competency for staff resources is determined during the orientation period and at least annually through performance evaluations and other department specific assessment processes. Physicians direct all aspects of a patient's medical care as delineated through the clinical privileging process and in accordance with the Medical Staff By-Laws. Registered Nurses support the medical aspect of care by assessing, directing, coordinating, and providing nursing care consistent with statutory requirements and according to the organization's approved Nursing Standards of Practice and hospital-wide policies and procedures. Allied health care professionals provide patient care and services keeping with their licensure requirements and in collaboration with physicians and registered nurses. Unlicensed staff may provide aspects of patient care or services at the direction of and under the supervision of licensed professionals.

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Nursing Care and Practice:

Defined as competently providing all aspects of the nursing process in accordance with Chapter 4723 of the Ohio Revised Code (ORC), which is the law regulating the Practice of Nursing in Ohio. This law gives the Ohio Board of Nursing the authority to establish and enforce the requirements for licensure of nurses in Ohio. This law defines the practice of both registered nurses and licensed practical nurses. All activities listed in the definitions, including the supervision of nursing care, constitute the practice of nursing and therefore require the nurse to have a current valid license to practice nursing in Ohio.

Patient Support:

Provided by the rich resource of individuals and departments which may not have direct contact with patients, but which support the integration and continuity of care provided throughout the continuum of care by the hands-on care providers.

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Scope of Services/Staffing Plans

Each patient care service department has a defined scope of service approved by the hospital's administration and medical staff, as appropriate. The scope of service includes:

- The types and age ranges of patients served;
- Methods used to assess and meet patient care needs (including services most frequently provided such as procedures, medication administration, surgery, etc.);
- The scope and complexity of patient care needs;
- The appropriateness, clinical necessity and timeliness of support services provided directly or through referral contact;
- The extent to which the level of care or service meets patient needs, hours ofoperation if other than 24 hours a day/7days a week, and a method used to ensure hours of operation meet the needs of the patients to be served with regard to availability and timeliness;
- The availability of necessary staff (staffing plans); and
- Recognized standards or practice guidelines.

Staffing plans for patient care service departments are developed based on the level and scope of care provided, the frequency of the care to be provided, and a determination of the level and mix of staff that can most appropriately, competently, and confidently provide the type of care needed. Nursing units are staffed to accommodate a projected average daily patient census.

Unit management (including nurse manager, assistant nurse manager, charge nurse or the Administrative Nursing Supervisor (ANS) provide onsite oversight in the absence of the Nurse Manager and review the demand for patient care in order to plan for adequate staffing. Staffing can be increased or decreased to meet patient needs or changes in volume. When the census is high or the need is great, float/resource staff are available to assist in providing care.

Administrative leaders, in conjunction with budget and performance measurements, review staffing within all patient care areas and monitor ongoing regulatory requirements. Each department staffing plan is formally reviewed during the budget cycle and takes into consideration workload measures, utilization review, employee turnover, performance assessment, improvement activities, and changes in patient needs or expectations. A variety of workload measurement tools are utilized to help assess the effectiveness of staffing plan.

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Standards of Care

Individualized health care at The James is the integrated practice of medicine and support of patients based upon the individual's unique biology, behavior, and environment. It is envisioned we will utilize gene-based information to understand each person's individual requirements for the maintenance of their health, prevention of disease, and therapy tailored to their genetic uniqueness. Therefore, the direction of personalized health care is to be predictive and preventive.

Patients of The James Cancer Hospital and Richard J. Solove Research Institute can expect that:

- Hospital staff provide the correct procedures, treatments, interventions and care. The efficacy and appropriateness of care will be demonstrated based on patient assessment and reassessments, evidence-based practices and achievement of desired outcomes.
- Hospital staff design, implement and evaluate care delivery systems and services which are consistently focused on patient-centered care that is delivered with compassion, respect and dignity for each individual without bias, and in a manner that best meets the individual needs of the patients and families.
- Staff will provide a uniform standard of care and services throughout the organization.
- Patient care will be coordinated through interdisciplinary collaboration to ensure continuity and seamless delivery of care to the greatest extent possible.
- Efficient use of financial and human resources, streamlined processes, decentralized services, enhanced communication, and supportive technological advancements all while focused on quality of care and patient safety.

Patient Assessment:

Individual patient and family care requirements are determined by on-going assessments performed by qualified health professionals. Each service providing patient care within the organization has defined the scope of assessment provided. This assessment and reassessment of patient care needs continues throughout the continuum and the patient's contact with The James.

Coordination of Care:

Staff provide patients discharge planning to facilitate continuity of medical care and/or other care in order to meet identified needs. Discharge planning is timely, addressed during initial assessment and/or upon admission as well as during discharge planning process and can be initiated by any member of the multidisciplinary team. Patient Care Resource Managers,

Advanced Practice Nurses, and Social Workers coordinate and maintain close contact with the health care team members to finalize a distinct discharge plan best suited for each patient.

The medical staff is assigned to a clinical department or division. Each clinical department has an appointed chair responsible for a variety of administrative duties including development and implementation of policies that support the provision of departmental services and maintaining the proper number of qualified and competent personnel needed to provide care within the service needs of the department.

Care Delivery Model

Individualized, patient-focused care is the model in which teams deliver care for similar cancer patient populations, closely linking the physician and other caregivers for optimal communication and service delivery. Personalized patient-focused care is guided by the following principles:

- The patient and family will experience the benefits of individualized care that integrates skills of all care team members. These benefits include enhanced quality of care, improved service, appropriate length of hospitalization and value-based cost related to quality outcomes and safety.
- Hospital employees will demonstrate behaviors consistent with the philosophy of personalized health care. This philosophical foundation reflects a culture of collaboration, enthusiasm and mutual respect.
- Effective communication will impact patient care by ensuring timeliness of services, utilizing staff resources appropriately, and maximize the patient's involvement in their own plan of care.
- Configuring departmental and physician services to accommodate the care needs of the patient in a timely manner will maximize quality of patient care and patientsatisfaction.
- Primary nursing characteristics, such as relationship-based care, a conceptual framework supporting the professional practice model, are used to reflect the guiding philosophy and vision of providing individualized care.
- The patient and family will be involved in establishing the plan of care to ensure services that accommodate their needs, goals and requests.

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Patient Rights and Organizational Ethics

Patient Rights:

To promote effective and compassionate care, The James' systems, processes, policies, and programs are designed to reflect an overall concern and commitment to each person's dignity and privacy. All hospital employees, physicians and staff have an ethical obligation to respect and support the rights of every patient in all interactions. It is the responsibility of all employees, physicians and staff to support the efforts of the health care team, and for seeing that the patient's rights are respected. Each patient (and/or family member as appropriate) is given a list of patient rights and responsibilities upon admission and copies of this list are posted in conspicuous places throughout the hospital.

Organizational Ethics:

The James utilizes an ethics policy that articulates the organization's responsibility to patients, staff, physicians, and community served. General guiding principles include:

- Services and capabilities offered meet identified patient and community needs and are fairly and accurately represented to the public.
- The hospital adheres to a uniform standard of care throughout the organization, providing services to those patients for whom we can safely provide care. The James does not discriminate based upon age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity or expression, or source of payment.
- Patients will only be billed for care and services provided.

Biomedical Ethics:

A biomedical ethical issue arises when there is uncertainty or disagreement regarding medical decisions involving moral, social, or economic situations that impact human life. A mechanism is in place to provide consultation in the area of biomedical ethics in order to:

- Improve patient care and ensure patient safety.
- Clarify any uncertainties regarding medical decisions.
- Explore the values and principles of underlying disagreements.

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

- Facilitate communication between the attending physician, the patient, members ofthe treatment team and the patient's family (as appropriate).
- Mediate and resolve disagreements.

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Integration of Patient Care and Support Services

The importance of a collaborative interdisciplinary team approach, which takes into account the unique knowledge, judgment, and skills of a variety of disciplines in achieving desired patient outcomes, serves as a foundation for integration of patient care. Continual process improvement initiatives support effective integration of hospital and health system policies, procedures and protocols, and relationships between departments. See appendix A (Page 18) for a listing of support services.

An open line of communication exists between all departments providing patient care, patient services and support services within the hospital, and, as appropriate with community agencies to ensure efficient, effective and continuous patient care. To facilitate effective interdepartmental relationships, problem solving is encouraged at the level closest to the problem at hand. Staff is receptive to addressing one another's issues and concerns and work to achieve mutually acceptable solutions. Supervisors and managers have the responsibility and authority to mutually solve problems and seek solutions within their scope; positive interdepartmental communications are strongly encouraged. Direct patient care services maintain open communication channels and forums with each other; as well as with service support departments to ensure continuity of patient care, maintenance of a safe patient environment, and positive outcomes.

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Consultations and Referrals for Patient Services

The James provides services as identified in this plan in order to meet the needs of our community. Patients who have assessed needs that require services not offered at The James are transferred in a timely manner after stabilization; and/or transfers are arranged with another quality facility.

Safe transportation is provided by air or ground ambulance with staff and equipment appropriate to the required level of care. Physician consultation occurs prior to transfer to ensure continuity of care. Referrals for outpatient care occur based on patient need.

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Information Management Plan

The overall goal for information management is to support the mission of The James. Specific information management goals related to patient care include:

- Developing and maintaining an integrated information and communication network linking research, academic and clinical activities.
- Developing computer-based patient records with integrated clinical management and decision support.
- Supporting administrative and business functions with information technologies that enable improved quality of services, cost effectiveness, and flexibility.
- Building an information infrastructure that supports the continuous improvement initiative of the organization.
- Ensuring the integrity and security of the hospital's information resources and protect patient confidentiality.

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Patient Organization Improvement Activities

All departments participate in the hospital's plan for improving organizational performance.

Plan Review

The hospital's Plan for Providing Patient Care will be reviewed regularly by the leadership to ensure the plan is adequate, current, and that the hospital maintains compliance with the plan. Interim adjustments to the overall plan are made as necessary to accommodate changes in patient population, care delivery systems, processes that affect the delivery, and level of patient care required.

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Appendix A: Scope of Services for Ancillary and Support Services

Other hospital services that support the comfort and safety of patients are coordinated and provided in a manner that ensures direct patient care and services are maintained in an uninterrupted, efficient, and continuous manner. These support services will be fully integrated with the patient services departments of the hospital:

DEPARTMENT	SERVICE
Central Sterile Supply	Coordinates the comprehensive cleaning, decontamination, assembly and dispensing of surgical instruments, equipment and supplies needed for regular surgical procedures in related departments.
Chaplaincy and Clinical Pastoral Education	Assist patients, their families and hospital personnel in meeting spiritual needs through professional pastoral and spiritual care and education.
Clinical Engineering	Routine equipment evaluation, maintenance, and repair of electronic equipment, evaluation of patient owned equipment. Refer to James Hospital Policy 04-08 "Equipment Safety for Patient Care Areas."
Cell Therapy Laboratory	Responsible for the processing, cryopreservation and storage of cells for patients undergoing bone marrow or peripheral blood stem cell transplantation.
Clinical Call Center	Nurse-run telephone triage department that receives and manages telephone calls regarding established James patients outsidenormal business hours. The hours of operation for this department are: 4:00 p.m. – 8:30 a.m. Monday through Friday and 24 hours a dayon Saturday, Sunday and all university holidays.
Communications and Marketing	Responsible for developing strategies and programs to promote the organization's overall image, brand, reputation, and specific products and services to targeted internal and external audiences. Manages all media relations, advertising, internal communications, special events, digital and social properties, collateral materials and publications for the hospital.
Decedent Affairs	Provide support to families of patients who died and assist them with completing required disposition decisions. Ensure notification of the CMS designated Organ Procurement Agency – Lifeline of Ohio (Lifeline). Promote and facilitate organ/eye/tissue donation by serving as the OSU Hospital Lifeline Liaison. Analyze data provided by Lifeline regarding organ/tissue/eye donation.
Diagnostic Testing Areas	Provide tests based on verbal, electronic or written consult requests. Final Reports are included in the patient record.
Early Response Team (ERT)	Provide timely diagnostic and therapeutic intervention before there is a cardiac or respiratory arrest or an unplanned transfer to the Intensive Care Unit. The team is comprised of response RN and Respiratory Therapist trained to assist patient care staff when there are signs that a patient's health is declining.
Educational Development and Resources	Provides and promotes ongoing development and training experiences to all members of The James Cancer Hospital community; provide staff enrichment programs, organizational development, leadership development, orientation and training, skills training, continuing education, competency assessment and development, literacy programs and student affiliations.
Endoscopy	Provide services to patients requiring a nonsurgical review of their digestive tract.
Environmental Services	Provide housekeeping/cleaning and disinfecting of patient rooms and nursing unit environments.
Epidemiology	Enhance the quality of patient care and the work environment by minimizing the risk of acquiring infection within the hospital and ambulatory settings.

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Facilities Operations	Provide oversight, maintenance and repair of the building's life safety, fire safety, and utility systems. Provides preventative, repair and routine maintenance in all areas of all buildings serving patients, guests, and staff.
Financial Services	Assist managers in preparation and management of capital and operational budgets; provide comprehensive patient billing services and works with patients and payers to facilitate meeting all payer requirements for payment.
Human Resources	Serve as a liaison for managers regarding all human resources information and services; assist departments with restructuring efforts; provide proactive strategies for managing planned change within the health system; assist with Employee/Labor Relations issues; assists with performance management process; develops compensation strategies; develop hiring strategies and coordinates process for placements; provide strategies to facilitate sensitivity to issues of cultural diversity; provide human resources information to employees, and established equity for payroll.
Immediate Care Center (ICC)	Patients are seen for symptom management related to their disease, or treatment of their disease, and any acute needs requiring evaluation by an advanced practice provider (APP), subsequent treatments, and/or supportive care infusion therapy. Patient visits may include diagnostic, interpretive analysis, and minor invasive procedures. Referrals to other physicians, home care and hospice agencies, dieticians etc. are made by our APPs in collaboration with the primary team.
Information Systems	Assist departments to explore, deploy and integrate reliable, state-of-the-art information systems technology solutions to manage change.
Laboratory	Provide laboratory testing of ambulatory patients with a diagnosis of malignant disease and those that require urgent medical treatment given by the emergency department. Lab Reports are included in the patient record.
Materials Management	Supply stock in patient care areas.
Medical Information Management	Maintain patient records serving the needs of the patient, provider, institution and various third parties to health care in the inpatient and ambulatory setting.
Nutrition Services	Provide nutrition care and food service to The James and ambulatory site patients, staff and visitors. Clinical nutrition assessment and consultation are available in both inpatient and outpatient settings. The department provides food service to inpatients and selected ambulatory settings.
Oncology Laboratories	Provide clinical laboratory support services for medical, surgical blood & marrow transplantation and radiation oncology units.
Pathology	The Molecular Pathology Laboratory provides testing of inpatient and ambulatory patients with a diagnosis of malignant disease and/or genetic disease. Final Reports are included in the patient record.
James Patient Access Services (JPAS)	Coordinate registration/admissions with nursing management.
Patient Care Resource Management and Social Services	Provide personalized care coordination and resource management with patients and families. Provide discharge planning, coordination of external agency contacts for patient care needs and crisis intervention and support for patients and their families. Provide services upon phone/consult request of physician, nurse or the patient or family.
Patient Education	Provide easy-to-understand educational resources that facilitate patient learning and encourage the patient to take an active role in their care. These resources are evidence-based, comply with national standards for health literacy/plain language/accessibility and meet Joint Commission and organizational standards. Based on their assessment, clinicians use patient education resources to assist in patient and caregiver understanding and to reinforce the learning provided during their hospital stay or clinic visit.

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Patient Experience	Develop programs for support of patient relations and customer service and information desk. Volunteers do way-finding, host visitors in waiting areas, serve as patient/family advisors and assist staff. Volunteer Services serves as a liaison for the Service Board auxiliary, which annually grants money to department-initiatedprojects, enhancing the patient and family experience.
Perioperative Services	Provide personalized care of the patient requiring surgical services, from pre-anesthesia through recovery, for the ambulatory and inpatient surgical patient.
Pharmacy	Patient care services are delivered via specialty practice pharmacists and clinical generalists. Each practitioner promotes optimal medication use and assists in achieving the therapeutic goals of the patients. Areas of service include, but are not limited to: Oncology, Breast Oncology, Hematology, Blood & Marrow Transplant, Gynecologic Oncology, Pain and Palliative Care, Anticoagulation Management, Infectious Disease, and Intensive Care.
Operations Improvement/Process Engineers	Operations Improvement Process Engineers utilize industrial engineering knowledge and skills, as well as LEAN and Six Sigma methods to provide internal consulting, coaching and training services for all departments across all parts of The James Cancer Hospital in order to develop, implement, and monitor more efficient, cost-effective business processes and strategies.
Pulmonary Diagnostics Lab	Provide services to patients requiring an evaluation of the respiratory system including pulmonary function testing, bronchoscopy and other diagnostic/interventional pulmonary procedures.
Quality and Patient Safety	Provide integrated quality management and facilitate continuous quality improvement efforts throughout the Hospital. Focus on the culture of safety and work with teams to provide information on trends and improvement opportunities.
Radiation Oncology	Responsible for clinical care related to the application of radiation treatments.
Radiology Services	Provide state-of-the-art radiological diagnostic and therapeutic testing and treatment. Services offered by the Radiology Imaging Department range from general radiography and fluoroscopy to new and advanced interventional procedures, contrast imaging, which include, but not limited to CT, MRI, IVP, etc., in which contrast agents are administered by IV certified radiology technologists.
Rehabilitation Services	Physical therapists, occupational therapists, speech and language pathologists and recreational therapists, evaluate, formulate a plan of care, and provide treatment based on physician referral and along with the interdisciplinary medical team for appropriate treatment and education needed for the established discharge plan.
Respiratory Therapy	Provide respiratory therapeutic interventions and diagnostic testing, by physician order including ventilator support, bronchodilator therapy, and pulmonary hygiene.
Safety	Hospital safety personnel handle issues associated with licensing and regulations, such as EPA, OSHA, and fire regulations.
Security	Provide a safe and secure environment for patients, visitors, and staff members by responding to emergencies such as workplace violence, fires, bomb threats, internal and external disasters, armed aggressors, or any other incident that needs emergency response.
Social Work Services	Social Work Services are provided to patients/families to meet their medically related social and emotional needs as they impact on their medical condition, treatment, recovery and safe transition from one care environment to another. Social workers provide psychosocial assessment and intervention, crisis intervention, financial counseling, discharge planning, health education, provision of material resources and linkage with community agencies. Consults can be requested by members of the treatment team, patients or their family members.

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Staff Development and Education	Provide and promote ongoing employee development and training related to oncology care, provides clinical orientation, and continuing education of staff.
Transfer Center	Coordinate with inpatient units and ancillary departments to ensure patient flow efficiency and timely access for patients who seek care. Provide transparency real-time across the Medical Center on capacity and all ADT (Admission, Discharge, and Transfer) activity. Timely and accurate patient placement based on level of care and service line is expedited through a capacity management technology platform.
Transportation	Supply patients with a secure and proficient transport within the Wexner Medical Center by transferring patients between rooms/floors within the hospitals, taking patients to and from test sites, and discharging patients to Dodd Rehabilitation Center, On-Site Hospice, and the Morgue.
Wound Care	Wound Care includes diagnosis and management for skin impairments.

Revised: May, 2020

MSAC Approval: May 15, 2020

QPAC Approval: July 28, 2020

Board Approval: _____

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

The James
THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Attachment VIII

Contracted Services Annual Evaluation Report – 2019

Submitted by: Accreditation

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

The James
THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

Overview
A contract evaluation survey was developed to encompass a broader group of contracts/vendors/services as required by CMS Condition of Participation 482.12 (E) Standard that states all contracted services provided in the hospital are in compliance with Conditions of Participations for hospitals. Operational owners were required to complete an evaluation for each assigned vendor. The survey was developed in Qualtrics and contained a total of 26 questions. The survey questions illicit information on whether contracts/vendors/services are accredited by The Joint Commission or other regulatory bodies, whether the contract meets TJC standards, the nature and scope of the contract, how often contracts are monitored for key quality and performance indicators, the type of improvement efforts made in the last year, and whether the contracted service completes compliance related activities such as providing orientation to contracted staff, ongoing education and assuring licensure, registration or certification requirements are met. Other types of questions relate to clinical laboratory services. There were 131 responses to the survey.

Contract Breakdown
The contracts were categorized based on the nature of the contract, by category name, and vendor. Depending on the scope of services provided, the 131 responses broken down into one of the following categories: Conditions of Participation, Direct Patient Care, Professional Service or Supplies. If the operational owner did not specify the name of the contract, the response was categorized in the "Non-Applicable" category. The pie chart below provides a percent breakdown of the categories of the vendors reflected in the survey. A majority of the responses were from the Professional Service or COP category.

Figure 1: Contract Categorization

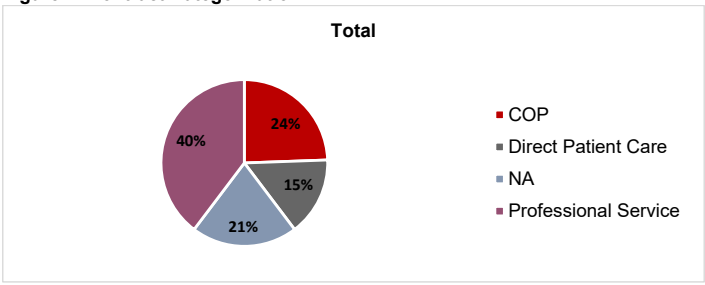
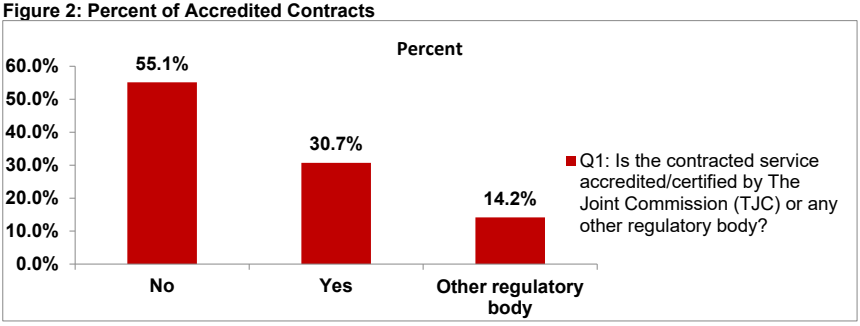


Figure 2 below provides an overview of the percent of contracts accredited or certified by The Joint Commission or any other regulatory bodies. Almost 60 percent of respondents reported that the contracted service is not accredited/certified by TJC while over 14 percent of respondents selected "other regulatory body". About 55 percent of respondents selected "yes". Respondents that answered "no" to this question manage contracts certified by manufacturer standards. Other types of contracts not accredited/certified by TJC were concentrated in environmental services, community development, and nutrition.

Figure 2: Percent of Accredited Contracts



THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

The James
THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

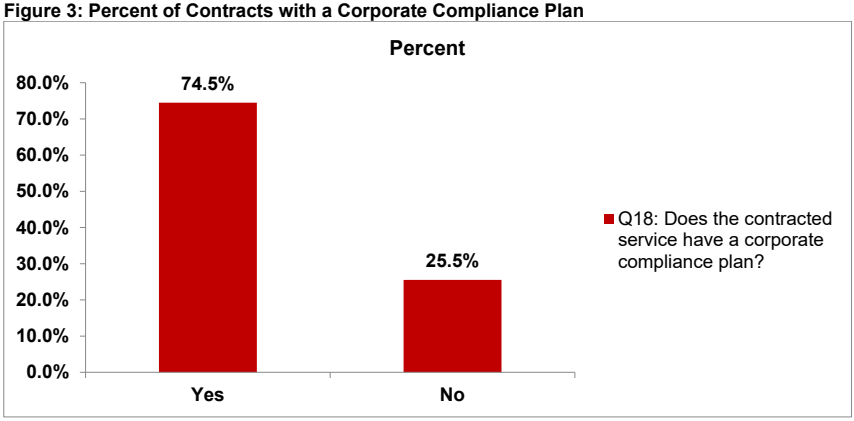
Quality and Performance Indicators
Operational owners described improvement made with the contracted service within the last year. Most of the improvements made concentrated around improved communications through additional team meetings and increase in response times. Other improvements consisted of increased provider coverage and medical review. Operations owners were asked about how often they receive key quality and performance indicators. The table below shows the percent of operation owners that receive direct observation, audit, incident report, efficiency, and satisfaction report data. Cells >18% were highlighted. Bi-weekly direct observation, monthly audits, monthly efficiency, and satisfaction report data were provided the most. Many respondents indicated that some data, especially contracts related to patient care, is provided daily or weekly. This likely accounts for the high percentages in the "other" category.

Table 1: Data Submission for Key Quality and Performance Indicators

	Direct Observation	Audits	Incident Reports	Efficiency	Satisfaction Reports	Other
Annually	6.3%	8.3%	2.0%	6.3%	12.2%	3.7%
Bi-weekly	18.8%	14.6%	10.0%	14.6%	14.3%	11.1%
Monthly	8.3%	29.2%	12.0%	29.2%	22.4%	7.4%
Quarterly	10.4%	8.3%	6.0%	4.2%	8.2%	3.7%
Other	56.3%	39.6%	70.0%	45.8%	42.9%	74.1%

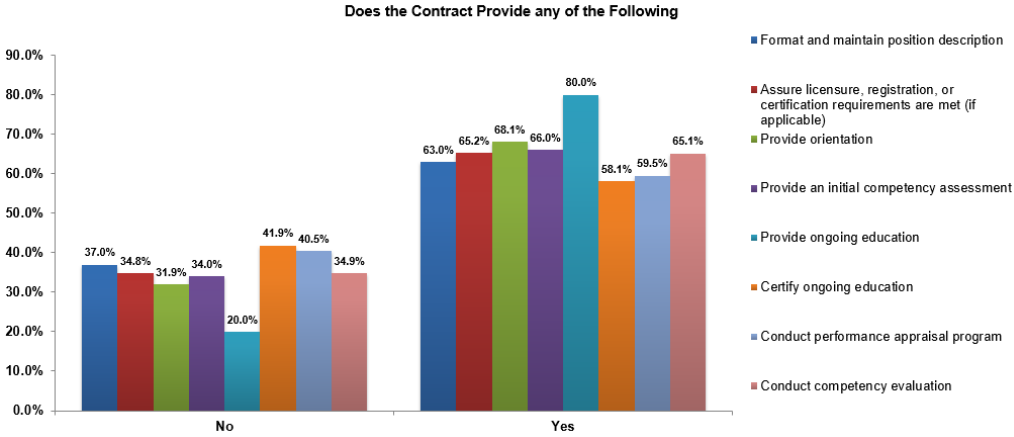
Evidence of contracts that comply with the CMS CoP 482.12 (E) Standard relate to corporate compliance. Well over half of the contracted services (74.5%) have a corporate compliance plan (Figure 3).

Figure 3: Percent of Contracts with a Corporate Compliance Plan



Activities that encompass compliance entail contracts that provide orientation, ongoing education, assess competencies, format and maintain position description, conduct performance appraisals, conduct competency evaluation, certify ongoing education and assure licensure, registration, or certification require are met (if applicable). Figure 4 provides an overview of the compliance categories. Well over half (65.2 %) of the contracted services assure licensure, registration, or certification requirements are met. Out of all the compliance activities, performance for ongoing education is high with over two-thirds of the contracts (80%) meeting this activity. Furthermore, over half (68.1%) of the contracts provide orientation. A couple of opportunities for improvement is conducting competency evaluations and certifying ongoing education.

Figure 4: Compliance Activities



Conclusion

This baseline report provides an overview of the hospital's contracted services concerning vendors that operate within four areas: Conditions of Participation, Direct Patient Care, Professional Service, or Supplies. The evaluation shows that relatively all of the contracts follow manufacturer standards, receive certification from TJC, or regulated by another governmental agency or association. Furthermore, it's clear that the operational owners regularly review key quality and performance information. Contractors provide an array of compliance activities, which correspond to the requirements of federal and/or state regulations. While the Qualtrics survey did not have a 100 percent completion rate, next year's survey and report will include greater collaboration with purchasing and the operational owners to reflect all contracts in the evaluation report. This will enable hospital leadership to further identify areas of strengths and opportunities for improvement. As follow-up to this evaluation, the hospitals will ensure more regular communication with contractors in addition to enhanced oversight of contract terms and conditions in order to improve clinical and professional operations of these services.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

The James
THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Attachment IX

Contracted Services Annual Evaluation Report – 2019

Submitted by: Accreditation and Compliance

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

The James
THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

Overview
A contract evaluation survey was developed to encompass a broader group of contracts/vendors/services as required by CMS Condition of Participation 482.12 (E) Standard that requires the hospital to ascertain that all contractor services provided in the hospital are in compliance with Conditions of Participations for hospitals. Operational owners were required to complete an evaluation for each assigned vendor. The survey was developed in Qualtrics and contained a total of 26 questions. The survey questions illicit information on whether contracts/vendors/services are accredited by The Joint Commission or other regulatory bodies, whether the contract meets TJC standards, the nature and scope of the contract, how often contracts are monitored for key quality and performance indicators, the type of improvement efforts made in the last year, and whether the contracted service completes compliance related activities such as providing orientation to contracted staff, ongoing education and assuring licensure, registration or certification requirements are met. Other types of questions relate to clinical laboratory services. There were 131 responses to the survey.

Contract Breakdown
The contracts were categorized based on the nature of the contract, by category name, and vendor. Depending on the scope of services provided, the 131 responses broken down into one of the following categories: Conditions of Participation, Direct Patient Care, Professional Service or Supplies. If the operational owner did not specify the name of the contract, the response was categorized in the "Non-Applicable" category. The pie chart below provides a percent breakdown of the categories of the vendors reflected in the survey. A majority of the responses were from the Professional Service or COP category.

Figure 1: Contract Categorization

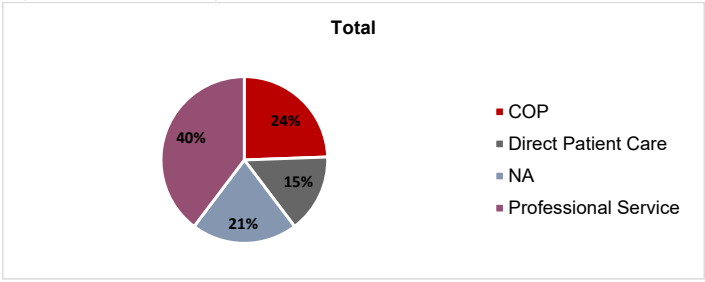
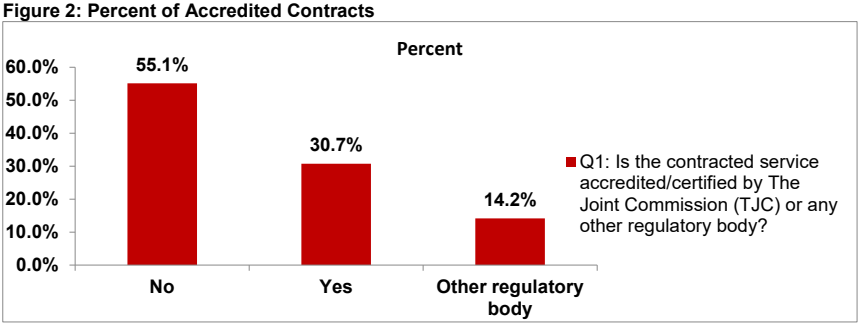


Figure 2 below provides an overview of the percent of contracts accredited or certified by The Joint Commission or any other regulatory bodies. Almost 60 percent of respondents reported that the contracted service is not accredited/certified by TJC while over 14 percent of respondents selected "other regulatory body". About 55 percent of respondents selected "yes". Respondents that answered "no" to this question manage contracts certified by manufacturer standards. Other types of contracts not accredited/certified by TJC were concentrated in environmental services, community development, and nutrition.

Figure 2: Percent of Accredited Contracts



THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

The James
THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

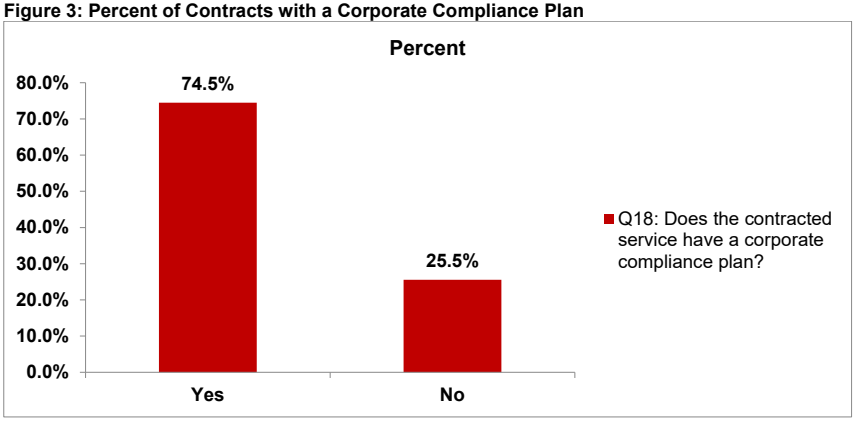
Quality and Performance Indicators
Operational owners described improvement made with the contracted service within the last year. Most of the improvements made concentrated around improved communications through additional team meetings and increase in response times. Other improvements consisted of increased provider coverage and medical review. Operations owners were asked about how often they receive key quality and performance indicators. The table below shows the percent of operation owners that receive direct observation, audit, incident report, efficiency, and satisfaction report data. Cells >18% were highlighted. Bi-weekly direct observation, monthly audits, monthly efficiency, and satisfaction report data were provided the most. Many respondents indicated that some data, especially contracts related to patient care, is provided daily or weekly. This likely accounts for the high percentages in the "other" category.

Table 1: Data Submission for Key Quality and Performance Indicators

	Direct Observation	Audits	Incident Reports	Efficiency	Satisfaction Reports	Other
Annually	6.3%	8.3%	2.0%	6.3%	12.2%	3.7%
Bi-weekly	18.8%	14.6%	10.0%	14.6%	14.3%	11.1%
Monthly	8.3%	29.2%	12.0%	29.2%	22.4%	7.4%
Quarterly	10.4%	8.3%	6.0%	4.2%	8.2%	3.7%
Other	56.3%	39.6%	70.0%	45.8%	42.9%	74.1%

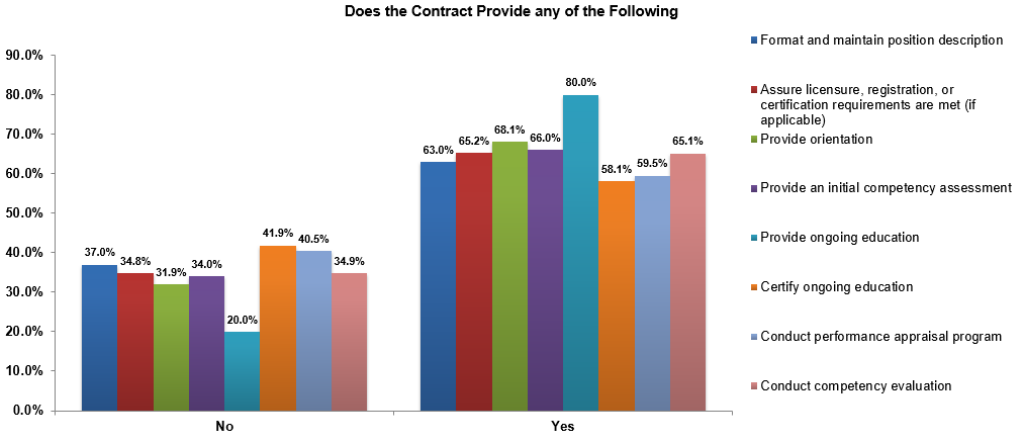
Evidence of contracts that comply with the CMS CoP 482.12 (E) Standard relate to corporate compliance. Well over half of the contracted services (74.5%) have a corporate compliance plan (Figure 3).

Figure 3: Percent of Contracts with a Corporate Compliance Plan



Activities that encompass compliance entail contracts that provide orientation, ongoing education, assess competencies, format and maintain position description, conduct performance appraisals, conduct competency evaluation, certify ongoing education and assure licensure, registration, or certification require are met (if applicable). Figure 4 provides an overview of the compliance categories. Well over half (65.2 %) of the contracted services assure licensure, registration, or certification requirements are met. Out of all the compliance activities, performance for ongoing education is high with over two-thirds of the contracts (80%) meeting this activity. Furthermore, over half (68.1%) of the contracts provide orientation. A couple of opportunities for improvement is conducting competency evaluations and certifying ongoing education.

Figure 4: Compliance Activities



Conclusion

This baseline report provides an overview of the hospital's contracted services concerning vendors that operate within four areas: Conditions of Participation, Direct Patient Care, Professional Service, or Supplies. The evaluation shows that relatively all of the contracts follow manufacturer standards, receive certification from TJC, or regulated by another governmental agency or association. Furthermore, it's clear that the operational owners regularly review key quality and performance information. Contractors provide an array of compliance activities, which correspond to the requirements of federal and/or state regulations. While the Qualtrics survey did not have a 100 percent completion rate, next year's survey and report will include greater collaboration with purchasing and the operational owners to reflect all contracts in the evaluation report. This will enable hospital leadership to further identify areas of strengths and opportunities for improvement. As follow-up to this evaluation, the hospitals will ensure more regular communication with contractors in addition to enhanced oversight of contract terms and conditions in order to improve clinical and professional operations of these services.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Ohio State University Wexner Medical Center
Hospital Division
Doan Hall 168
410 W. 10th Avenue
Columbus, OH 43210
614-293-9700 Phone

wexnermedical.osu.edu

Attachment X

June 19, 2020

Nora Colburn, MD
Shandra Day, MD
Division of Infectious Disease
The Ohio State University Wexner Medical Center
410 W 10th Ave, N-1122 Doan Hall
Columbus, OH-43210-1267

Dear Drs. Colburn and Day:

Thank you for your continued service as the leaders for the Infection Control and Clinical Epidemiology program for the Ohio State University Wexner Medical Center (OSUWMC).

For the purposes of this letter, the OSU Wexner Medical Center includes University Hospital, East Hospital, Brain and Spine Hospital, Richard M. Ross Heart Hospital, Harding Hospital, Dodd Rehabilitation Hospital, Ambulatory Clinics and Services.

In accordance with new CMS Regulations (CMS 482.42), as the medical and nursing leadership of the Medical Center, we will be forwarding your appointment as the leadership of this program to the OSUWMC board for final approval.

We deeply appreciate your willingness to serve the Ohio State University Wexner Medical Center in this important capacity.

Sincerely,

Andrew Thomas, MD
Chief Clinical Officer
Senior Vice President for Health Sciences

Cheryl Hoying

Cheryl Hoying, PhD, RN, NEA-BC, FACHE, FAONL, FAAN
Chief Nurse Executive and Patient Care Services Officer

The James

THE OHIO STATE UNIVERSITY
COMPREHENSIVE CANCER CENTER

The Ohio State University
Comprehensive Cancer Center –
Arthur G. James Cancer Hospital and
Richard J. Solove Research Institute

Hospital Division

460 W. 10th Avenue
Columbus, OH 43210-1240
614-293-3121

cancer.osu.edu

Attachment XI

June 4, 2020

Christina Liscynesky, MD
Division of Infectious Disease
OSUCCC-The James
410 W 10th Ave, N-1122 Doan Hall
Columbus, OH-43210-1267

Dear Dr. Liscynesky:

Thank you for agreeing to serve as the leader for the Infection Control Program for The Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (OSUCCC – The James). In accordance with CMS 482.42, we will be moving our recommendation for your leadership role forward to the Wexner Medical Center Board for final approval.

We deeply appreciate your willingness to serve the Ohio State University Comprehensive Cancer Center — James Cancer Hospital in this important capacity.

Sincerely,

Dr. David E Cohn, MD
Chief Medical Officer
OSUCCC – The James

Kris Kipp, MSN, RN
Executive Director, Clinical Services
Chief Nursing Officer
OSUCCC – The James

NCI CCC
A Comprehensive Cancer Center Designated by the National Cancer Institute

Ohio State is a Comprehensive Cancer Center designated by the National Cancer Institute.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Ohio State University Wexner Medical Center
Hospital Division
Doan Hall 168
410 W. 10th Avenue
Columbus, OH 43210
614-293-9700 Phone

wexnermedical.osu.edu

Attachment XII

June 19, 2020

Kurt Stevenson, MD
Division of Infectious Disease
The Ohio State University Wexner Medical Center
410 W 10th Ave, N-1122 Doan Hall
Columbus, OH-43210-1267

Dear Dr. Stevenson:

Thank you for continued service as the Medical Director of the Antimicrobial Stewardship program for the Ohio State University Wexner Medical Center (OSUWMC).

For the purposes of this letter, the OSU Wexner Medical Center includes University Hospital, East Hospital, Brain and Spine Hospital, Richard M. Ross Heart Hospital, Harding Hospital, Dodd Rehabilitation Hospital, Ambulatory Clinics and Services.

In accordance with new CMS regulations (CMS 482.42), as the medical and pharmacy leadership for the Medical Center, we will be forwarding your appointment as the leader of this program to the OSUWMC board for their approval.

We deeply appreciate your willingness to serve the Ohio State University Wexner Medical Center in this important capacity.

Sincerely

Andrew Thomas, MD
Chief Clinical Officer
Senior Vice President for Health Services

Robert J. Weber, PharmD
Administrator, Pharmacy

The James

THE OHIO STATE UNIVERSITY
COMPREHENSIVE CANCER CENTER

The Ohio State University
Comprehensive Cancer Center –
Arthur G. James Cancer Hospital and
Richard J. Solove Research Institute

Hospital Division

460 W. 10th Avenue
Columbus, OH 43210-1240
614-293-3121

cancer.osu.edu

Attachment XIII

June 4, 2020

Mark Lustberg, MD, PHD
Division of Infectious Disease
OSUCCC-The James
460 West 10th Ave. 5th floor
Columbus, OH-43210-1267

Dear Dr. Lustberg:

Thank you for agreeing to serve as the leader for the Antimicrobial Stewardship Program for The Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (OSUCCC – The James). In accordance with CMS 482.42, we will be moving our recommendation for your leadership role forward to the Wexner Medical Center Board for final approval.

We deeply appreciate your willingness to serve the Ohio State University Comprehensive Cancer Center — James Cancer Hospital in this important capacity.

Sincerely,

Dr. David E Cohn, MD
Chief Medical Officer
OSUCCC-The James

Robert J. Weber

Robert Weber, PharmD, MS
Chief Pharmacy Officer and Administrator
Pharmacy Services
OSUCCC-The James and OSU Wexner Medical Center

NCI CCC
A Comprehensive Cancer Center Designated by the National Cancer Institute

Ohio State is a Comprehensive Cancer Center designated by the National Cancer Institute.

Appendix V

Project Data Sheet for Board of Trustees Approval

Wexner Medical Center Inpatient Hospital

OSU-180391 (CNI# 17000099)

Project Location: 10th Avenue / Cannon Drive

- **approval requested and amount**

increase professional services	$58.1M
increase construction	$1,634.7M
total requested amount	$1,692.8M

- **project budget**

professional services	$153.4M
construction w/contingency	$1,637.5M
OSEP scope	$6.2M
total project budget	$1,797.1M

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

- **project schedule**

BoT professional services approval	2/18
design/bidding	3/18 – 12/20
construction - tower	10/20 – 6/25
construction – renovation	12/21 – 8/25
facility opening	First Quarter 2026

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

- **planning framework**
  - the project was included in the FY 2018 and FY 2020 Capital Investment Plans; the FY 2021 Capital Investment Plan will include the remainder of design and construction work
  - the project aligns with the Wexner Medical Center strategic plan by replacing and increasing inpatient beds, supporting and prioritizing access for patients and visitors, and delivering an unequalled patient experience

- **project scope**
  - the project will design and construct a new, approximately 1.9M square foot inpatient hospital tower with up to 820 beds in private-room settings, replacing and expanding on the 440 beds in Rhodes Hall and Doan Hall including an additional 84 James beds
  - facilities will include state-of-the-art diagnostic, treatment and inpatient service areas including emergency department, imaging, operating rooms, 60 neonatal intensive care unit bassinets, critical care and medical/surgical beds, and leading-edge digital technologies to advance patient care, teaching and research.
  - renovation of the James and Ross for blood bank, support services and building connections
  - the inpatient hospital is the cornerstone of a larger project that includes the Inpatient Hospital Garage and supporting infrastructure and the off-site Central Sterile Supply
  - OSEP scope includes bringing electric, water and steam to the Inpatient Hospital Tower and will be delivered by the project team

- **project team**

University project manager:	Ragan Fallang
AE/design architect:	Henningson Durham & Richardson
CM at Risk:	Walsh-Turner (joint venture)

Project Data Sheet for Board of Trustees Approval

Wexner Medical Center Inpatient Hospital

OSU-180391 (CNI# 17000099)

Project Location: 10th Avenue / Cannon Drive

- **approval requested**
  - approval is requested to increase professional services and construction contracts, including OSEP scope

- **project team**

University project manager:	Ragan Fallang
AE/design architect:	Henningson Durham & Richardson
CM at Risk:	Walsh-Turner (joint venture)

Wexner Medical Center Inpatient Hospital

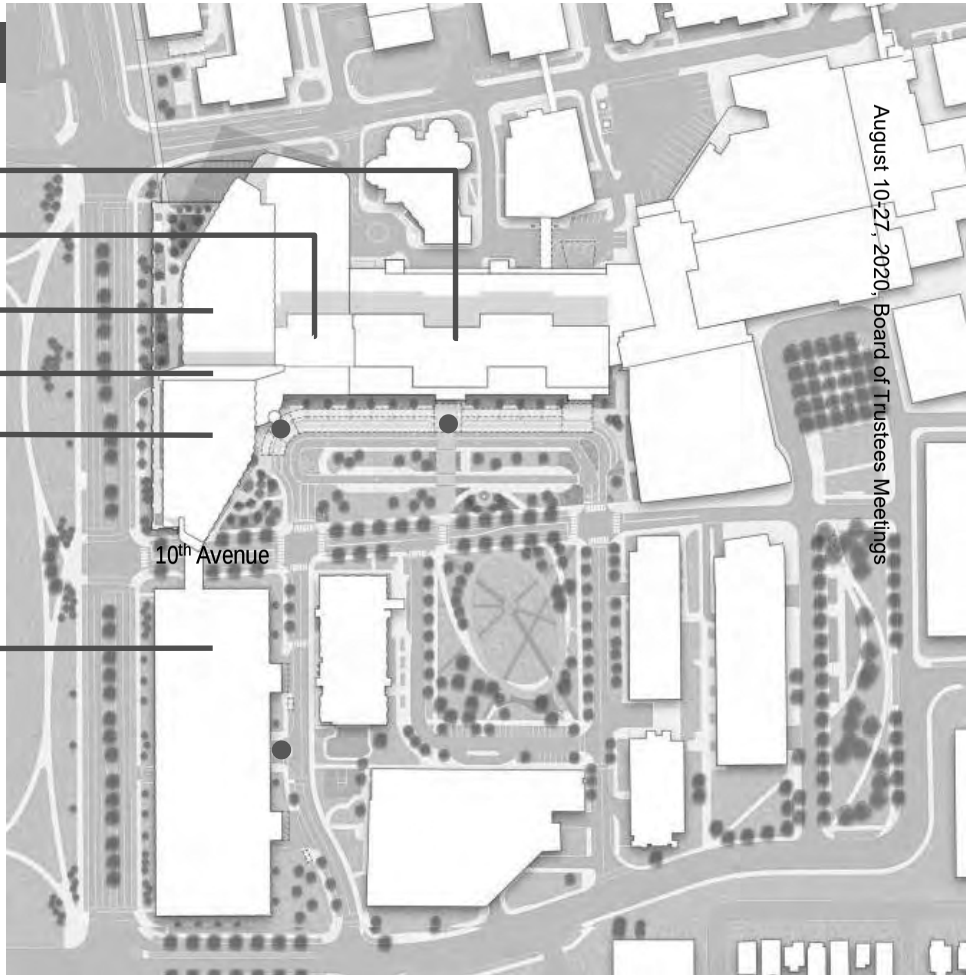
The Ohio State University Board of Trustees

—

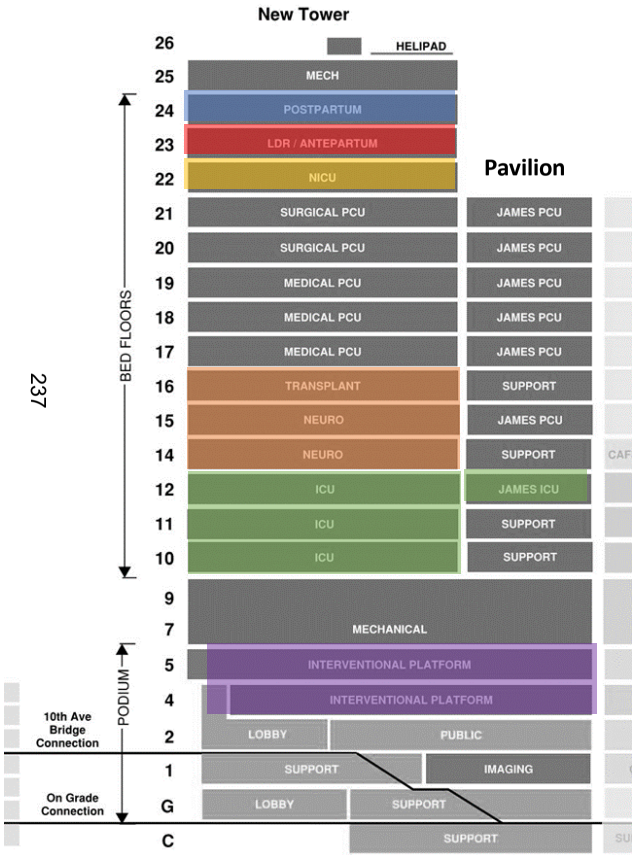
August 26, 2020

THE OHIO STATE UNIVERSITY

Site


The James
James “Pavilion”
North Tower
University Hospital
South Tower
10th Avenue
New Visitor Garage

Hospital Program: Summary

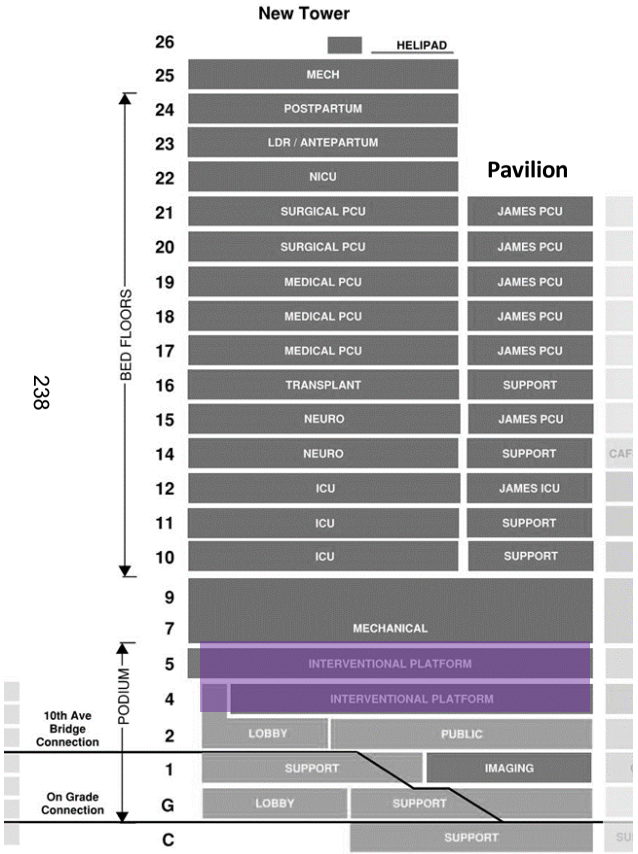


- 820 Adult Inpatient Beds + 60 NICU bassinets
- 24 Operating Rooms
- Comprehensive Imaging Modalities
- Welcoming Public Spaces
  - Indoor/Outdoor Respite Spaces
  - Conference and Event Center
- Clinical and Administrative Support Spaces

Postpartum
Antepartum/ Labor & Delivery
Neonatal ICU (NICU) “Couplet Care”
PCU Beds “Convertible” to ICU Beds
ICU Beds
Surgical / Endoscopies Center

August 10-27, 2020, Board of Trustees Meetings

Hospital Program: Surgical / Endoscopies Center



Surgical / Endoscopies Center

- 24 Surgical ORs

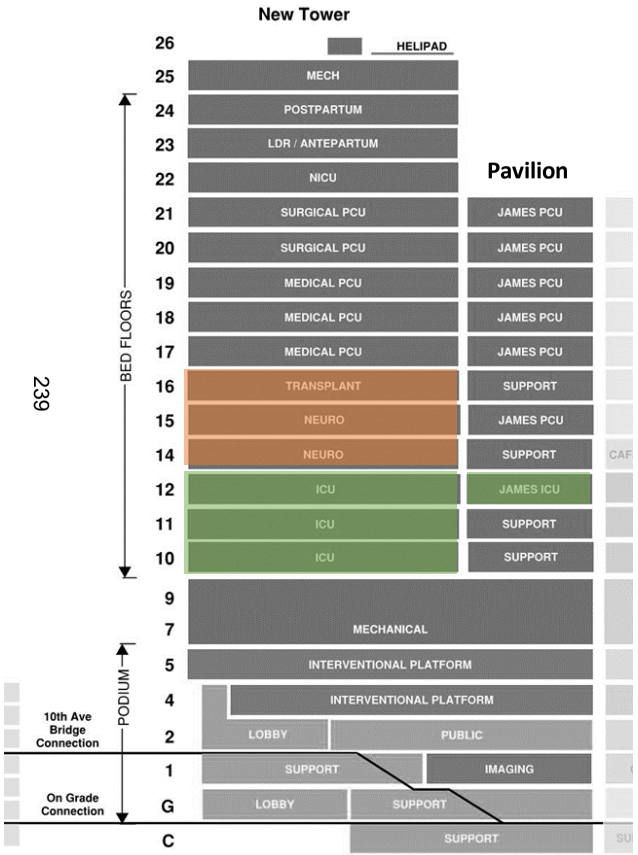
  10 Interventional Radiology Suites

  6 Endoscopy Suites

  4 Bronchoscopy Suites
- "Standardization" of ORs enables more efficient case management
- All ORs, IRs "Robotic-Capable"
- Total Area: 218,500 SF

Surgical / Endoscopies Center

Hospital Program: Critical Care Services



- 360 ICU (Intensive Care) Beds or Beds “Convertible” to ICU
- 52 additional ICU Beds in the James and new James “Pavilion”
- In comparison, Doan/Rhodes contain 38 “inadequate” ICU Beds

PCU Beds “Convertible” to ICU Beds

ICU Beds

Hospital Program: New Patient (PCU) Room

240

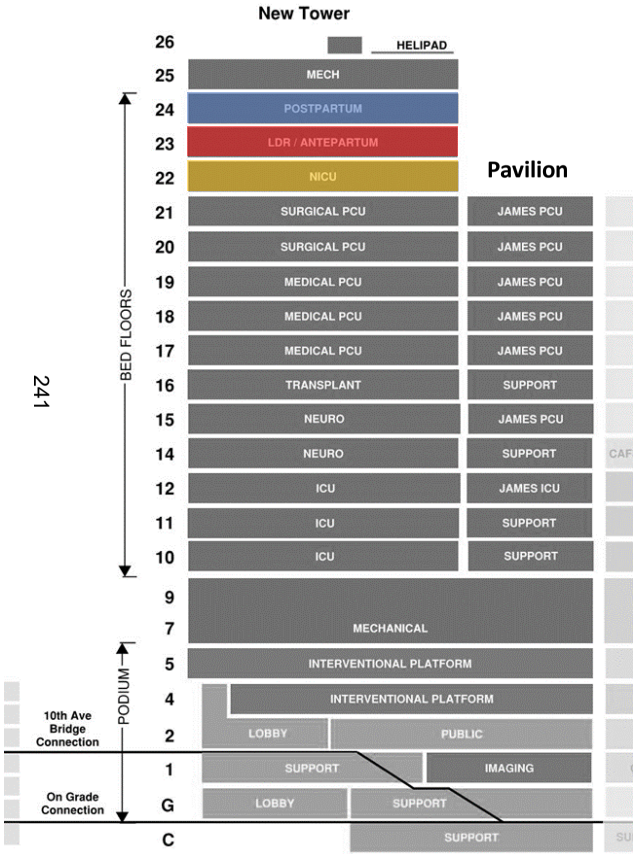
- Sizing the Room — 349 Net SF

Patient Zone	178
Family Zone	53
Bathroom	46
Entrance	72
	349 Net SF

- Patient Comfort
  - Room Height: 9’2”
  - Unobstructed Window: 9’-6” x 9’
  - Digital Footwall: 75” SCREEN

August 10-27, 2020, Board of Trustees Meetings

Hospital Program: Women and Infants



Women and Infants Program

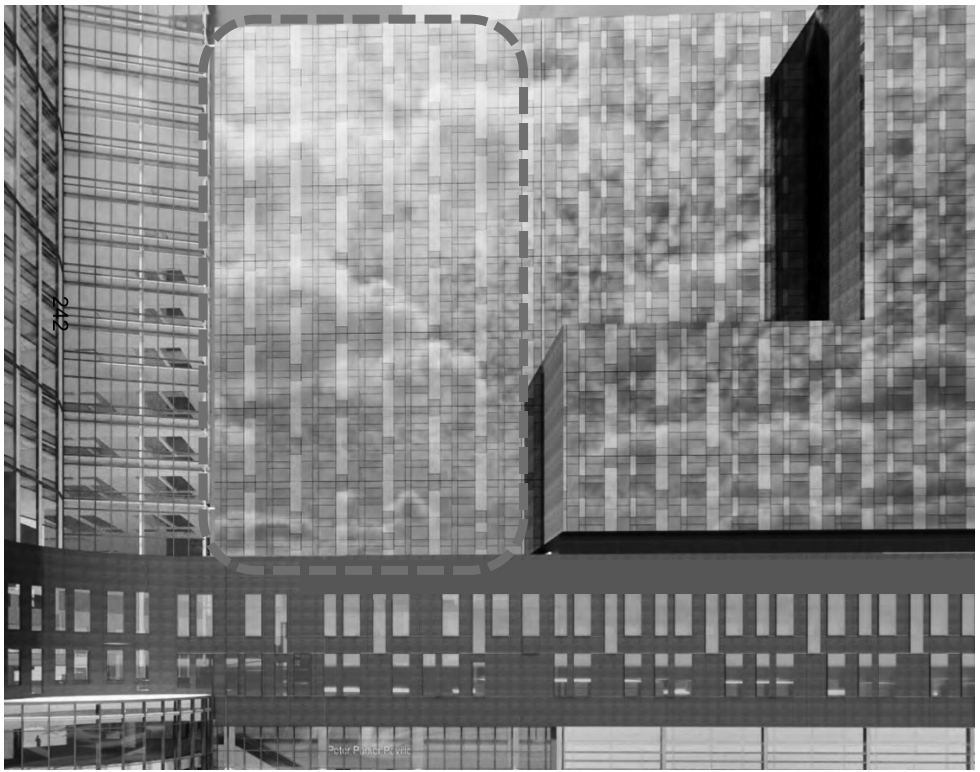
- 76 Antepartum; Postpartum Beds 36% increase in prior capacity
- 25% increase in "Birthing Suites"
- NICU: **Nationwide Children's Hospital** – OSU Partnership
  - 60 Bassinets, including 9 Couplet Suites (Mom and baby together)

Postpartum

Antepartum/ Labor & Delivery

Neonatal ICU (NICU) "Couplet Care"

Hospital Program: James "Pavilion"



- 11 Floors, 110,000 GSF "addition" to the James providing transition to University Hospital Tower
- 84 additional "James Beds" consistent with Medical Center's Strategic Plan

University Hospital

HIGH-RIS
HIGH-RIS
GROUN

August 10-27-2020, Board of Trustee Meetings

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Project Components & Cost

Hospital Project: Project Components

Components	Sq. Ft.	Total Project Cost
Central Sterile Supply Building	62,000	$45,300,000
Visitor Garage & Infrastructure (1887 Parking Spaces)	715,000	$101,000,000
Hospital Tower	1,904,000	$1,791,000,000*
Rhodes/Doan Support Services	307,000	Included in Tower Cost
Total	2,988,000 Sq. Ft.	$1,937,300,000

*Does not include $6.2M in Ohio State Energy Partners funding for utilities scope

Hospital Project: Hospital Tower Total Project Cost

Hospital Tower Cost Components	Total Project Cost ($ millions) as of July 31, 2020
Construction Cost	$1,204
Covid Upgrades	4
Medical, Other Equipment, etc.	291
Design, Pre-Construction, Commissioning	118
Project Administration	35
Contingency	139
Total	$1,791*

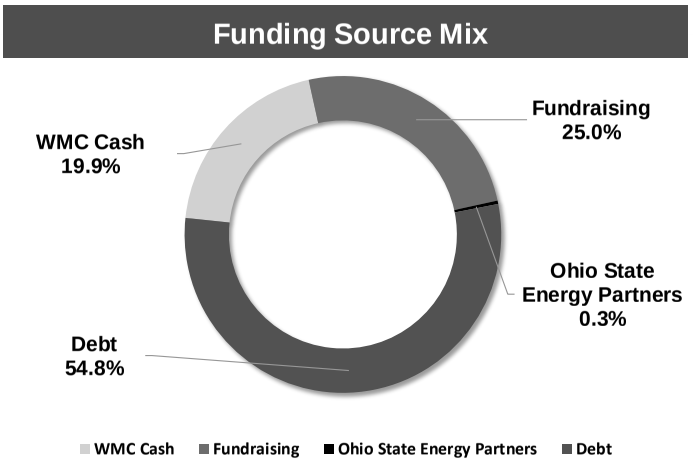
*Does not include $6.2M in Ohio State Energy Partners funding for utilities scope

Project Funding

Hospital Project: Funding Sources

- Funding sources have been programmed and vetted through the university's strategic long-range financial planning process.
- Funding sources will be utilized over the FY21-FY25 time period.

Funding Sources ($ in millions)		
WMC Cash	$	357.0
Fundraising		450.0
Ohio State Energy Partners		6.2
Debt		984.0
Total	$	1,797.2



Discussion/Questions