



APPENDIX II

Board of Trustees

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

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trustees.osu.edu

SUMMARY OF ACTIONS TAKEN

August 17, 2021 - Wexner Medical Center Board Meeting

Members Present:

Erin P. Hoefflinger
Hiroyuki Fujita
Alan A. Stockmeister
John W. Zeiger

Cindy Hilsheimer
Gary R. Heminger (ex officio)
Kristina M. Johnson (ex officio)

Harold L. Paz (ex officio)
Melissa L. Gilliam (ex officio)
Michael Papadakis (ex officio)

Members Present via Zoom:

Abigail S. Wexner
Carly G. Sobol

W.G. "Jerry" Jurgensen
Amy Chronis

Members Absent:

Leslie H. Wexner

Stephen D. Steinour

Robert H. Schottenstein

PUBLIC SESSION

The Wexner Medical Center Board convened for its 39th meeting on Wednesday, August 17, 2021, in person at the Longaberger Alumni House on the Columbus campus and virtually over Zoom. Board Secretary Jessica A. Eveland called the meeting to order at 1:00 p.m.

Item for Action

1. Approval of Minutes: No changes were requested to the May 18, 2021, meeting minutes; therefore, a formal vote was not required, and the minutes were considered approved.

Items for Discussion

2. Chancellor's Report: Dr. Harold Paz*, EVP and Chancellor for Health Affairs at Ohio State and CEO of the Wexner Medical Center, welcomed Provost Melissa Gilliam to her role and as a new member of the Wexner Medical Center Board. He highlighted the construction work that is being done on the 1.9 million-square-foot inpatient hospital tower, which will help the medical center to revolutionize patient care, groundbreaking research and innovative training for the next generation of healthcare professionals.

Dr. Paz also shared the medical center's recently released Health Equity and Anti Racism Report, which provides a snapshot of achievements since the Anti Racism Action Plan was established a little over a year ago. The report highlights work done by partnering with the community to shine a spotlight on programs that have long been a part of Ohio State's legacy of caring for our neighbors and also areas we plan to improve so we can have a meaningful and sustainable impact.

Given our ambitious vision to build the academic health center of the future, the medical center is focused on providing more convenient and accessible health care experiences for everyone. To that end, we recently announced three new innovative home health relationships – DispatchHealth, which offers patients an expanded opportunity to receive convenient and safe medical care in their own homes; the

**This was the final meeting prior to Dr. Harold Paz stepping down from his role.*



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Livongo telehealth program for patients with diabetes; and Alternative Solutions Health Network to strengthen our post-acute home care. Dr. Paz also shared that we are making tremendous progress with our outpatient care strategy, including the recent opening of the Outpatient Care New Albany facility, which offers comprehensive health care in a convenient community setting, including advanced imaging, lab work, specialized treatments, physical therapy and outpatient surgery. In its first weeks of being open, the facility saw more than 3,100 patients and booked more than 20,000 patients for future appointments.

Meanwhile, *U.S. News & World Report* has ranked the Wexner Medical Center among the nation's best hospitals for the 29th consecutive year. Overall, the medical center is once again ranked as the No. 1 hospital in Columbus and second in the state of Ohio, and 10 of our specialties were ranked among the top programs of their kind in the United States.

Finally, Dr. Paz also welcomed a few new members of the medical center leadership team, including Mr. Jay Anderson, Chief Operating Officer; Dr. Cheryl Lee, first-ever Chief Health Equity Officer; Mr. Matt Albers, Deputy General Counsel; Mr. Rachit Thariani, Chief Administrative Officer, Post-Acute and Home-Based Care Division; and Mr. Michael Faber, Vice President of the Wexner Medical Center and Health Sciences Advancement.

(See Attachment I for background information, page 102)

3. Leading the Way: Comprehensive Transplant Center: Dr. Ken Washburn, Director of the Comprehensive Transplant Center, gave an overview of the medical center's highly respected transplant program. Since 1967, Ohio State has saved 11,000 people needing a liver, heart, lung, pancreas or kidney. Less than 10% of the nation's transplant centers can say the same. Dr. Washburn talked about the program's growth, quality and the innovative work being done by a variety of scientist researchers. Over the last five year, the transplant program has almost doubled in size. Over the past several years, Ohio State's program was consistently in the top 20, but in the last four years it has moved up to the top 10. In the month of July, the program had its biggest month ever, performing 70 transplants across all organ systems. When it comes to quality, we are also above the national outcomes for every single organ system, and have been for several years, which is a true testament to the program and its team.

(See Attachment II for background information, page 110)

4. James Cancer Hospital Report: Dr. William Farrar, CEO of the James Cancer Hospital, shared details about the James Wellbeing Advisory Council, which has been tasked with providing as many health and wellness program options as possible to help faculty and staff take care of themselves and cope with daily stressors in their lives. He also shared concerns around the dramatic drops the James has seen, due to the pandemic, in annual well visits and immunizations. Over the past year, we have seen a significant decrease in HPV vaccinations. HPV can cause up to six types of cancer and since March of 2020 an estimated 1 million doses of HPV vaccine have been missed by adults with public insurance. That is a decline of 21% over pre-pandemic levels. The James joined 71 NCI-Designated Cancer Centers to issue a joint statement urging the nation's healthcare systems, physicians, parents and others to get the HPV vaccination effort back on track. This is only the fourth time that all 71 NCI centers have come together to issue a national call to action. Dr. Farrar also shared that Ohio State is the nation's first academic medical center to test a new FDA-approved cancer screening procedure for computer-aided polyp detection. This could potentially reduce colorectal cancer by more than 40%. He also shared that the Multinational Association of Supportive Care in Cancer (MSACC) has certified the James Cancer Hospital as an MSACC-Designated Center of Excellence and Supportive Care. The James is only the second institution in the United States to receive this certification, which validates our commitment to uphold standards and provide comprehensive patient-centered services in supportive care. Lastly, he thanked the more than 10,000 people who participated in the 2021 Pelotonia – 6,000 riders and 4,000 volunteers. We have now collectively raised more than \$230 million for cancer research at the James.

(See Attachment III for background information, page 134)



5. Wexner Medical Center Financial Report: Wexner Medical Center CFO Mark Larmore reported on the pre-audit financial results for the year ended June 30, 2021, at the health system and medical center. The health system – which includes the seven hospitals – saw excess revenue of more than \$329 million, which was \$54.8 million ahead of budget and about \$15 million ahead of where the system was at this time the previous year. With nearly \$3.6 billion in operating revenue, the system grew year-over-year by around \$300 million. The combined Wexner Medical Center results, consisting of the health system, College of Medicine and OSU Physicians, showed nearly \$386 million in excess revenue with a margin of 8.4% compared to last year's nearly \$365 million with a margin of 8.8%. Total revenue grew 10.7% for a total of \$4.56 billion. On the pre-audit balance sheet for the combined medical center, total assets are slightly under \$6 billion, which is an increase of nearly \$466 million from the prior year.

(See Attachment IV for background information, page 143)

Items for Action

6. Resolution No. 2022-01, Recommend for Approval Acceptance of Real Property:

AT 1539 CLIFTON AVENUE
COLUMBUS, FRANKLIN COUNTY, OHIO

Synopsis: Authorization to accept a gift of real property located near University Hospital East, at 1539 Clifton Avenue, City of Columbus, Franklin County, Ohio, for strategic holding and potential future development, is proposed.

WHEREAS The Ohio State University ("University") seeks to accept approximately 0.13 acres of unimproved real property located near University Hospital East, on Clifton Avenue, in the City of Columbus, Ohio; and

WHEREAS the property is intended to support future general expansion and redevelopment:

NOW THEREFORE

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

(See Attachment V for background information, page 149)



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7. Resolution No. 2022-02, Recommend for Approval Purchase of Real Property:

AT TAYLOR AVENUE AND ATCHESON STREETS,
COLUMBUS, FRANKLIN COUNTY, OHIO

Synopsis: Authorization to acquire property located adjacent to Outpatient Care East, near Atcheson Street and Taylor Avenue, City of Columbus, Franklin County, Ohio, for general expansion and redevelopment purposes, is proposed.

WHEREAS The Ohio State University ("University") seeks to acquire approximately 1.5 acres of unimproved real property located at Outpatient Care East, near Taylor Avenue, in the City of Columbus, Ohio; and

WHEREAS the property is intended to support future general expansion and redevelopment:

NOW THEREFORE

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

(See Attachment VI for background information, page 150)

8. Resolution No. 2022-03, Recommend Approval to Enter Into/Increase Professional Services and Enter Into/Increase Construction Contracts:

APPROVAL TO ENTER INTO PROFESSIONAL SERVICES CONTRACTS

Martha Morehouse Tower Upgrades
WMC Facility Optimization Study

APPROVAL TO ENTER INTO/INCREASE PROFESSIONAL SERVICES AND CONSTRUCTION CONTRACTS

Atwell – ADL Simulation Lab
University Hospital East – 4th Floor OR Upgrades

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

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

	Prof. Serv. Approval Requested	Total Requested	
Martha Morehouse Tower Upgrades	\$2.5M	\$2.5M	Auxiliary Funds
WMC Facility Optimization Study	\$1.0M	\$1.0M	Auxiliary Funds



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

	Prof. Serv. Approval Requested	Construction Approval Requested	Total Requested	
Atwell – ADL Simulation Lab	\$0.4M	\$4.2M	\$4.6M	University funds
University Hospital East – 4th Floor OR Upgrades	\$0.8M	\$2.1M	\$2.9M	Auxiliary funds

NOW THEREFORE

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

(See Attachment VII for background information, page 151)

Action: Upon the motion of Dr. Paz, seconded by Mr. Stockmeister, the board adopted the foregoing resolutions by unanimous voice vote with the following members present and voting: Mrs. Hoeflinger, Dr. Fujita, Mr. Stockmeister, Mr. Zeiger, Ms. Hilsheimer, Mr. Heminger, Dr. Johnson, Dr. Paz, Dr. Gilliam and Mr. Papadakis.

9. Resolution No. 2022-04, QPAC 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 FY2022-2023 are as follows:

Quality and Professional Affairs Committee

- Alan A. Stockmeister, Chair
- Erin P. Hoeflinger
- Carly G. Sobol
- Harold L. Paz
- MELISSA L. GILLIAM**
- Michael Papadakis
- JAY M. ANDERSON**
- Andrew M. Thomas
- David E. Cohn
- Elizabeth Seely
- Scott A. Holliday
- Iahn Gonsenhauser
- Jacalyn Buck
- Kristopher M. Kipp
- Lisa Keder
- Alison R. Walker
- Abigail S. Wexner (ex officio)



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10. Resolution No. 2022-05, Scope of Care, The Ohio State University Ambulatory Surgery Center, Outpatient Care New Albany:

Synopsis: Approval of the annual review of the scope of patient care services for The Ohio State University Ambulatory Surgery Center — Outpatient Care New Albany, 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 scope of care describes services related to elective outpatient procedures at The Ohio State University Ambulatory Surgery Center — Outpatient Care New Albany; and

WHEREAS the scope of care for The Ohio State University Ambulatory Surgery Center — Outpatient Care New Albany was approved by the Medical Staff Administrative Committee (University Hospitals) on July 14, 2021; and

WHEREAS on July 27, 2021, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the scope of patient care services for The Ohio State University Ambulatory Surgery Center — Outpatient Care New Albany:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the scope of care for The Ohio State University Ambulatory Surgery Center — Outpatient Care New Albany as outlined in the attached document.

(See Attachment VIII for background information, page 155)

11. Resolution No. 2022-06, Clinical Quality Management, Patient Safety, and Service Plans:

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 FY22 outlines the 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 FY22 was approved by the Quality Leadership Council June 30, 2021; and

WHEREAS the annual review of the Clinical Quality, Patient Safety and Reliability Plan for FY22 was approved by the University Hospitals Medical Staff Administrative Committee on July 14, 2021; and

WHEREAS on July 27, 2021, 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 FY22 for University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital:



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NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the Clinical Quality Management, Patient Safety, and Service Plan for FY22 (attached) for University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital.

(See Attachment IX for background information, page 164)

12. Resolution No. 2022-07, Clinical Quality, Patient Safety, and Reliability Plan:

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, Patient Safety, and Reliability Plan for FY22 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, Patient Safety, and Reliability Plan for FY22 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, Patient Safety, and Reliability Plan for FY22 was approved by The James Quality, Patient Safety, and Reliability Committee on July 7, 2021; and

WHEREAS the annual review of the Clinical Quality, Patient Safety, and Reliability Plan for FY22 was approved by The James Medical Staff Administration Committee on July 16, 2021; and

WHEREAS on July 27, 2021, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the annual review of the Clinical Quality, Patient Safety, and Reliability Plan for FY22 for The James:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the Clinical Quality, Patient Safety, and Reliability Plan for FY22 (attached) for The James.

(See Attachment X for background information, page 197)

13. Resolution No. 2022-08, Plan for Patient Care Services:

OHIO STATE UNIVERSITY HOSPITALS d/b/a OSU WEXNER MEDICAL CENTER

Synopsis: Approval of the annual review of the plan for 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



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WHEREAS the plan for 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 patient care services was approved by the Medical Staff Administrative Committee (University Hospitals) on June 9, 2021; and

WHEREAS on July 27, 2021, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the annual review of the plan for patient care services:

NOW THEREFORE

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

(See Attachment XI for background information, page 231)

14. Resolution No. 2022-09, Plan for Patient Care Services:

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 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 patient 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 patient care services was approved by the Medical Staff Administrative Committee (The James) on July 16, 2021; and

WHEREAS on July 27, 2021, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the annual review of the plan for patient care services:

NOW THEREFORE

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

(See Attachment XII for background information, page 244)



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15. Resolution No. 2022-10, Direct Patient Care Services Contracts and Patient Impact Service Contracts Evaluations:

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 April 14, 2021; and

WHEREAS on July 27, 2021, 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 XIII for background information, page 260)

16. Resolution No. 2022-11, Direct Patient Care Services Contracts Patient Impact Service Contracts Evaluation:

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 July 16, 2021; and



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WHEREAS on July 27, 2021, 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 XIV for background information, page 262)

17. Resolution No. 2022-12, Antimicrobial Stewardship Program:

OHIO STATE UNIVERSITY HOSPITALS d/b/a OSU 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 Jeremy Young, 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. Young serve as the Medical Director responsible for the Antimicrobial Stewardship Program by letter (attached) dated July 8, 2021; and

WHEREAS on July 27, 2021, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve Dr. Young 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. Young 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 XV for background information, page 268)



18. Resolution No. 2022-13, Antimicrobial Stewardship Program Leader:

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 Zeinab El Boghdadly, MBCh 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. El Boghdadly serves as the leader responsible for the Antimicrobial Stewardship Program by letter (attached) dated June 21, 2021; and

WHEREAS on July 27, 2021, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve Dr. El Boghdadly 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. El Boghdadly serve as the leader responsible for the Antimicrobial Stewardship Program at The James.

(See Attachment XVI for background information, page 269)

Action: Upon the motion of Dr. Fujita, seconded by Mr. Zeiger, the board approved the foregoing motions by unanimous roll call vote with the following non-public members present and voting: Mrs. Hoeflinger, Dr. Fujita, Mr. Stockmeister, Mr. Zeiger, Mr. Heminger, Dr. Johnson, Dr. Paz, Dr. Gilliam and Mr. Papadakis.

EXECUTIVE SESSION

It was moved by Dr. Johnson, and seconded by Ms. Hilsheimer, that the board recess into executive session to consider business-sensitive trade secrets and quality matters required to be kept confidential by federal and state statutes, to consult with legal counsel regarding pending or imminent litigation, 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: Mrs. Hoeflinger, Dr. Fujita, Mr. Stockmeister, Mr. Zeiger, Ms. Hilsheimer, Mr. Heminger, Dr. Johnson, Dr. Paz, Dr. Gilliam and Mr. Papadakis.

The board entered executive session at 2:07 p.m. and adjourned at 4:59 p.m.

ATTACHMENT I



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WEXNER MEDICAL CENTER

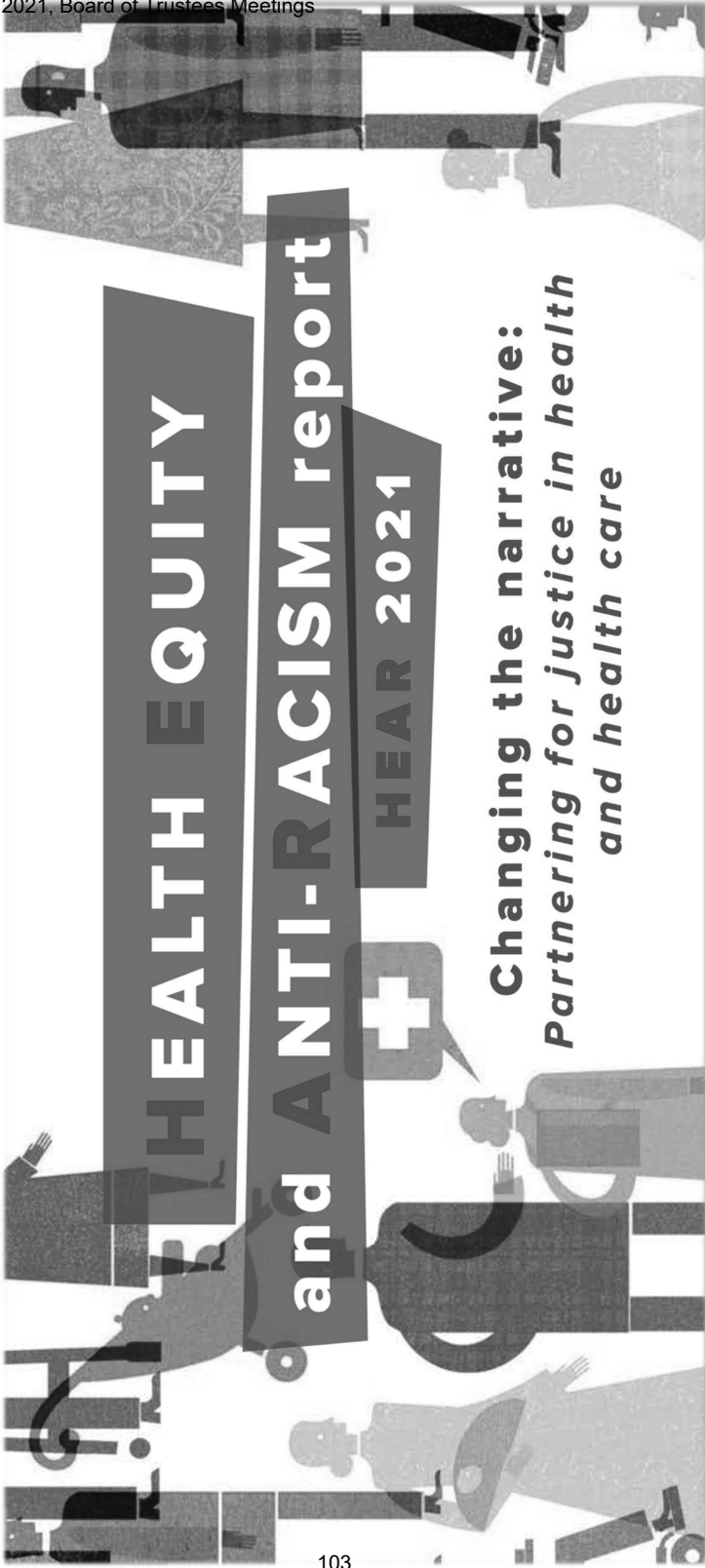
CHANCELLOR'S REPORT

Hai Paz, MD

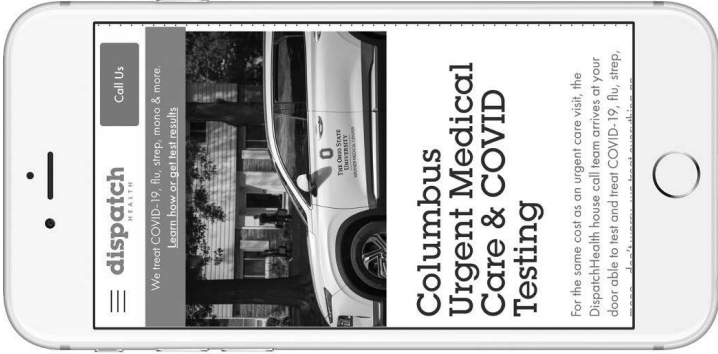
*Executive Vice President and Chancellor for Health Affairs, The Ohio State University
Chief Executive Officer, Ohio State Wexner Medical Center*

Tuesday, August 17

Health Equity and Anti-Racism | Inaugural Report



Expanding the Continuum of Care | New Partnerships



dispatchhealth

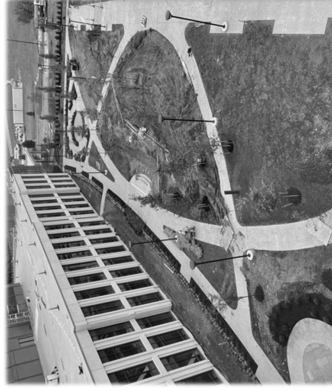
TeladocTM HEALTH



ALTERNATE SOLUTIONS

Health Network

Expanding the Continuum of Care | Outpatient Care New Albany



Welcome | New Leaders

August 17-19, 2021, Board of Trustees Meetings



Matthew Albers, JD



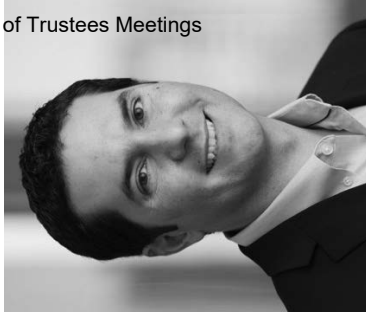
Rachit Thariani



Jay Anderson



Cheryl Lee, MD



Michael Faber, EdM

US News and World Report | Best Hospitals Rankings

Nationally ranked in
10 of 15
 specialties

Ranked
#2
 in Ohio

Rated “High Performing” in
13 of 17
 procedures and conditions

Recognized in
24
 types of care

Ranked
#1
 Columbus Metro

#1 HOSPITAL IN COLUMBUS



Nationally Ranked in **10** adult specialties



Pelotonia | Thank You Team Buckeye



Thank You

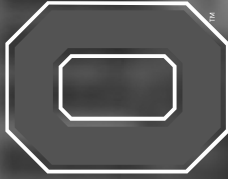


wexnermedical.osu.edu





ATTACHMENT II



Comprehensive Transplant Center 2021 Board Update

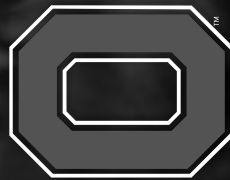
Kenneth Washburn, MD

Professor, Department of Surgery

Executive Director, Comprehensive Transplant Center

Chief, Division of Surgery, Department of Surgery

August 17, 2021



Comprehensive Transplant Center

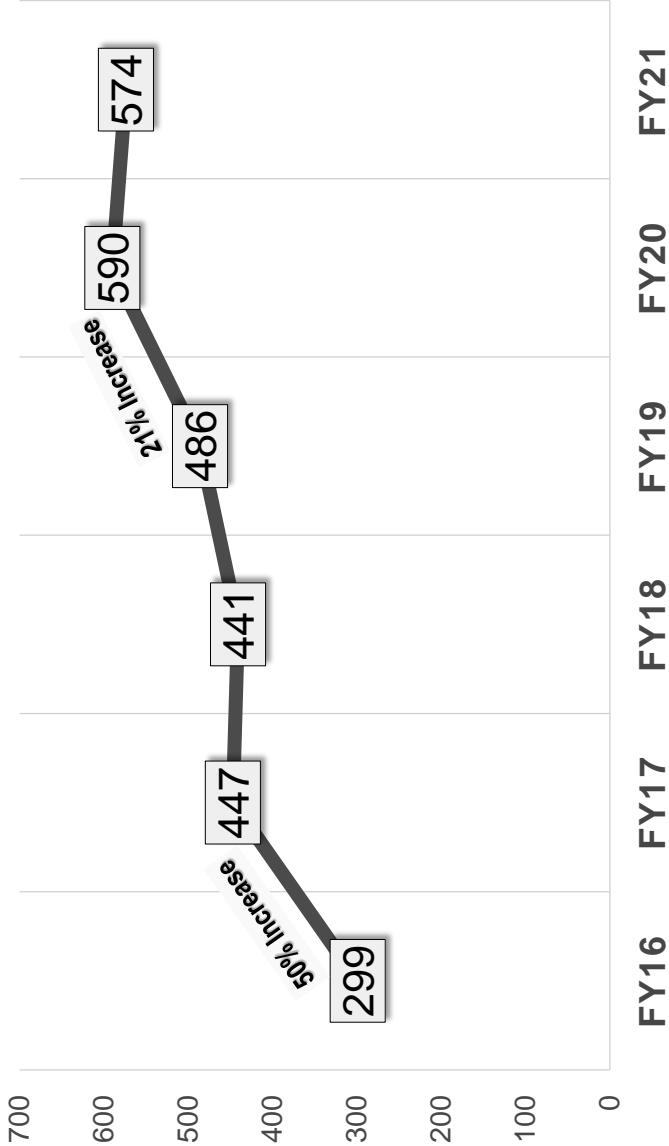
GROWTH

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THE OHIO STATE
UNIVERSITY
WEXNER MEDICAL CENTER

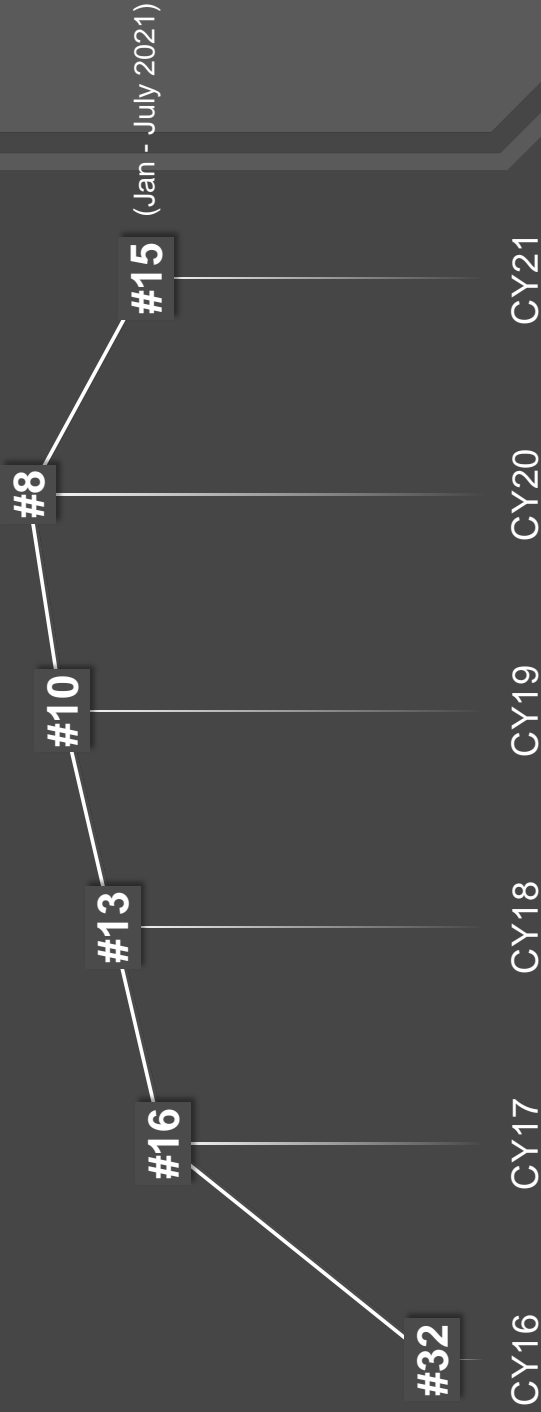
Transplant Surgery Volume



Central Ohio's only adult transplant center

1 of 2 centers in Ohio capable of transplanting ALL solid organs

National Ranking by Volume (n = 250 U.S. Transplant Centers)



National Volume 2021 (Jan – June)

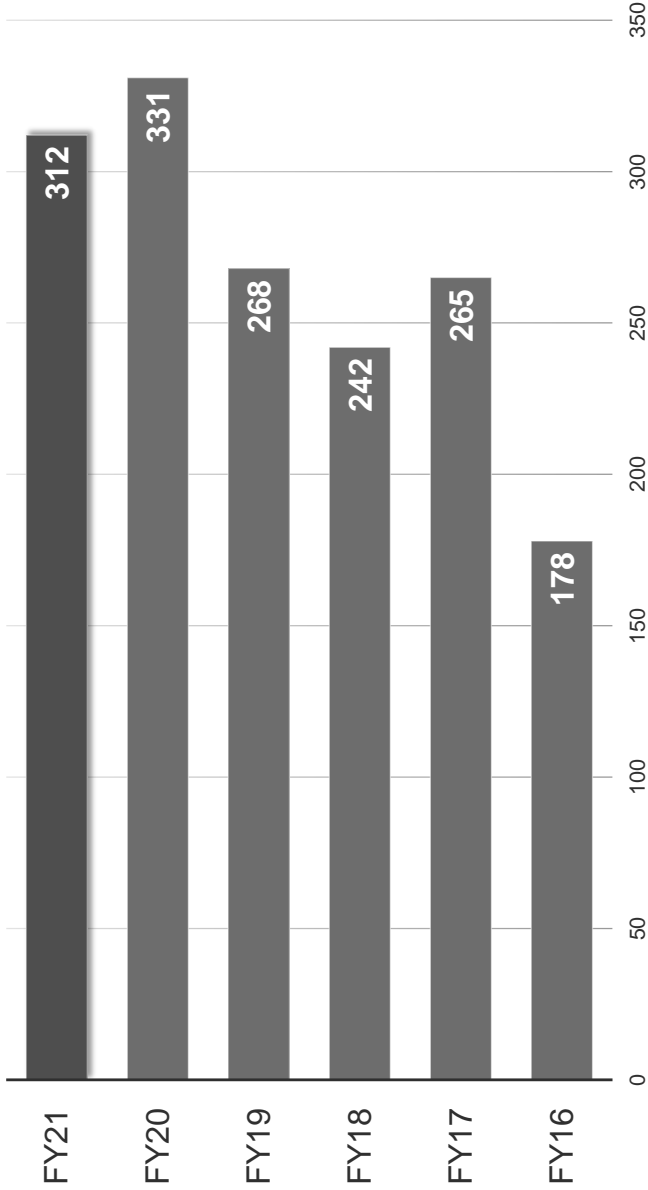
#15 for All Organs Transplanted

(n = 250 centers)

##	All Transplant Centers	Total Organs	Kidney	Liver	Panc	K-P	Heart	Lung	Heart-Lung
		21,060	12,503	4,704	78	442	1,931	1,339	18
1	CA – University of California at Los Angeles Medical Center	368	211	74	1	1	38	40	0
2	AZ – Mayo Clinic Hospital	367	233	104	0	15	15	0	0
3	OH – The Cleveland Clinic Foundation	366	158	116	3	7	22	55	0
4	CA – University of California San Francisco Medical Center	337	204	73	0	11	12	36	1
5	FL – Jackson Memorial Hospital Univ of Miami School of Medicine	320	186	91	7	7	7	14	0
6	TN – Vanderbilt University Medical Center	317	156	59	0	6	71	24	1
7	FL – Tampa General Hospital	311	182	84	0	5	14	26	0
8	IN – Indiana University Health	302	159	84	6	12	17	19	0
9	CA – Cedars-Sinai Medical Center	298	138	62	1	5	65	27	0
10	SC – Medical University of South Carolina	293	222	36	3	7	17	8	0
11	TX – Houston Methodist Hospital	292	117	94	1	8	31	39	2
12	GA – Emory University Hospital	290	188	71	0	3	20	8	0
13	GA – Piedmont Hospital	284	198	72	0	6	8	0	0
14	NC – Duke University Hospital	280	119	56	0	4	49	52	0
15	OH – Ohio State University Wexner Medical Center	280	148	70	0	7	18	37	0
16	IL – Northwestern Memorial Hospital	276	145	65	3	9	19	35	0
17	MO – Barnes-Jewish Hospital	273	128	81	2	6	18	38	0
18	NY – NY Presbyterian Hospital/Columbia Univ. Medical Center	272	104	57	3	2	50	53	1
19	VA – VCU Health System Authority, VCUMC	266	156	92	0	5	13	0	0
20	NY – NYU Langone Health	258	177	23	0	8	25	24	1



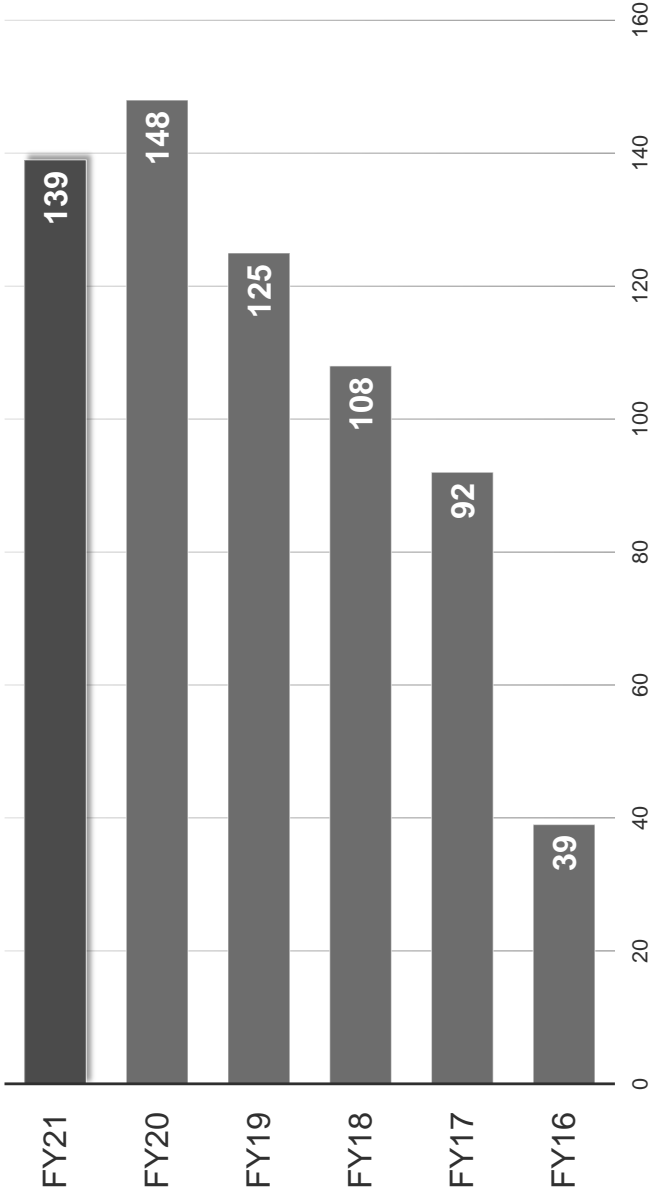
Kidney Transplant



**“Best in Ohio”
for Patient
Outcomes
(July 2021)**

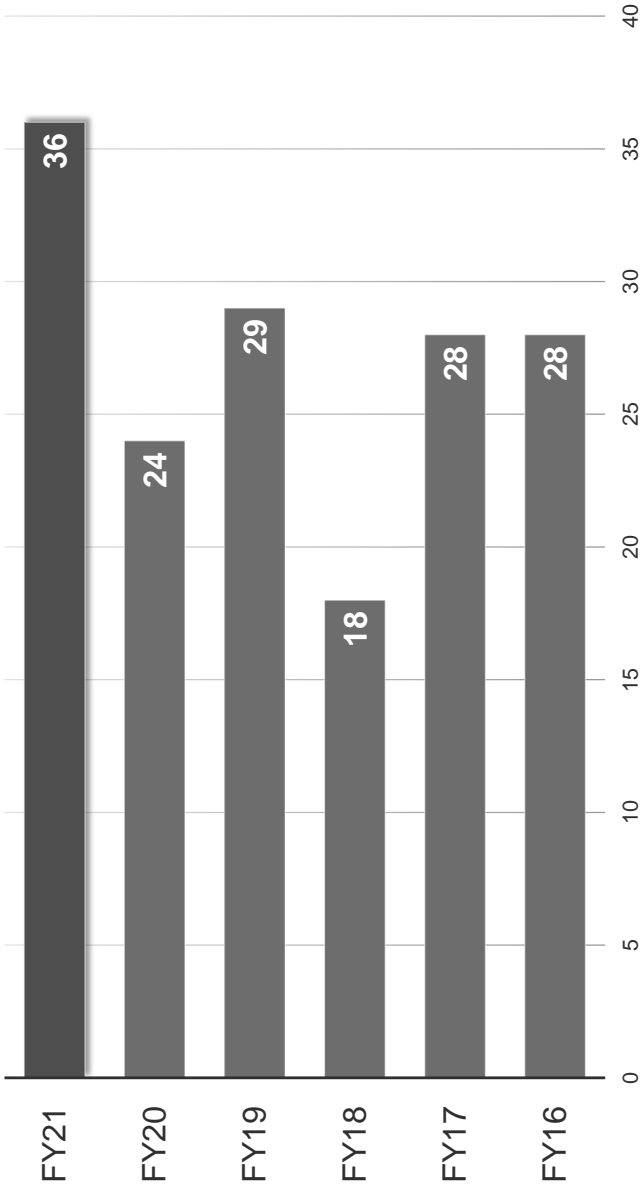
**#19 by Volume
Nationally
(Jan - July 2021)**

Liver Transplant



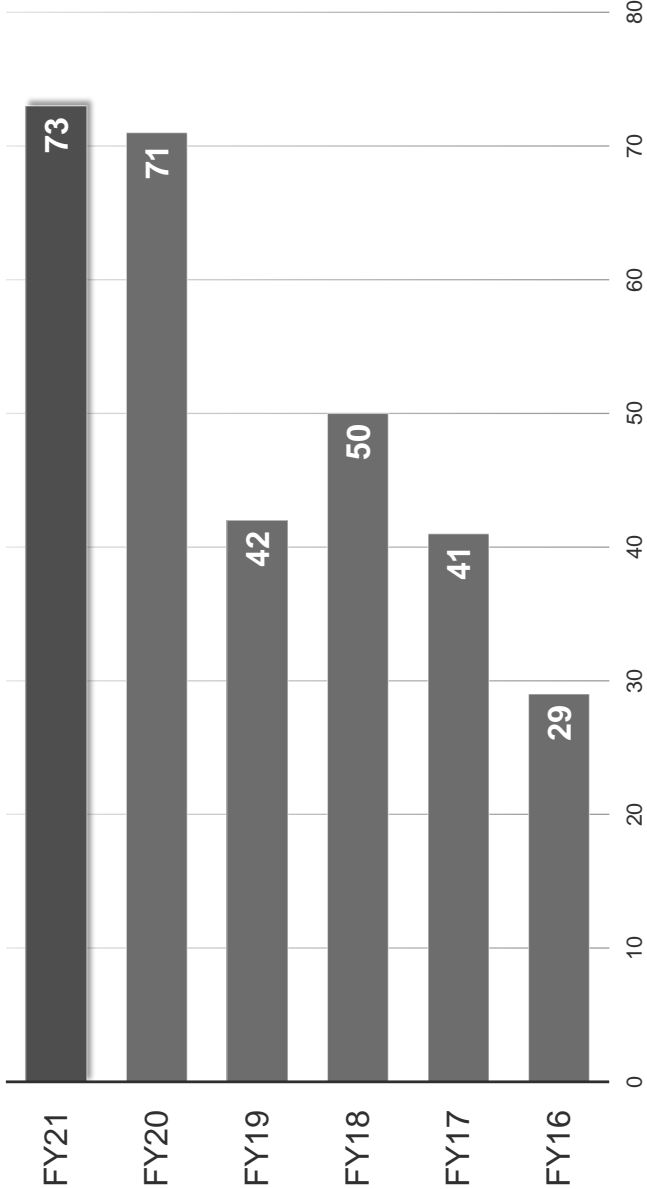
**#21 by Volume
Nationally**
(Jan - July 2021)

Heart Transplant

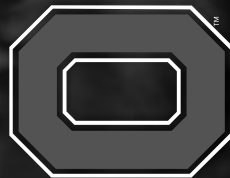


**#39 by Volume
Nationally**
(Jan - July 2021)

Lung Transplant



**#10 by Volume
Nationally**
(Jan - July 2021)



Comprehensive Transplant Center

QUALITY

ity Wexner Medi

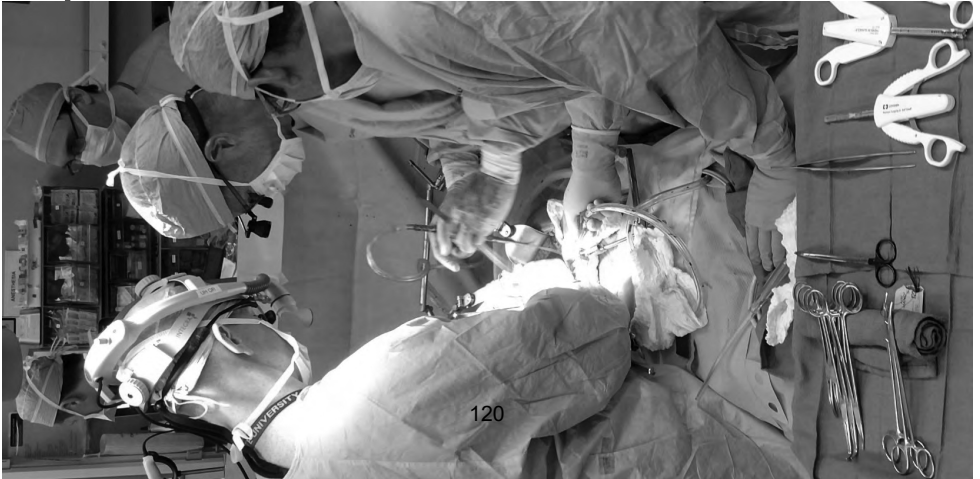


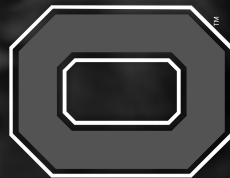
THE OHIO STATE
UNIVERSITY
WEXNER MEDICAL CENTER

Patient Survival Data

(Data released July 6, 2021)

1-YEAR PATIENT SURVIVAL	
OSUWMC ACTUAL	NATIONAL OUTCOMES
Heart (n=62)	91.88% (n=5,868)
Lung (121)	89.68% (n=5,508)
Liver (n=254)	93.92% (n=15,447)
Kidney (n=533)	97.62% (n=40,563)
Above National Outcomes	





Comprehensive Transplant Center

RESEARCH & INNOVATION

University of
Cincinnati
Wexner Medical Center



THE OHIO STATE
UNIVERSITY
WEXNER MEDICAL CENTER

Bumgardner Transplant Immunology Lab

Improving lives with new discoveries

Mission:

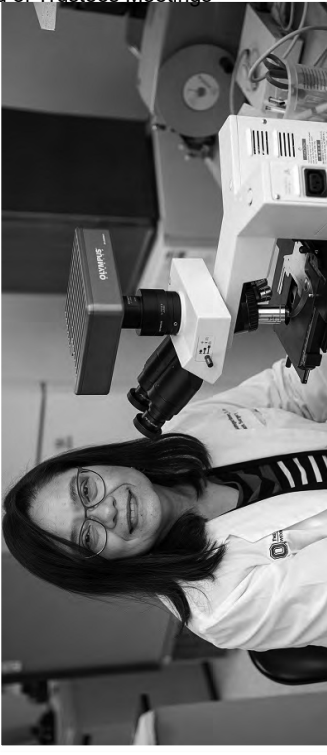
Investigate immune response to develop immunotherapies to prolong survival of transplanted organs

Current Awards:

- ARTIST NIH/NIAID Grant – \$1.6M
(Principal Investigator for Advanced Research Training in Immunology for Surgical Research Trainees)
- NIH RO1 Grant – \$2.6M
- TL1 NIH Grant – \$258K

Recent News:

Uncovered an immune cell that may predict a transplant patient's risk of developing antibodies that cause organ rejection



Ginny Bumgardner, MD, PhD

Lab Director

Associate Dean, ADM-Medicine Administration

Director, Medical Student Research

Director, Department of Surgery Research Training Program

Director, College of Medicine's Master of Medical Science Program

COPPER Lab

Improving lives with new discoveries

Mission:

Development of ex-vivo organ perfusion for organ assessment, repair and modification to improve transplant outcomes and increase the number of available organs for transplant

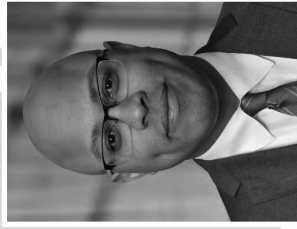
Current Awards:

- Accelerator Award (Drs. Whitson & Black jointly)
- Dr. Whitson:
 - NIH ROI – \$3.4M
 - Defense Dept – \$3.6M
- Dr. Black: NIH ROI – \$3.2M

Recent News:

- First ex-vivo lung perfusion study in 2016
- First ex-vivo liver perfusion study in 2019

Bryan Whitson, MD, PhD
Lab Co-Director



Sylvester Black, MD, PhD
Lab Co-Director

Schenk Transplant Immunology Lab

Improving lives with new discoveries

Mission:

Investigate immune response to develop immunotherapies to prolong survival of transplanted organs

Current Awards:

- AHA Career Development Award
- Ohio Solid Organ Transplant Consortium Grant

Recent News:

- Newest lab, opened in 2019
- Focus on T cell biology in transplantation



Austin Schenk, MD, PhD
Lab Director

Transplant Biorepository

Mission:

Provide high quality, clinically annotated samples from normal and diseased organs for OSU-affiliated research

Significance:

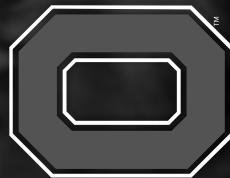
- Prior to 2017 start, OSU did not have a human tissue processing center (outside of The James)
- Human tissue is in high demand for research as animal models do not always yield accurate results
 - Access to human tissue facilitates innovation and allows investigators to be competitive for grants and high impact publications

Recent News:

- Processed nearly 5,000 tissue samples to date (both normal and diseased)
- Support 12 OSU and NCH investigators
- Provide research tissue for Battelle, Boehringer Ingelheim, Natera and CareDx



Brenda Reader, PhD
Lab Director



Comprehensive Transplant Center

OUTREACH & EXPANSION

ity Wexner Medi



THE OHIO STATE
UNIVERSITY
WEXNER MEDICAL CENTER

3 Transplant Clinics – Dayton, Lima, Cincy

Healthy State Alliance with Mercy Health

Opened Oct 2017 - Dayton



Beavercreek Health Center

Liver = clinic 1x/every other month, alternating with Cincy
Kidney = clinic 1x/month
Lung = clinic 1x/every other month, moving to Cincy in Sept

FY21 Patients Seen = 79

Opened July 2020 – Lima



MH – St. Rita’s Medical Center

Liver = clinic 1x/month
Kidney = clinic 1x/month
Lung = clinic 1x/every other month

Patients Seen at Location = 140

- 6 transplanted
- 1 transplant scheduled
- 5 added to wait list

Opened Oct 2020 - Cincinnati



The Jewish Hospital – MH

Liver = clinic 1x/every other month
Lung = opening Sept. 2021, alternate months with Lima

Patients Seen at Location = 17

- 1 added to wait list

COVID-19 Related Lung Transplants

Regional area of expertise

- 7 double lung transplants related to COVID-19 since 12/10/2020 with no deaths (all in-state)
- 40+ referrals (approx. 25% out-of-state – IN, MI, WI, KY)
- Many of our out-of-state referrals came to OSU after being turned down in their local state
- Cleveland Clinic also performing in Ohio, but as of April we have performed more
- Matthew Henn, MD drafting scientific paper on care findings

Lung Transplant Leadership



Bryan Whitson, MD, PhD
Surgical Director



David Nunley, MD
Medical Director

The Columbus Dispatch

Some Ohio COVID patients get second shot at life thanks to lung transplants

Max Filby The Columbus Dispatch

Greg Borden knew that COVID-19 would wreak havoc on his city. He thought it, but he never expected it would take his lungs in the process.

After a year of “living in a bubble,” Borden, 40, of Enon, caught the virus in mid-November.

“When COVID hit me, my breathing was so decimated,” he said. “I could hardly walk or move around.”

After Borden was hospitalized, doctors took a scan of his lungs that revealed a buildup of scar tissue. Soon afterward, they told him he’d need a rare double-lung transplant.



Greg Borden, 40, of Enon, rests in a bed at Ohio State University Wexner Medical Center after receiving a double-lung transplant. Borden needed the transplant after suffering a severe case of COVID-19. Photo provided

Organ Recovery Innovations

- **Ex-Vivo Organ Perfusion**
 - Rehabilitates organs once considered unusable for transplant

- **5 Doan Hall**
 - Heart
 - Lung
 - Liver
 - Kidney

Organ Assessment and Repair Center

 **THE OHIO STATE UNIVERSITY**
WEXNER MEDICAL CENTER
Comprehensive Transplant Center



- **Organ Recovery Team (ORT)**

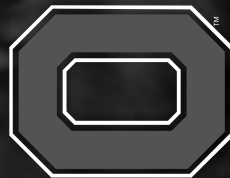
- 9 organ recovery specialists
- 18 months in operation
- Facilitated 550+ transplants
- Review 15-20 organ offers per day
- Coordinated 200+ transport flights



It Takes
A Village...



Team Members Strong!



Comprehensive Transplant Center

MILESTONES

ity Wexner Medi



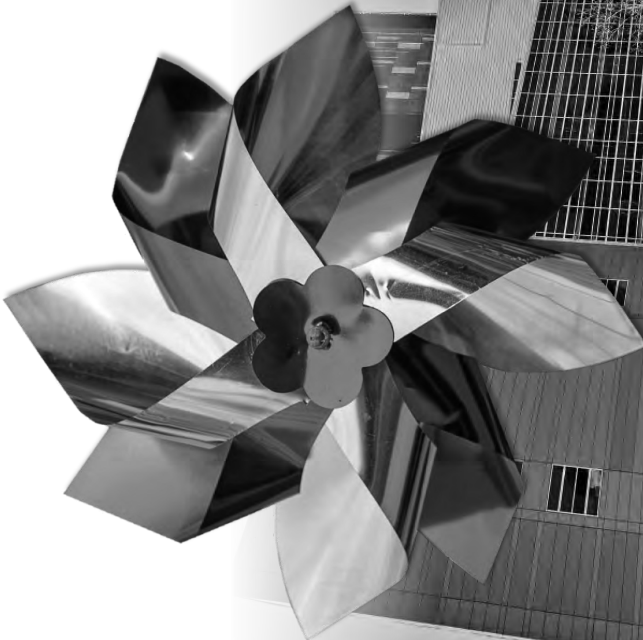
FY21 Milestones

Comprehensive Transplant Center

- 11,000 solid organ transplants
 - 10,000 abdominal transplants
 - 1,000 cardiothoracic transplants
- Consistently ranked top 20 transplant center by volume last 5 years
- Expanded pinwheels messaging during Donate Life Month
 - East Hospital
 - Mercy Health – St. Rita’s Medical Center
 - The Jewish Hospital – Mercy Health



Comments



The Ohio State University Wexner



THE OHIO STATE
UNIVERSITY

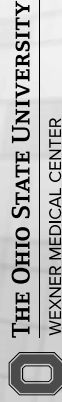
WEXNER MEDICAL CENTER

Wexner Medical Center Board Report

William Farrar, MD
August 17, 2021



The James



Creating a Cancer-free World.
One Person, One Discovery at a Time.

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

The OSUCCC – James is prioritizing the health and well-being of our faculty and staff by providing evidence-based resources, tools and education to support individuals in their journey to optimal wellness.

James Well-Being Advisory Council



Engaging in meaningful discussions with faculty and staff



Developing, implementing and providing tools and resources for support



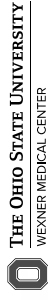
Identifying opportunities for education and training



Prioritizing taking care of ourselves, each other and our community

The James

The OSUCCC-James program is closely aligned with several OSUWMC and OSU programs including: Gabbe Health and Wellness, Your Plan for Health, the Employee Assistance Program and Caring for Our Own



A large research study at the OSUCCC – James will evaluate how vaccination against SARS-CoV-2, the virus that causes COVID-19, impacts the immune system of cancer patients.

A new study, known as SIIREN, will:

- Advance the scientific community's overall understanding of how effective the SARS-CoV-2 mRNA vaccine is in preventing the COVID-19 infection;
- Determine whether the vaccine is less effective in cancer patients receiving certain therapies; and
- Shed light on how long immunity lasts.



Co-principal investigators for the study are Peter Shields, MD (left), deputy director of the OSUCCC – James, and Zihai Li, MD, PhD (right), director of the Pelotonia Institute for Immuno-Oncology (PIIO) at the OSUCCC – James.

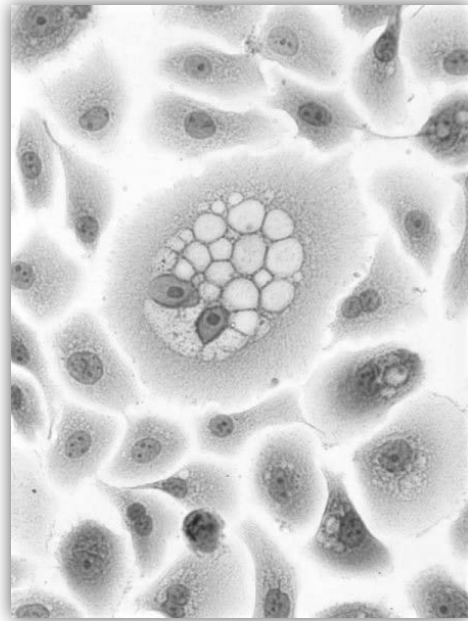
Note: As of mid-June, 28 individuals were enrolled in the trial, including 18 patients with cancer and 10 control individuals.

The COVID-19 pandemic has profoundly interrupted the delivery of key preventive services, resulting in many U.S. adults missing routine screenings.

Cancers caused by human papillomavirus (HPV) are a significant public health problem in the United States. But these cancers are preventable with HPV vaccination.

137

On May 21, the OSUCCC – James joined together with several NCI cancer centers across America to issue a joint statement urging the nation’s health care systems, physicians, parents and children, and young adults to get the human papillomavirus (HPV) vaccination effort back on track.



The James

A new computer-aided colon polyp detection tool used for colorectal cancer screening could reduce cancer rates by 40%.

The Ohio State University is the first academic medical center in the United States to utilize a new computer-aided system for screening colonoscopy in patients undergoing testing at the OSUWMC and OSUCCC – James.

This is a game-changer for early detection of colorectal cancer because it pairs the expertise of a highly trained physician with the power of artificial intelligence to identify potential high-risk lesions that may have gone undetected with the human eye alone.



The James

Note: Research is being led by Dr. Darwin Conwell, director of the Division of Gastroenterology, Hepatology and Nutrition at the Ohio State College of Medicine. Dr. Conwell is a gastroenterologist at the OSUCCC – James and the Wexner Medical Center.



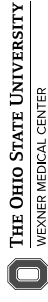
The Multinational Association of Supportive Care in Cancer (MASCC) has certified the OSUCCC – James as an MASCC-Designated Center of Excellence in Supportive Care in Cancer for 2021 to 2024.



Certification criteria include a supportive care focus in clinical activities, research, and educational initiatives, as well as adherence to international guidelines.

The OSUCCC – James is only the second institution in the United States to receive this certification, which recognizes oncology centers that demonstrate best practices in supportive cancer care.

The James



The OSUCCC – James has added two Ohio hospital systems to The James Cancer Network (JCN) – a system of collaborations among many institutions in cancer care.

Memorial Health



Memorial Health in Union County, a not-for-profit community hospital serving Union and five surrounding counties, joined on Feb. 1. With cancer services primarily in Maysville and Urbana, Memorial Health has a robust and growing cancer program.

Mercy Health – Lorain



Mercy Health – Lorain, which opened June 1, is part of Mercy Health, the largest health care provider in Ohio. Mercy Health – Lorain has a strong cancer program that offers therapies and surgical technologies for several cancer types.

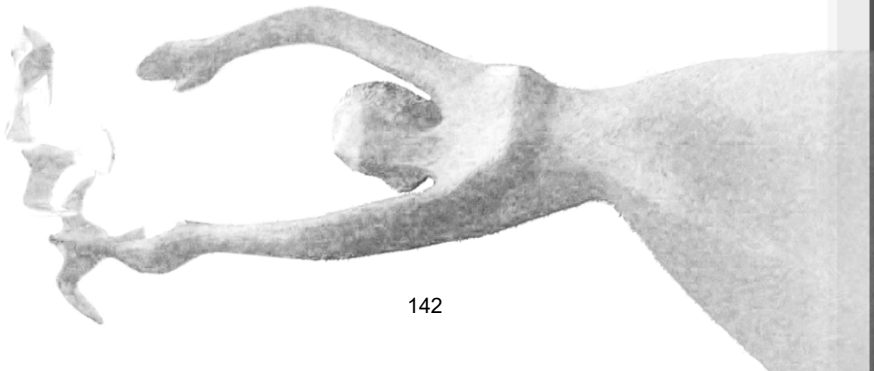
The Pelotonia community has come together in profound ways over the past 12 years, and this year has been no exception.



10,300+
2021 participants

\$10.6M+
2021 funds raised

\$228M+
All time funds raised



Thank You!

The James





Wexner Medical Center Financial Report Public Session

August 17, 2021



FY21 Year in Review

The Ohio State University Health System

Consolidated Statement of Operations

For the YTD ended: June 30, 2021

(in thousands)

OSUHS						
	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	\$ 3,579,036	\$ 3,494,102	\$ 84,934	2.4%	\$ 3,221,114	11.1%
Operating Expenses						
Salaries and Benefits	1,496,815	1,499,078	2,263	0.2%	1,460,666	-2.5%
Resident/Purchases Physician Services	126,897	124,758	(2,139)	-1.7%	116,598	-8.8%
Supplies	419,098	385,152	(33,946)	-8.8%	364,303	-15.0%
Drugs and Pharmaceuticals	463,869	450,902	(12,967)	-2.9%	420,152	-10.4%
Services	324,074	336,805	12,731	3.8%	321,793	-0.7%
Depreciation	179,492	179,498	6	0.0%	170,511	-5.3%
Interest	29,508	29,508	-	0.0%	31,941	7.6%
Shared/University Overhead	73,221	72,384	(837)	-1.2%	65,825	-11.2%
Total Expense	3,112,974	3,078,085	(34,889)	-1.1%	2,951,789	-5.5%
Gain (Loss) from Operations (pre MCI)	466,061	416,017	50,044	12.0%	269,325	73.0%
Medical Center Investments	(183,964)	(183,964)	-	0.0%	(173,749)	-5.9%
Income from Investments	23,625	17,258	6,367	36.9%	22,272	6.1%
Other Gains (Losses)	23,632	25,227	(1,595)	---	196,218	---
Excess of Revenue over Expense	\$ 329,354	\$ 274,538	\$ 54,816	20.0%	\$ 314,066	4.9%
Margin Percentage	9.2%	7.9%	1.3%	17.1%	9.8%	-5.6%

The OSU Wexner Medical Center

Combined Statement of Operations
For the YTD ended: June 30, 2021
(in thousands)

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Revenue	\$4,566,803	\$4,463,793	\$ 103,011	2.3%	\$4,127,203	10.7%
Operating Expenses						
Salaries and Benefits	2,365,740	2,381,278	15,538	0.7%	2,261,050	-4.6%
Resident/Purchases Physician Service	126,897	124,758	(2,139)	-1.7%	116,598	-8.8%
Supplies	462,504	431,353	(31,151)	-7.2%	407,638	-13.5%
Drugs and Pharmaceuticals	472,885	460,121	(12,765)	-2.8%	429,662	-10.1%
Services	489,499	511,850	22,351	4.4%	488,919	-0.1%
Depreciation	196,026	201,660	5,634	2.8%	192,874	-1.6%
Interest/Debt	29,755	29,766	11	0.0%	32,220	7.7%
Other Operating Expense	26,756	13,199	(13,558)	-102.7%	(172,399)	115.5%
Medical Center Investments	11,021	16,763	5,743	34%	5,861	-88.0%
Total Expense	4,181,083	4,170,747	(10,336)	-0.2%	3,762,424	-11.1%
Excess of Revenue over Expense	\$ 385,721	\$ 293,046	\$ 92,675	31.6%	\$ 364,779	5.7%
Financial Metrics						
Integrated Margin Percentage	8.4%	6.6%	1.9%	28.7%	8.8%	-4.4%
Adjusted Admissions	129,767	139,705	(9,938)	-7.1%	127,329	1.9%
Operating Revenue per AA	\$ 27,580	\$ 25,011	\$ 2,570	10.3%	\$ 25,298	9.0%
Total Expense per AA	\$ 23,989	\$ 22,033	\$ (1,956)	-8.9%	\$ 23,182	-3.5%
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, 2021

(in thousands)

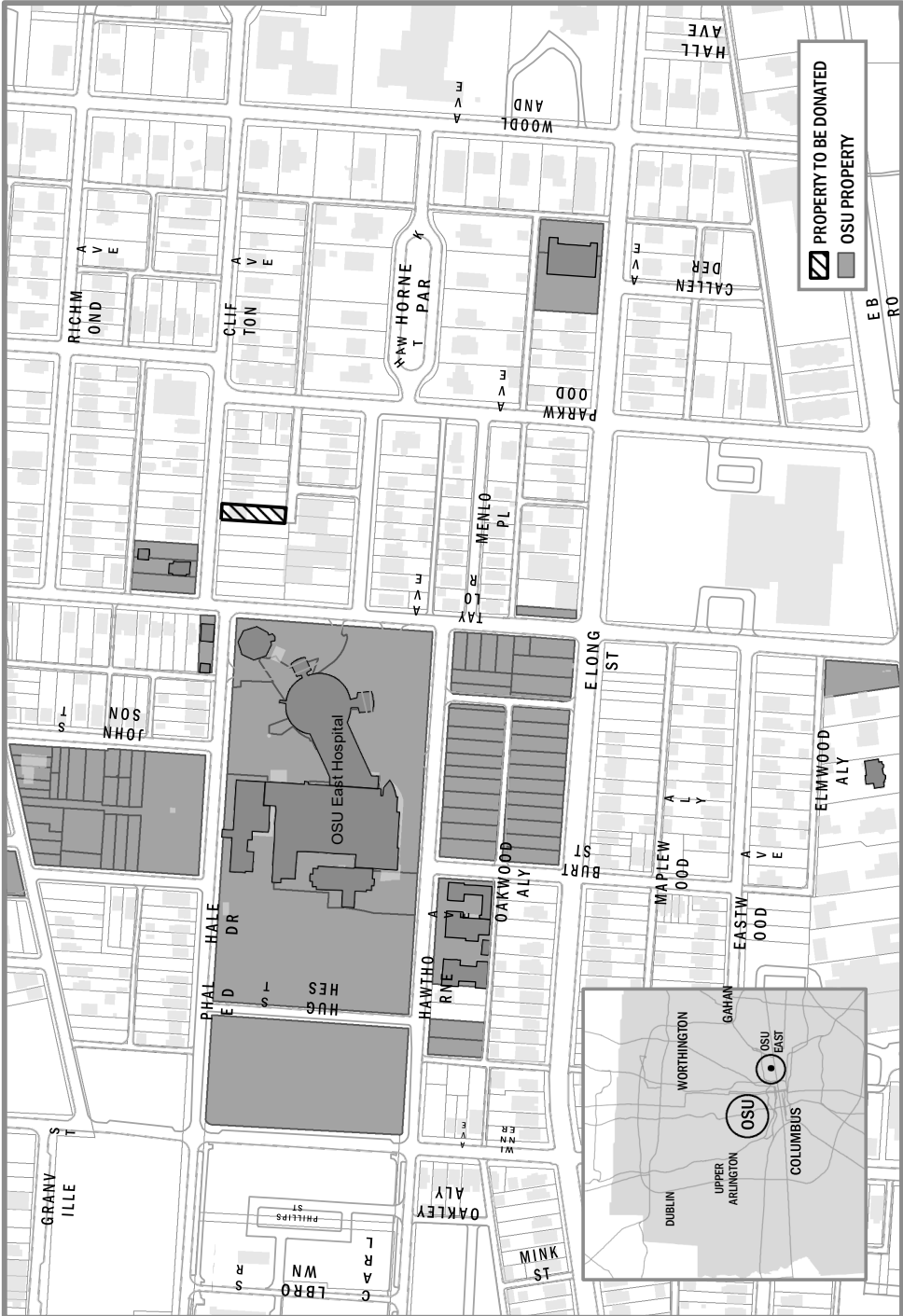
	June 2021	June 2020	Change
Cash	\$ 1,768,219	\$ 1,745,208	\$ 23,011
Net Patient Receivables	469,384	378,653	90,731
Other Current Assets	666,725	621,211	45,514
Assets Limited as to Use	432,455	421,698	10,757
Property, Plant & Equipment - Net	2,066,774	1,776,952	289,822
Other Assets	505,774	500,035	5,739
Total Assets	\$ 5,909,331	\$ 5,443,757	\$ 465,574
Current Liabilities	\$ 947,971	\$ 786,467	\$ 161,503
Other Liabilities	135,219	134,798	421
Long-Term Debt	602,415	660,405	(57,990)
Net Assets - Unrestricted	3,438,646	3,089,692	348,954
Net Assets - Restricted	785,081	772,395	12,686
Liabilities and Net Assets	\$ 5,909,331	\$ 5,443,757	\$ 465,574

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.

Thank You

Wexnermedical.osu.edu

ATTACHMENT V



Prepared By: The Ohio State University
Office of Planning, Architecture and Real Estate
Issue Date: June 29, 2021
The Ohio State University Board of Trustees

PROPERTY ACQUISITION
PID 010-020507
COLUMBUS, FRANKLIN COUNTY, OHIO 43203

 THE OHIO STATE UNIVERSITY

ATTACHMENT VI



Prepared By: The Ohio State University
Office of Planning, Architecture and Real Estate
Issue Date: June 29, 2021
The Ohio State University Board of Trustees

PROPERTY ACQUISITION
PID 010-039613
COLUMBUS, FRANKLIN COUNTY, OHIO 43203

THE OHIO STATE UNIVERSITY



ATTACHMENT VII

Project Data Sheet for Board of Trustees Approval

Martha Morehouse Tower Upgrades

OSU-220060 (REQ ID: FAC220001)

Project Location: Martha Morehouse Medical Plaza - Tower

- **approval requested and amount**
 professional services \$2.5M

- **project budget**
 professional services TBD
 construction TBD

 total TBD



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

- **project schedule**
 BoT approval 8/21
 design 11/21 – 11/22
 construction TBD
 facility opening TBD

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

- **planning framework**
 - this project is included in the FY22 Capital Investment Plan
 - project scope is based on a 2018 HVAC study and a 2021 renovation study; additional building envelope and electrical infrastructure studies have also been completed

- **project scope**
 - the project will provide HVAC systems upgrades for floors 1-6, 9, and 10, and interior waterproofing measures
 - the scope will also include ADA improvements and finish updates in select clinical areas, replacement of the nurse call system throughout, and electrical upgrades in the tower, pavilion and concourse
 - final scope and budget will be validated during design, and a phased construction schedule will be developed to maintain operations during the project

- **approval requested**
 - approval is requested to enter into professional services

-
- **project team**
 University project manager: Alexandra Radabaugh
 AE: TBD
 CM at Risk: TBD

Background
Facility Optimization Study of The Ohio State University Wexner Medical Center

In support of the Wexner Medical Center and the University's strategic plans, six major capital projects across inpatient, ambulatory, academic and research programs are under construction today. While this \$3.2B investment will transform the delivery of health care, education and research across the entire Wexner Medical Center enterprise, there is a need to better understand the opportunities and limitations of the remaining facilities.

To plan purposefully and thoughtfully, the Wexner Medical Center seeks approval to engage professional services firms to conduct a Facility Optimization Study of the Wexner Medical Center's real property inventory. This study will leverage and build upon previous strategic, capital and master planning efforts. This is an enterprise-wide evaluation of clinical, research and academic facilities and functions, exclusive of the major capital projects currently under construction.

The final deliverable of the Facility Optimization Study will be a long-range, enterprise-wide facility optimization strategy and implementation plan which informs the utilization, renovation, recapitalization, consolidation, or demolition of Wexner Medical Center facilities across the three strategic pillars of research, education and clinical care. It will bridge the gap between the six major projects and the second phase of the Wexner Medical Center capital investment plan.

The recommendations will be based on guidance gleaned from the strategic plan, market data, facility inventory, facility condition assessments, facility functional assessments and other data sources. The final deliverable will also include program summaries and recommended phasing plans with supporting capital requirements aligned to the long-range financial forecast.

The Wexner Medical Center Board and Board of Trustees will receive updates on the planning process at each meeting.

Project Data Sheet for Board of Trustees Approval

Atwell – ADL Simulation Lab

OSU-200050 (CNI #: 19000136, 20000163 / REQ ID COM22001)

Project Location: Atwell Hall

- **approval requested and amount**

increase professional services	\$0.4M
increase construction w/contingency	\$4.2M

- **project budget**

professional services	\$0.4M
construction w/contingency	\$4.2M
total project budget	\$4.6M

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

- **project schedule**

BoT professional services approval	08/21
design	04/20 – 03/21
BoT construction approval	08/21
construction-phase 1	05/21 – 12/21
construction-phase 2	10/21 – 05/22
facility opening-phase 1	01/22
facility opening-phase 2	06/22

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

- **planning framework**

- this project is included in the FY21 and FY22 Capital Investment Plans

- **project scope**

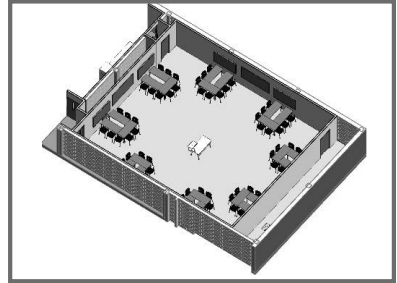
- phase 1 will renovate space in Atwell to create program space for the School of Health and Rehabilitation Services; construction includes the creation of an additional level in existing double height space for a flexible research laboratory and a 48-person, active learning classroom, and support space
- phase 2 will renovate additional space in Atwell to create a 16-bed athletic training classroom with storage and faculty offices, an Active Daily Living (ADL) mock apartment, a 3-bed simulation exam space with observation room, and support space
- the project has increased from \$2.9M to \$4.6M to include the second phase

- **approval requested**

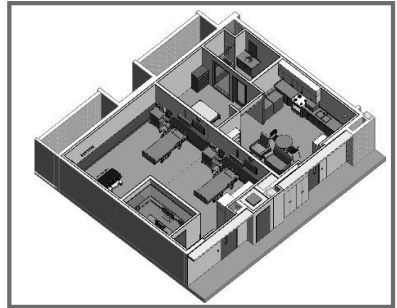
- approval is requested to increase professional services and construction contracts

- **project team**

University project manager:	Josh Kranyik
AE/design architect:	Design Group
CM at Risk or Design Builder:	Robertson Construction



Phase 1: Active Learning Classroom



Phase 2: ADL Simulation Exam Suite

Project Data Sheet for Board of Trustees Approval

UHE – 4th Floor OR Upgrades

OSU-210545 (REQ ID: EAST210011)

Project Location: OSU East North Tower

- **approval requested and amount**

professional services	\$0.8M
construction w/ contingency	\$2.1M

- **project budget**

professional services	TBD
construction w/contingency	TBD
total project budget	TBD

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

- **project schedule**

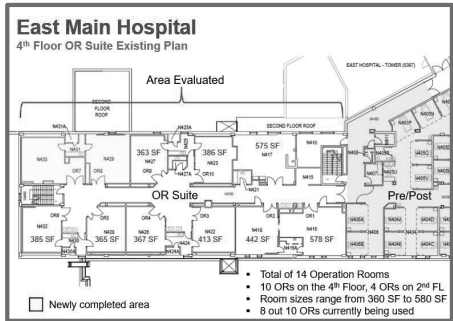
BoT professional services approval	08/21
BoT construction appr – phase 1	08/21
design	09/21 – 04/22
construction – phase 1	05/22 – 11/22
construction – phase 2	TBD
facility opening	TBD

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

- **planning framework**
 - phase 1 of this project is included in the FY18 and FY19 Capital Investment Plans

- **project scope**
 - phase 1 will renovate up to four existing ORs including new finishes, HVAC, med gas and electrical upgrades, new lights/booms, new AV integration equipment, and new flooring
 - phase 2 scope will renovate additional existing ORs
 - approval requested is for programming for both phases of the project and complete design and construction services for phase 1
 - final budget and scope will be validated during programming and design

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



-
- **project team**

University project manager:	Lance Timmons
AE/design architect:	TBD
CM at Risk:	TBD

ATTACHMENT VIII

OSU AMBULATORY SURGERY CENTER
Scope of Care – Outpatient Care New Albany
Clinical Departments

Approved By:



Dr. M. Guerin MD
Medical Director

X 

Sheryl Burch MA, BSN, RN
Director - Ambulatory Surgery

Department/ Patient Care Unit Name: The Ohio State University Ambulatory Surgery Center – Outpatient Care New Albany. The Center is an Ambulatory Surgery Center which provides for services related to elective outpatient procedures.

Types (and age range) of patients served:

Age:

- 18 or more years of age.
- Patients aged 13 to 17 with the following requirements please follow below approval process:
 1. Treating physician has admitting privileges at an age appropriate inpatient center
 2. Permission from Medical Director or Designee
 3. Minimum Height/ Weight requirements: 5'0" and 100 pounds. Variance shall require medical director (or designee) approval.
 4. All patients will have an anesthesia evaluation at the Pre-Procedure Preparation. Variance shall require medical director (or designee) approval.

Approved OSC Executive Team: May 24, 2021

Date Last Revised:

Date Last Reviewed:

- 5. Pediatric BMI limit is 40.0.
 - 6. An accompanying responsible adult, preferably the custodial parent or legal guardian, must remain present in the building. A custodial parent or legal guardian must be available by phone during the surgery admission.
- Physical Status:
- ASA I-II.
 - ASA III without signs or symptoms of uncontrolled or decompensated conditions.
 - ASA IV without signs or symptoms of uncontrolled or decompensated conditions and anesthesia limited to Monitored Anesthesia Care (MAC).
 - ASA III or IV patients may not have straight Local without Anesthesia care; they may have MAC or General Anesthesia at the discretion of the Anesthesiologist
 - General and MAC Anesthesia will be administered by Department of Anesthesia providers. Conscious sedation will be administered by any individual provider credentialed to do so.

Procedure Length

- Procedures requiring more than 4 hours of total OR time will need prior authorization by the Medical Director or designee.
- Patients anticipated to have an extended PACU length of stay will need prior authorization by the Medical Director or designee.
- These cases will be scheduled no later than the first case in a physician's block and will be scheduled to end by 3:00pm.

DNR:

All patients admitted to the center will have their DNR status suspended during their admission per current Medical Center Guidelines.

Malignant Hyperthermia:

Patients with a personal or family history of MH must be reviewed by the Medical Director or Designee.

Morbid Obesity:

Patients will be considered with identified criteria - Variance shall require medical director (or designee) approval.

- All patients must have current height & weight in IHIS before scheduled at the ASC.
- Patients with BMI > 35.0 **OR** weight > 300 pounds may not be performed in the prone position if anesthetized and unable to move themselves into that position.
- Patients with BMI > 45.0 **OR** weight > 300 pounds may not be performed in the lateral position if anesthetized and unable to move themselves into that position.

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Date Last Revised:

Date Last Reviewed:

- Patients with a BMI 45.0-55.0 will be considered. Procedure planned should require minimal sedation and the patient should be evaluated by an in-person or video Pre-Procedure Preparation appointment. Elective conversion to General Anesthesia will not be an option. If General Anesthesia conversion is an anticipated option, the surgery/procedure should not be scheduled at the ASC.
- No patient with BMI > 55.0 will be accepted at the ASC.
- No pediatric (age < 18 years) patient with BMI > 40.0 will be accepted at the ASC.

Hemodialysis:

Hemodialysis patients cannot have procedure/surgery and hemodialysis scheduled on the same day. Either the date of procedure/surgery or dialysis must be changed if they are scheduled for the same day.

Ambulation:

Patients must be able to ambulate with minimal assistance including ability to stand up and pivot to cart.

- Procedures will not be performed with patient's personal medical equipment (i.e. wheelchairs).

Anesthesia:

General and MAC Anesthesia will be administered by Department of Anesthesia providers. Conscious sedation will be administered by any individual provider credentialed to do so.

Difficult Airway:

Patients with a history of difficult airway / intubation must be evaluated in-person or video by the Pre-Procedure Preparation department and approved by the Medical Director or Designee.

Pacemakers / Defibrillators:

- Patients with isolated pacemakers must have the device evaluated by their Cardiologist within twelve (12) months prior to Date of Service. Documentation of interrogation must be readily available and there should be no change in patient's clinical status since last cardiac evaluation.
- Patients with pacemakers will not be considered for ESWL procedures without OSU Pacer Clinic personnel on site throughout the surgical procedure.
- Patients with AICD's are considered for MAC Anesthesia/conscious sedation only. Patients must be evaluated by their cardiologist within six (6) months prior to Date of Service. Documentation of interrogation must be readily available and there should be no change in patient's clinical status since last cardiac evaluation. If placing a magnet would deprogram the AICD, these patients would not be candidates for the ASC.

Approved OSC Executive Team: May 24, 2021

Date Last Revised:

Date Last Reviewed:

Reference:

Crossley, George H. et al "The Heart Rhythm Society (HRS)/American Society of." *Heart Rhythm* 8.7 (2011): 1114-140. Print.

Michael, Platonov A., MD, Anne Gillis, MD, and Katherine M. Kavanagh, MD. "Pacemakers, Implantable Cardioverter/Defibrillators." *Journal of Endourology* 22.2 (2008), 243-47. Print.

Obstructive Sleep Apnea:

Anesthesiology services will evaluate the appropriateness of outpatient procedures/surgery, given the patient's OSA history, the proposed procedure and the patient's co-morbidities.

- Patients with known diagnosis of OSA that have optimized co-morbid medical conditions will be considered if they are able to use a continuous positive airway pressure device in the post op period.
- Patients with a presumed diagnosis of OSA based on screening (STOP Bang) questionnaire, and with optimized co-morbid conditions, will be considered for the OSC if postoperative pain can be managed predominantly with non-opioid analgesia.

Reference:

Joshi, Girish P., MBBS, MD, FFARSCI, Saravanan P. Ankichetty, MD, DA, MBA, Tong J. Gan, MD, MHS, FRCA, and Frances Chung, MBBS, FRCPC. "Society for Ambulatory Anesthesia Consensus." *Anesthesia & Analgesia* 115.5 (2012): 1060-068.

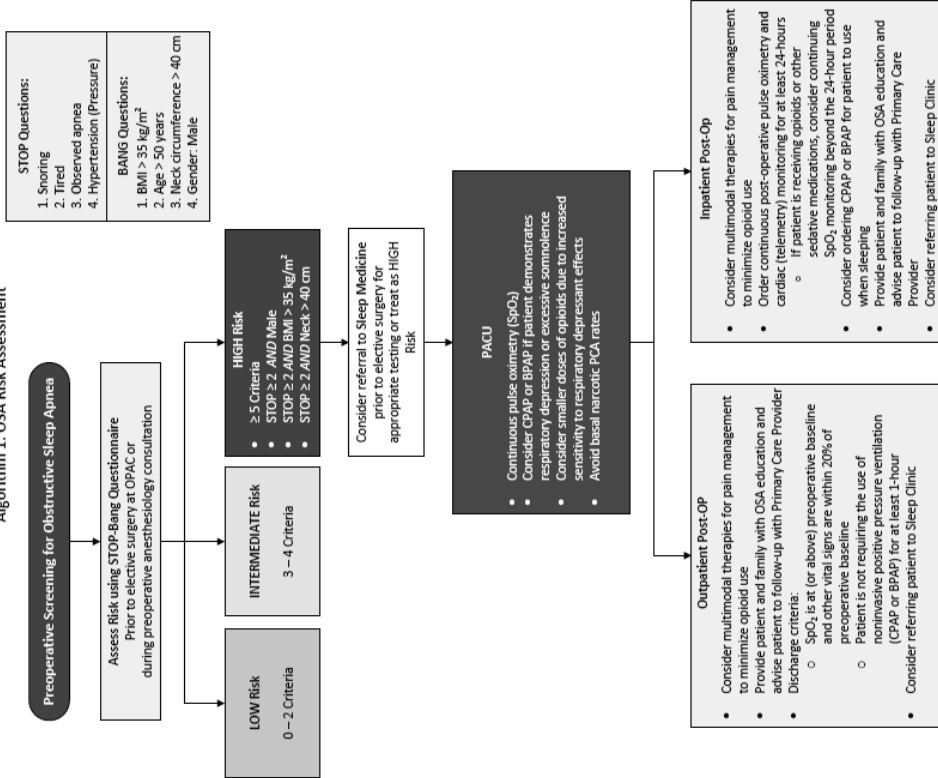
Approved OSC Executive Team: May 24, 2021

Date Last Revised:

Date Last Reviewed:

Algorithm 1: OSA Risk Assessment

2



5

Date Last Revised:
Date Last Reviewed:

Patients requiring isolation precautions (contact, droplet, airborne) as defined by medical center guidelines will not be admitted to the center.

Patients with wounds that are bleeding or draining will have sites contained with an occlusive dressing and treated with standard precautions. Patients with drainage that cannot be contained may have procedure completed at an alternate OSU location offering contact isolation.

Patients with known current Bed Bug infestation will not have their procedure performed at the Ambulatory Surgery Center.

Management of MRSA in Ambulatory Surgical Facilities. (n.d.). *Management of MRSA in Ambulatory Surgical Facilities*. Retrieved from <http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/Jun7%282%29/Pages/61.aspx>

Guide to Infection Prevention In Outpatient Settings: Minimum Expectations for Safe Care. (n.d.). *CDC.Gov*. Retrieved from

Pregnancy:

No patient with a known pregnancy or positive pregnancy test may be treated at the ASC.

Developmental Disabilities/Special Needs:

The ASC will be provided an updated History & Physical that includes diagnosis of specific conditions/ syndromes. Along with the H&P, the “Functional Ability Assessment” will be completed. All Developmentally Disabled/ Special Needs patients require Anesthesia approval prior to scheduling.

Toxicology Screen:

All patients who appear to be intoxicated and who test positive on Date of Service for methamphetamines, amphetamines, cocaine &/or alcohol will have their procedure cancelled. Patients testing positive for other drugs will be evaluated on an individual basis.

Preoperative Evaluation:

Patients may undergo pre-operative testing according to the current Pre Anesthetic Testing Algorithm. Complete pre-operative services are available by a Pre-Procedure Preparation appointment.

Accompanying Adult:

Patients who have undergone minor, superficial procedures **without sedation** may be discharged at the discretion of their admitting physician. If the procedure performed involves the hand, eye, or foot & impairs their visual acuity, or hand/ foot dexterity to the degree that they cannot operate a motor vehicle, the patient will not be permitted to drive when discharged.

Approved OSC Executive Team: May 24, 2021

Date Last Revised:

Date Last Reviewed:

All other patients will require an accompanying adult (18 or more years of age) to provide patient transportation upon discharge. The ASC will recommend that the adult representative remain at the ASC throughout the procedure. Patients will be made aware that the absence of an accompanying adult may result in their procedure being cancelled. Patients found to be without transportation after their procedure will be discharged according to current medical center policy.

Scope and complexity of patient’s care needs:

Four operating rooms located on the second floor of The Ohio State University Outpatient Care New Albany servicing the following specialties: General Surgery, Colorectal, Gynecology, Ophthalmology, Plastic Surgery and Urology. Four endoscopy procedure rooms and one motility lab located on the second floor of The Ohio State University Outpatient Care New Albany servicing from Gastroenterology, Hepatology and Nutrition (GHN), General Surgery and open access referrals. The Center is staffed from 0600AM-to 1700PM Monday through Friday, primarily for adult patients requiring surgical intervention under local anesthesia, conscious sedation, monitored anesthesia care, regional anesthesia or general anesthesia.

Patients are admitted to the Center on an ambulatory basis. Patients are required to have the ability to understand and carry out their discharge instructions or have a responsible adult which will assist them in fulfilling these needs.

All procedures performed at the Ambulatory Surgery Center are part of the Core Privileges approved by Ohio State University Wexner Medical Center.

The following types of procedures are not performed at the Center:

- Are associated with the risk of extensive blood loss.
- Require major or prolonged invasion of body cavities.
- Directly involve major blood vessels.
- Are an emergency or life threatening in nature.
- Noted on the CMS Inpatient Only List. This list will be reviewed and updated annually.

Methods used to assess and meet patient’s care needs:

Care of all patients experiencing surgical intervention is based on the nursing process and standards from AORN, ASPSN, SGNA and other National Peri-operative organizations supporting the service lines of the Center. Preoperatively, the RN verifies the patient, identifies the patient’s special needs, completes a patient assessment and develops a plan of care. Intra-operatively, the RN implements the patient’s plan of care and documents on the appropriate medical records (e.g.: Op-Time and hospital approved documents).

Approved OSC Executive Team: May 24, 2021

Date Last Revised:

Date Last Reviewed:

Methods used to determine the appropriateness, clinical necessity and timeliness of support services provided directly or through referral

The Circulating RN works collaboratively with the proceduralists, surgeons, anesthesiologists, PACU RN, and the Pre-op Holding RN in assessing, prioritizing and meeting the patient's individual needs. Based on the scheduled procedure and communication with the physician/surgeon and anesthesia, specific patient concerns regarding safety, infection control, positioning, and psychosocial needs are anticipated and met (e.g.: preparation of OR environment for latex allergy patient, isolation protocols implemented, limitation of patients range of motion, need for an interpreter or caregiver for MR/DD patients). The continued need for support is communicated to the receiving unit via the oral transfer report and IHIS documentation. A collaborative effort to improve this communication is ongoing. The success of this method is determined by the achievement of positive patient outcomes, reflected by PI monitors and retrospective chart reviews.

In the event of an identified patient need to receive services not provided at the Center, the patient will be transferred to the OSUMC for subsequent evaluation.

Standards of practice/ practice guidelines, when available

The Ambulatory Surgery Center provides services related to elective outpatient procedures in the fields of General Surgery, GYN, Gynecology, Ophthalmology, Plastic Surgery and Urology at 6100 N. Hamilton Road, Westerville Ohio 43081. The OSUWMC Board of Directors, the OSUWMC Medical Staff, in conjunction with the Ambulatory Executive Director, Ambulatory Medical Director, Senior Director, Associate and Administrative Directors & Nurse Manager assess, plan, implement, and evaluate the delivery of care and services. The Ambulatory leadership team is responsible for ensuring that the delivery of care provided is consistent with the mission, standards, and policies established for patient care. The Ambulatory leadership team promotes an environment that fosters empowerment through active participation in strategic planning and development of processes that ensure adequacy of services and resources to meet the current and projected community needs, policy establishment, and professional growth.

The objective of The Ohio State University Ambulatory Surgery Center is to deliver excellent surgical, procedural, and anesthesia services to those we serve in accordance with the standards set forth by The Joint Commission, CMS Conditions of Participations for Hospitals and The Vision and Mission statements of The Ohio State University Wexner Medical Center. The Scope of Care is designed to provide appropriate care and services for all patients in a timely manner.

Utilizing a multi-disciplinary approach in the delivery of patient care, our services promote continuous quality and performance improvement activities provided in an environment where collaboration and multi-disciplinary approaches to problem identification and resolution are the expectation. Important criteria and thresholds are measured and continuously monitored through our Quality and Performance Improvement process to optimize patient outcomes and assure the highest level of satisfaction for all of our customers. Results of our Quality and Performance Improvement activities are used to improve patient outcomes enhance our services and our staff performance.

Approved OSC Executive Team: May 24, 2021

Date Last Revised:

Date Last Reviewed:

Understanding that the provision of health care services is dynamic and fluid; the Scope of Care will be *reviewed at least annually* and revised as needed to reflect the changing patient needs, community changes, and or facility needs and initiatives.

Approved OSC Executive Team: May 24, 2021

Date Last Revised:

Date Last Reviewed:

ATTACHMENT IX



QUALITY LEADERSHIP COUNCIL

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

FY 2022

July 1, 2021 - June 30, 2022

Clinical Quality Management, Patient Safety, & Service Plan

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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:

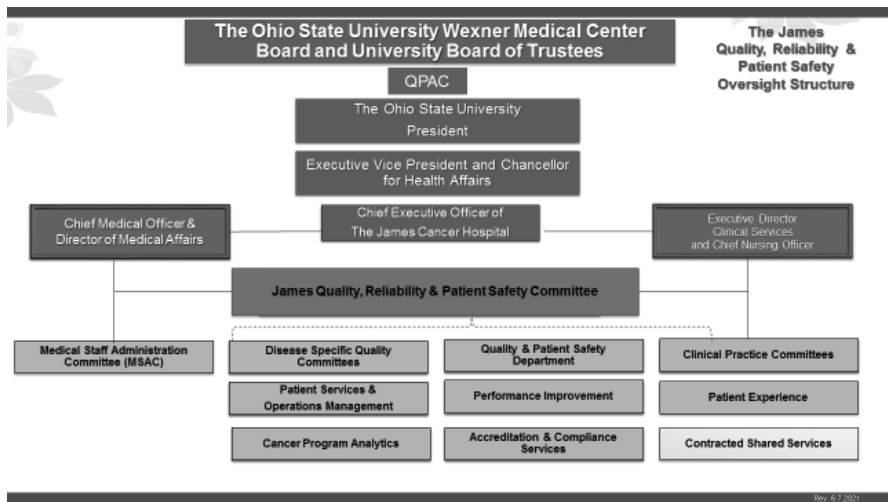
The purpose of the Clinical Quality Management, Patient Safety & Service Plan is to show measurable improvements in areas for which there is evidence they will improve health outcomes and value of patient care provided within The OSUWMC. The OSUWMC recognizes the importance of creating and maintaining 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. The Council's key strategic initiatives center on empathy, trust, and personal connections as well as leveraging technology to enhance communication with patients and families. The details on the priorities and initiatives for FY 22 can be found in Attachment V.

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 and teams.
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, Case 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.

UH Quality Council

Composition:

The committee will be led by the UH Triad Leaders for Quality & Patient Safety. The core members represent leaders from administration, surgery, medicine, nursing, pharmacy, analytics and GME.

Function: Review quality KPIs and improvement initiatives; discuss challenges and barriers; communicate decisions and share updates for broader awareness; and initiate task forces to address issues/ opportunities. Each KPI will have an Oversight Team that is responsible for providing direction on opportunities, chartering workgroups, and overseeing action plan development/implementation.

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 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 Operating Officer (COO)

The COO 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 CCO 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 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 Officers – Acute Care Division/Post-Acute and Home-Based Care Division/Outpatient and Ambulatory Division/Clinical and Physician Network

The OSUWMC Chief Administrative Officers are responsible to the Board for implementation of the Clinical Quality Management Patient Safety & Service Plan for their respective divisions.

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.

The department is comprised of five main functions – Clinical Quality, Patient Safety, Analytics, Disease and Outcome Management, and Peer Review. Attachment V shows the current Organizational Chart with a brief summary of each team.

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, survey management, and performance improvement. 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.

Analytics Center of Excellence

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

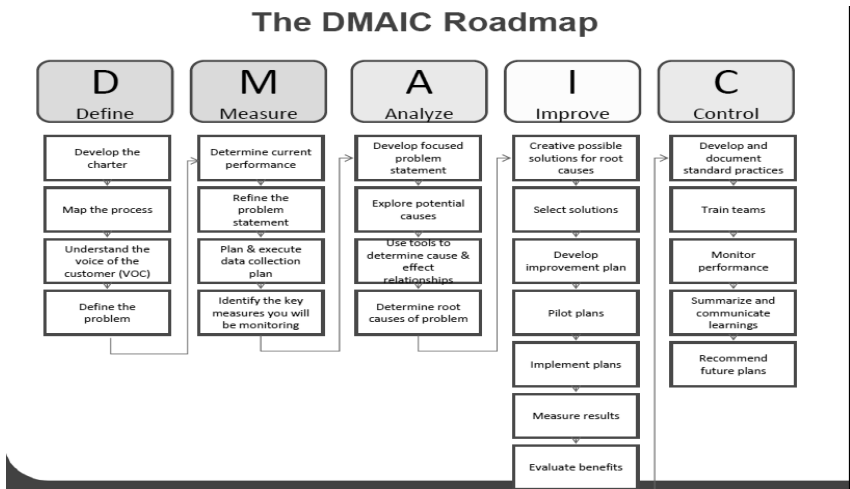
improvement methodologies and expert resources that provide the appropriate level of structure and support to assure the deliverables of the project are met with longer term sustainability.

***The Process Improvement Toolkit**

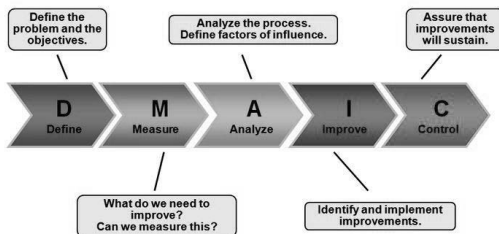
Methodology
PDCA
Rapid Cycle Improvement
DMAIC
Lean Principles

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.

The DMAIC Roadmap



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:

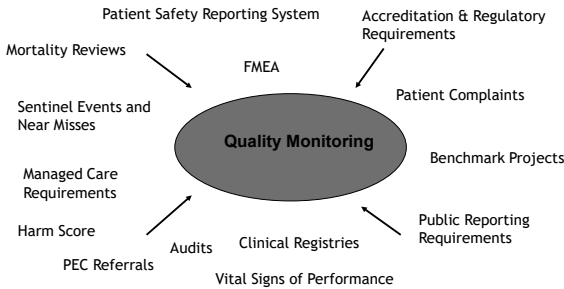
Any person, who is professionally involved in the care of a patient being reviewed, should not participate in peer review deliberations and voting. A person is professionally involved if they are responsible for patient care decision making either as a primary or consulting professional and/or have a 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

Methods for Monitoring



Determination of data needs

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

External reporting requirements

There are a number of external reporting requirements related to quality, safety, and service. These include regulatory, governmental, payer, and specialty certification organizations. 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 consists of patient experience indicators and comments gathered from surveys after discharge or visit to a hospital or outpatient area. The dashboard covers performance in areas such as overall experience, physician communication, nurse communication, responsiveness, and environment. It also measures process indicators, such as joint physician-nurse rounding and nurse leader rounding, as well as serves as a resource for best practices. The information contained on the dashboard is shared in various forums with staff, clinicians, administration, including the Boards. Performance on many of these indicators serves as annual goals for leaders and members of clinical and patient facing teams.

Quality, Patient Safety, and Service Educational Information

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

- On line videos

- Quality & Patient Safety Simulcasts
- 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

Contract Evaluation Template

2018 Evaluation of Contract Services

Name: _____ Telephone/Fax: _____
 Department: _____ Date that Contracted: _____
 Contract Services: _____ Medical Staff Review: ISO
 Date Contract Signed: _____ Contract Duration: _____

	YES	NO
1. Is the contract or service provided by the contract provider (or organization) applicable to the patient?		
2. If not, or if "questionable," why provide a non-covered POC service and what is the provider's rationale?		
3. Are there any financial or other incentives for the provider or organization for providing the service?		
4. Please describe the nature and degree of service provided.		
5. Is the national or regional service definition being followed?		
6. Are there any patient safety or quality improvement or other related services? Explain details.		
7. Do you monitor the quality and performance of the service? Describe how and how often you monitor (e.g. patient satisfaction, audits, incident reports, efficiency, satisfaction, etc.).		
8. Are there any other services or programs provided by the contract provider that you are aware of?		

2018 Contract Evaluation Form

	YES	NO
9. Is there a process in place to identify and respond to staff or patient areas of concern?		
10. Are there any compliance or regulatory issues? Describe details.		
11. Are there any other compliance or regulatory issues? Describe details.		
12. Are there any other compliance or regulatory issues? Describe details.		
13. Are there any other compliance or regulatory issues? Describe details.		
14. Are there any other compliance or regulatory issues? Describe details.		
15. Are there any other compliance or regulatory issues? Describe details.		
16. Are there any other compliance or regulatory issues? Describe details.		
17. Are there any other compliance or regulatory issues? Describe details.		
18. Are there any other compliance or regulatory issues? Describe details.		
19. Are there any other compliance or regulatory issues? Describe details.		

2018 Contract Evaluation Form



Attachment II: Priority Criteria

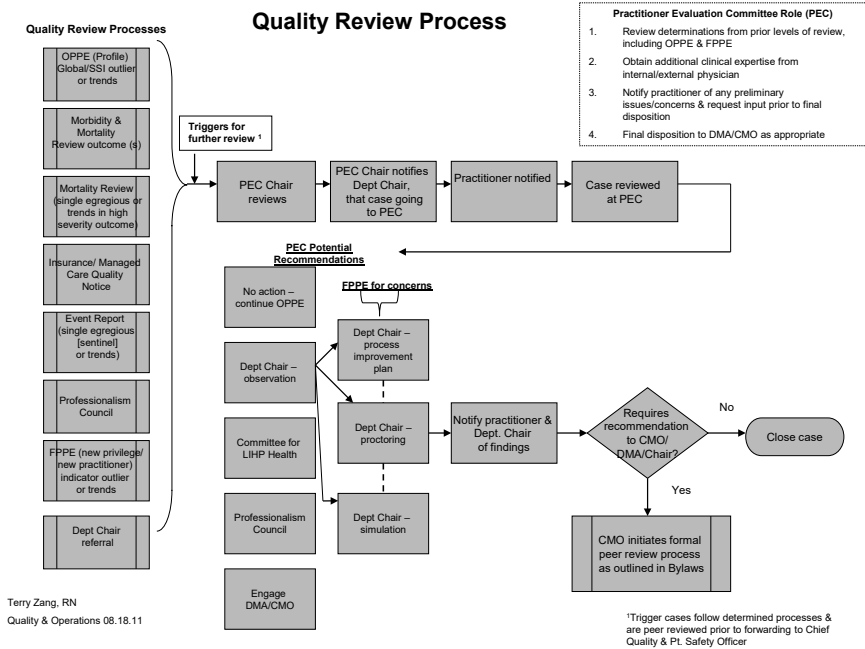
The following criteria are used to prioritize clinical value enhancement initiatives to ensure the appropriate allocation of resources.

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%	90 th percentile	85th Percentile (79.2%)
HCAHPS Overall (No James)	75.00%	90 th percentile	Keep FY 20 Goal (75.0%)
CG-CAHPS Willingness to Recommend	92.30%	90 th 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 xxxxxx SERVICE: INTERNAL MEDICINE-CARDIOVASCULAR MEDICINE Profile last revised by Provider: None									
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	2.63	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	102	n/a		Q2 2013	356	102	Feb 2013
B - Patient Care									
★	Autopsy Discrepancy	0	0.90	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 Rate: balloonized 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	86.7%	100.0%		Q4 2012	No Data	No Data	No Data
	CM - HF_3 ACEI or ARB for LVSD	n/a	48.8%	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)	0.80	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 Review	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	Peer 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	99.2%	91.9%	Feb 2013
G - Practice Based Learning and Improvement									
★	Surgical Team Safety Classifications Variances	0	0.00	0		Q2 2013	0	0.00	Feb 2013

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

Reviewed By	Outcome	Notes
Jan 28 2013 kname	Maintain privileges without modification	The Provider's performance meets expectations.

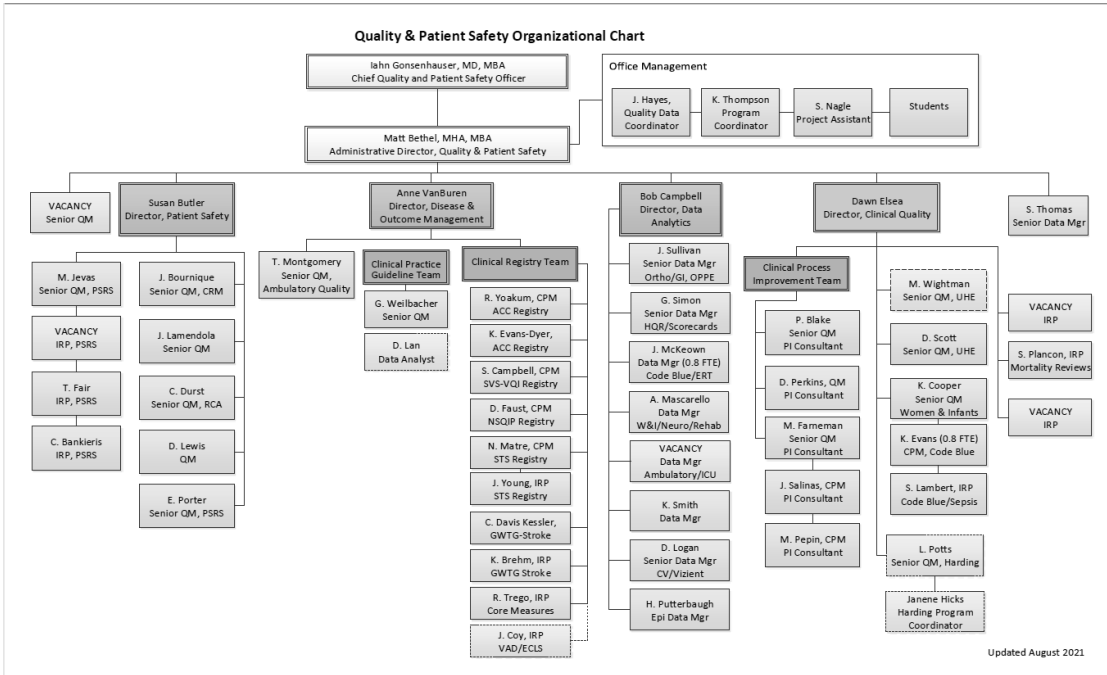
SPC Alert Legend

-  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

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This report is intended only for use in the treatment, assessment and operation of the entity listed herein. It is not intended to be used for any other purpose. If you are not the intended recipient of this information or the person responsible for ensuring this document is the intended recipient, you are hereby notified that any dissemination, distribution, printing or copying of this document is strictly prohibited.

Attachment V: Quality Organizational Chart



Quality and Patient Safety Teams:

Clinical Quality:

The Clinical Quality Team focuses on process improvement across the enterprise through business unit committee facilitation and rapid cycle improvement teams based on opportunities found in metric review. Consultation for front line led improvement efforts is also provided.

Patient Safety:

- Oversee Patient Safety Reporting System process and review all events
- Facilitate SEDGE and Sentinel Event process
- Facilitate Crew Resource Management
- Review all National Patient Safety Goals and provide gap analysis
- Annual FMEA
- Oversee patient safety leadership rounds

Analytics

The Analytics team provides data support for all department activities related to process improvement, patient safety and peer review. Information is gathered from multiple sources including Epic, Vizient, Midas, Clinical Registry software, PSRS, and other systems as needed.

Disease and Outcome Management

The Disease and Outcome Management team oversees and facilitates the process for creation of clinical practice guidelines. This includes creation of the guideline, the approval process, developing and monitoring metrics associated with the guideline and updating it at least every two years. This team is closely tied with IT to create tools used to increase adherence to the guidelines.

This team also oversees clinical registries used to evaluate performance, benchmark with peers nationally, identify opportunities, and drive improvement initiatives. Many are required for CMS reimbursement, public reporting, and other managed care or regulatory reporting requirements.

Peer Review

Quality oversees the Peer Review process across the entire medical staff. This includes facilitating the Provider Evaluation Committee, Ongoing Professional Practice Evaluation, responding to insurance inquiries and grievances, and monitoring all physician performance data. An evaluation was provided by an outside vendor and recommendations are currently being implemented.

ATTACHMENT X

The James



James Clinical Quality, Patient Safety, and Reliability Plan

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

Fiscal Year 2022

July 1, 2021 through June 30, 2022

The James Cancer Hospital Quality, Patient Safety and Reliability Plan

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The James Cancer Hospital & Solove Research Institute

Quality, Patient Safety, and Reliability Plan

MISSION, VISION, AND VALUES:

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

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

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

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

Definition:

The Clinical Quality, Patient Safety and Reliability 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. 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.

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 encompass all clinical services. Through close partnership with the Comprehensive Cancer Center, the plan includes quality and patient safety goals for process improvements related to functions and processes that involve both the Cancer Center and the hospital and ambulatory clinics/treatment areas.

With a close partnership within OSUWMC, this plan helps provide oversight of the clinical contracted services and serves as a component of the Quality Assurance and Performance Improvement (QAPI) requirements from the Center for Medicaid and Medicare services. These services are evaluated on annual basis by The James Quality, Patient Safety, and Reliability Committee, The James Medical Staff Administrative Committee (MSAC), and then forwarded each year to the Quality and Professional Affairs Committee (QPAC) as a part of the governing body, to ensure quality and safety of care is provided to all James' patients. See Attachment C – the contract evaluation sample for clinical services. (See Figure 1 Contracted Services)

Contracted Services – Patient Support Services

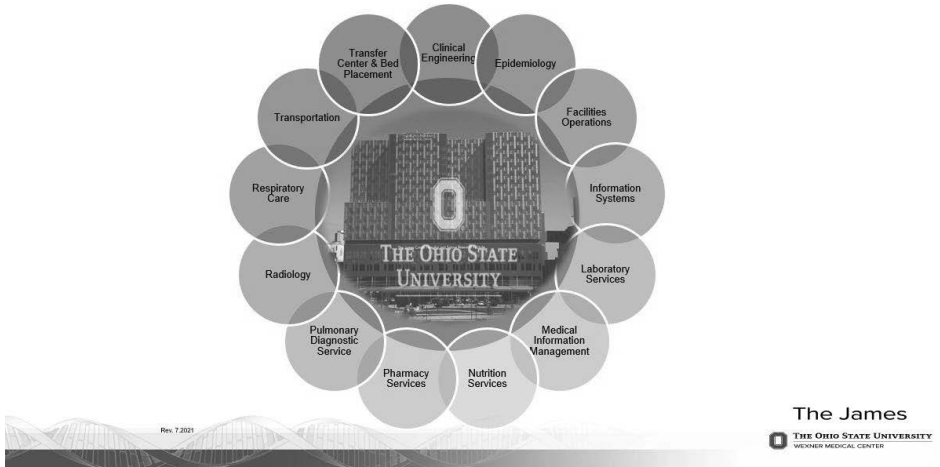


Figure 1 Contracted Services

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 Reliability 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.
10. Provide improvement processes to clinical systems to prevent or eliminate patient harm.

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 for The James are designed to target a specific focus for the cancer patient population and cancer research agendas. (See Figure 1).

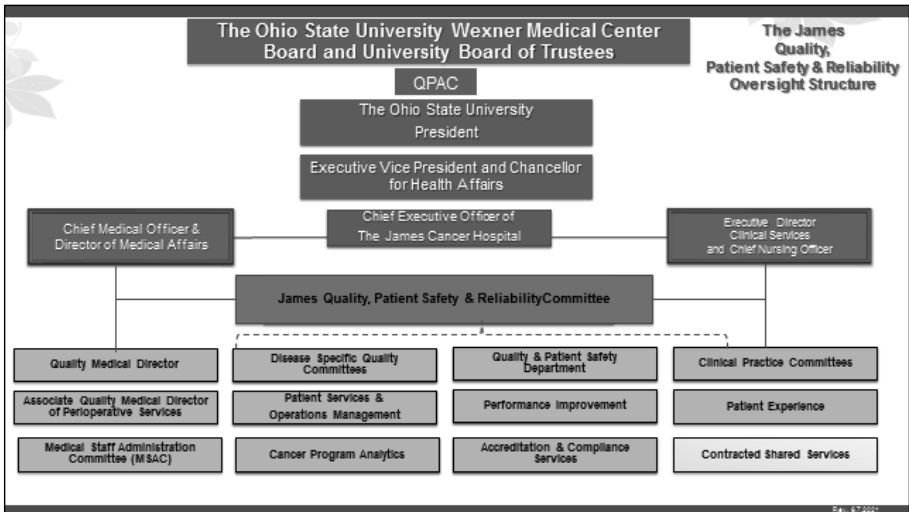


Figure 2 The James Quality, Patient Safety, & Reliability Oversight Structure

Governance and Committees:

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.

Quality and Professional Affairs Committee:

Composition:

This committee consists of no fewer than four voting members of the University Wexner Medical Center Board of Trustees. Members are appointed each year by the Chair of the OSUWMC Board, and one of these shall be assigned as the Chair of the committee. The CEO of the OSU Health System; CMO of the University Medical Center; CMO of The James; the medical director of credentialing for The James; the Chief of Medical Staff of the University hospitals; the Chief of Medical Staff for 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 serve in ex-officio, voting positions. Other members as may be appointed by The Chair of the OSUWMC board, in consultation with the Chair of Quality and Professional Affairs committee.

Function:

The QPAC shall be responsible for the following specific duties:

1. Reviewing and evaluating the Quality and Patient Safety programs of OSUWMC.
2. Overseeing all patient care activity in all facilities as a part of OSUWMC, including but not limited to, hospitals, clinics, ambulatory care, and physician office facilities.
3. Monitoring quality assurance performance in accordance with the standards set by OSUWMC.
4. Monitoring the achievement of accreditation and licensure requirements.
5. Reviewing and then recommending to the OSUWMC 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, as well as granting appropriate clinical privileges for the credentialing of practitioners recommended for membership and clinical privileges by the hospital's Medical Staff Administrative Committee (MSAC).
8. Reviewing and approving membership and granting appropriate clinical privileges for the expedited credentialing of such practitioners that are eligible by satisfying the minimum approved criteria which is determined by the OSUWMC board and recommended for membership and clinical privileges to the MSACs of OSUWMC and The James.
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 OSUWMC 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 on behalf of the medical staff pursuant to the medical staff bylaws and communicating such resolutions to the hospitals MSACs.
12. Such other responsibilities as assigned by the Chair of the OSUWMC 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 & Commission on Cancer Subcommittee (COC) (See Figure 2)

Composition:

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

Function:

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

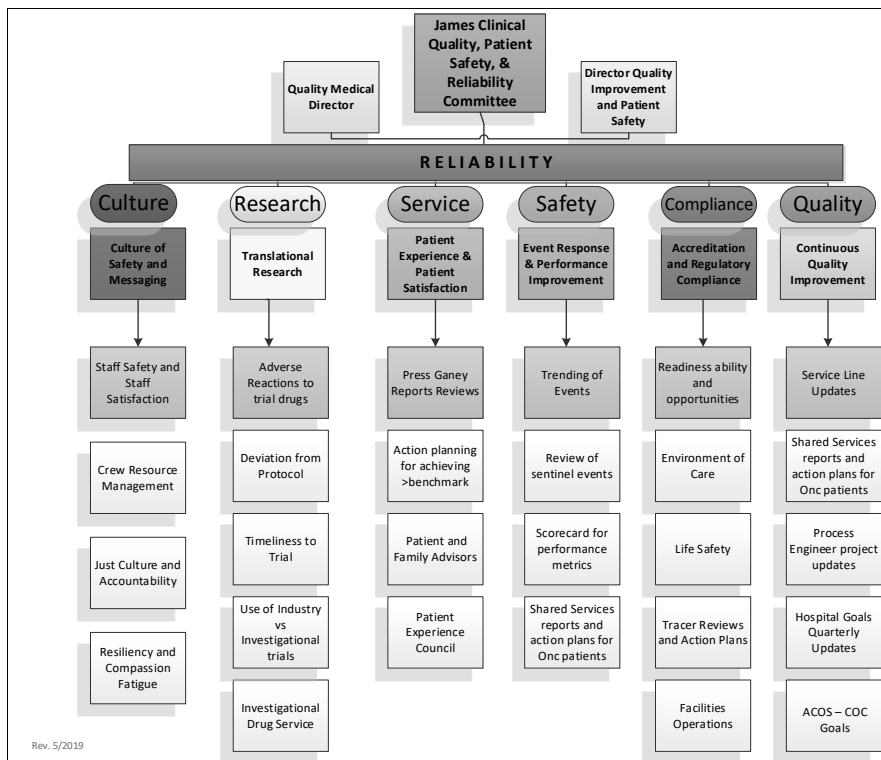


Figure 3 The James Quality, Patient Safety and Reliability Committee Structure

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:

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

- Oversees the service excellence reward and recognition program.
- Serves as a coordinating body for subcommittees working on specific aspects of the patient experience.

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

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

Health System Information Systems Steering Team (HSISST)

Composition:

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

Function:

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

Sentinel Event Committee and Sentinel Event Determination Group (SEDG):

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 Quality Medical Director for Perioperative services, and the Director of Quality Patient Safety and Nursing Quality. 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:

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

The James Quality, Patient Safety and Reliability Sub-Committees

Composition:

For the purposes of this 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.

The James Continuous Quality Improvement Teams and Operational Excellence

Composition:

For the purposes of this plan, 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

The management of clinical quality, patient safety and excellence are responsibilities of all faculty, staff and volunteers.

Executive Vice President and Chancellor for Health Affairs

The Chancellor leads 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 for 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 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 medical directors and the Chief Quality and Patient Safety Officer 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).

Associate Director of Perioperative Quality

The James Associate Director Perioperative Quality reports to the Medical Director Perioperative Services for The James, and is also responsible for assisting the Quality Department with medical review for patient safety and quality outcomes concerns. The physician works collaboratively with the health system quality medical directors and the Chief Quality and Patient Safety Officer in determining sentinel and significant events that occur within the perioperative service area, and can report events when needed to the peer review process.

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/or participate in corrective action plans for individual physicians, or the division/department as a whole.

Medical Director

Each business unit 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.

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

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 / CNO work and provide senior leadership within the nursing structure to influence the 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.

Nursing Staff

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 or 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. (See Figure 3)

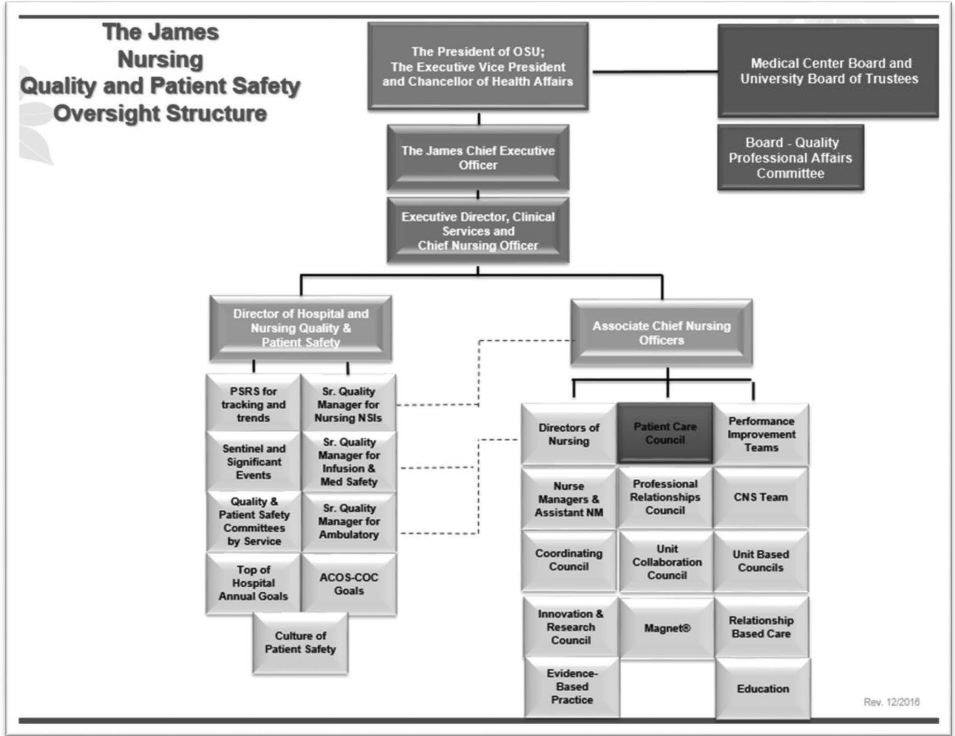


Figure 4 Nursing Quality

Director of Quality and Patient Safety, and Director of Nursing Quality

The Director for Quality and Patient Safety works directly with the executive leaders as well as the directors and managers of all areas in order to evaluate, plan and improve on patient safety and quality outcomes. The director reports to the Administrator for Patient Resource Management and is responsible for the output of the annual Quality 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. This role also has responsibility for oversight of the Nursing Quality Team, which focuses on Nurse-Sensitive Indicators (NSI) with front-line staff and other leaders.

Hospital Management Team

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; and,
- 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 resides 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. The Department maintains human and technical resources for interpreter services, information desks, patient relations, team facilitation, and use of performance improvement tools, data collection, statistical analysis, and reporting. The Department also oversees the Patient/Family Advisor Program which consists of current and former patients, or their primary caregivers, who have had experiences at any James facility. These individuals are volunteers who serve on committees and workgroups, as Advisory Council members, complete public speaking engagements and review materials.

Figure 5 Contracted Services - Patient Support Services

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 includes 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, 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; and
- **Equitable:** Unequal treatment should be a fact of the past; disparities in care should be eradicated.

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

1. **Care is based on continuous healing relationships.** Patients should receive care whenever they need it and in many forms, not just face-to-face visits. This implies that the health care system must be responsive at all times, and access to care should be provided over the Internet, by telephone, and by other means in addition to in-person visits.
2. **Care is customized according to patient needs and values.** The system should be designed to meet the most common types of needs, but should have the capability to respond to individual patient choices and preferences.
3. **The patient is the source of control.** Patients should be given the necessary information and opportunity to exercise the degree of control they choose over health care decisions that affect them. The system should be able to accommodate differences in patient preferences and encourage shared decision making.
4. **Knowledge is shared and information flows freely.** Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.
5. **Decision making is evidence-based.** Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.
6. **Safety is a system property.** Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.
7. **Transparency is necessary.** The system should make available to patients and their families information that enables them to make informed decisions when selecting a health plan, hospital, or clinical practice, or when choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.
8. **Needs are anticipated.** The system should anticipate patient needs, rather than simply react to events.
9. **Waste is continuously decreased.** The system should not waste resources or patient time.
10. **Cooperation among clinicians is a priority.** Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

Following these principles, The James 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 and Operational Excellence

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 and,
- A broad toolkit of continuous quality improvement methodologies and expert resources that provide the appropriate level of structure and support to assure the deliverables of the project are met with long term sustainability. With the increased organizational emphasis on utilizing a metric-driven approach to reducing medical errors, eliminating rework, and enhancing efficiency and effectiveness of work, DMAIC (See Fig 5), DMADV (See Fig 6), and Green and Lean (See Fig 7) project methods are used to help focus our efforts.

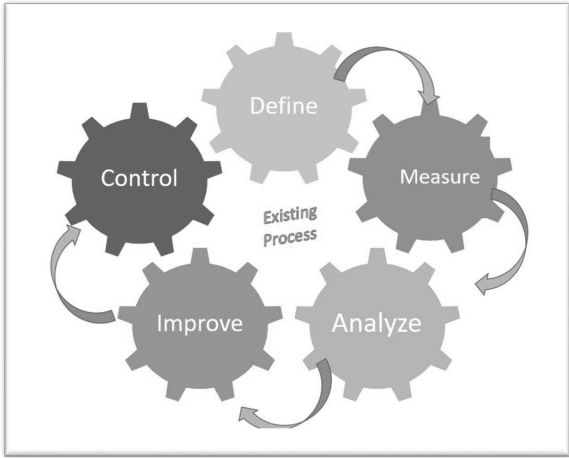


Figure 5 DMAIC

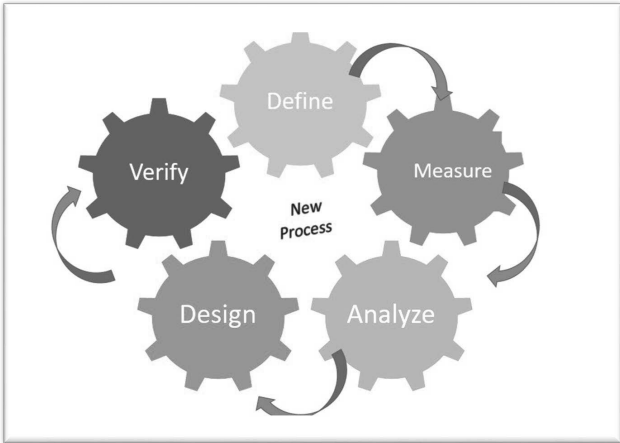


Figure 6 DMADV



Figure 7 LEAN

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 on-going and reviewed by The James Quality and Patient Safety Committee each year.

External reporting requirements

There are a number of external reporting requirements related to quality, safety, and service. These include regulatory, governmental, payer, and specialty certification organizations. The table below displays some examples of external organizations where quality, safety, and service data are reported. (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 8 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 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 9)

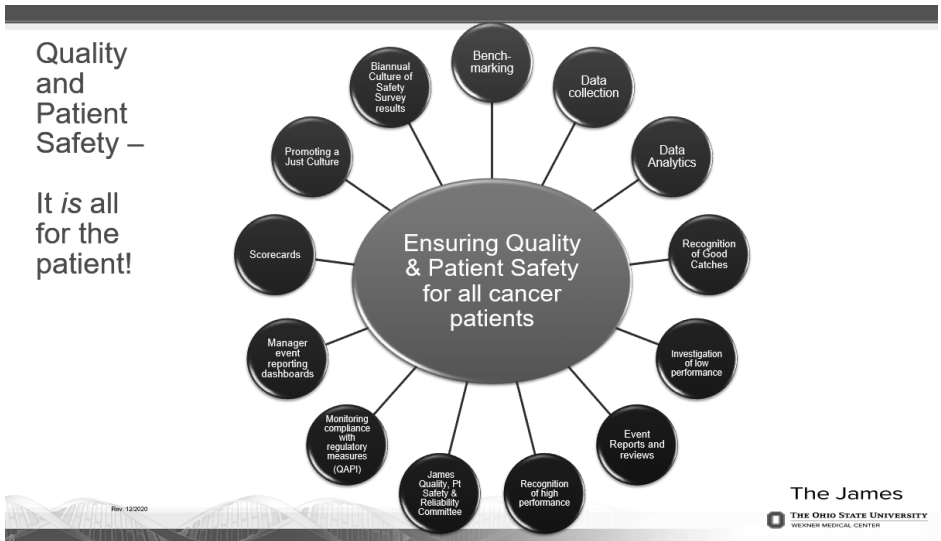


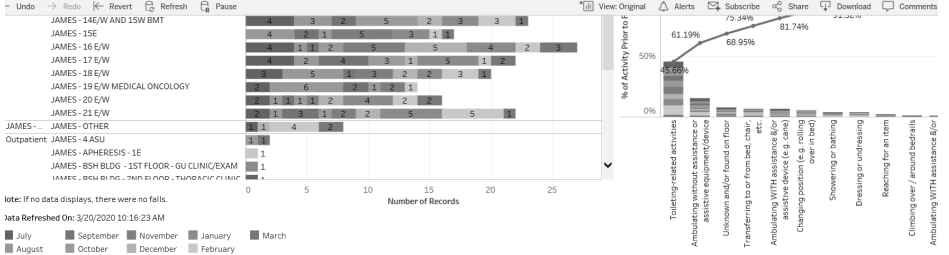
Figure 9 Quality & Patient Safety Monitoring

The James Patient Quality and Safety Scorecard

Patient Safety is the highest priority for all faculty and staff at The James. As a crucial element to caring for our patients, there is an on-going process of monitoring safety events and any untoward trends from patient care. The James Patient 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 10) 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, 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. 11) evaluates opportunities each quarter at The James Quality and Patient Safety Committee, as well as monthly at the Medical Staff Administrative Committee. Annually, safety goals are reviewed and adjusted as necessary by use of event trending, regulatory changes, needs identified from the culture of safety surveys and/or national cancer benchmarks.

Patient Safety Scorecard James Quality



Event Details

Day of Event occurrence date	Ref	Setting	Location
July 1, 2019	PSR-62230	Inpatient	JAMES - 17 E/W
July 2, 2019	PSR-62315	Inpatient	JAMES - 12 SURGICAL ONCOLOGY
July 3, 2019	PSR-62373	Outpatient	JAMES - BSH BLDG - 2ND FLOOR - THORACCIC CLINIC
July 4, 2019	PSR-62384	Inpatient	JAMES - 14E/W AND 15W BMT

Falls Hour of Day

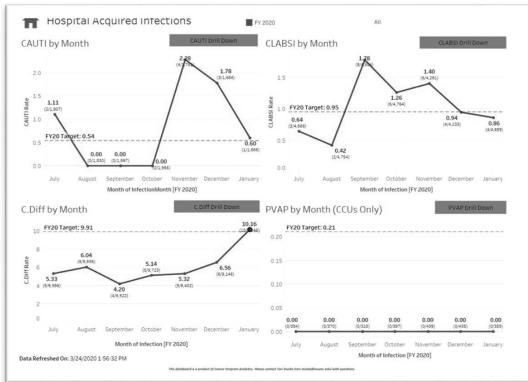
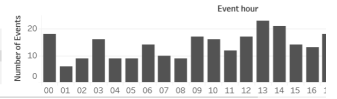


Figure 10 Quality & Patient Safety Scorecard example

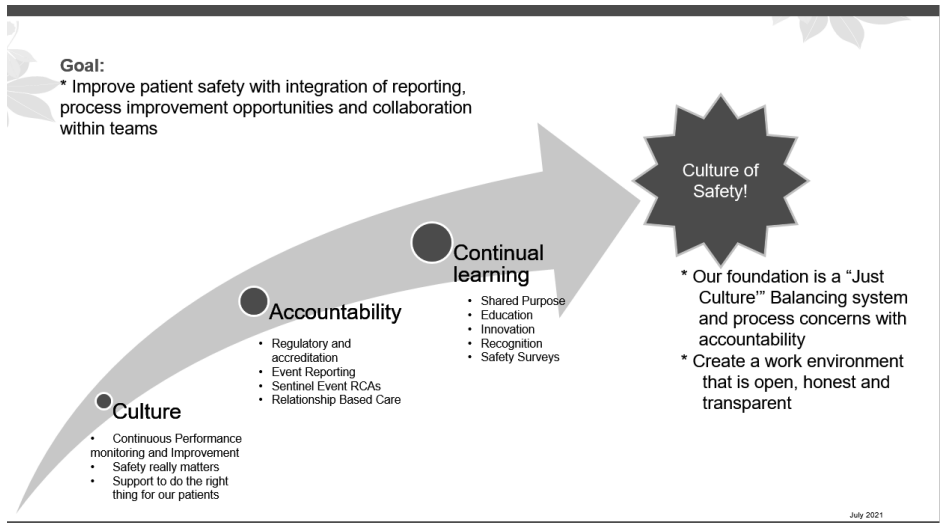


Figure 11 Patient Safety Program

The James Patient Satisfaction Portal/Dashboard

The Patient Satisfaction dashboard (See Fig 12) is a set of patient experience indicators gathered from surveys after discharge or visit to a system based clinic or hospital. The dashboard covers performance in areas such as physician communication, nursing responsiveness, pain management, admitting and discharging speed and quality in addition to many other service categories. The information is shared in forums with staff, clinicians, administration, including the Boards. Performances on many of these indicators serve as annual goals for leaders and members of clinical and patient experience teams.

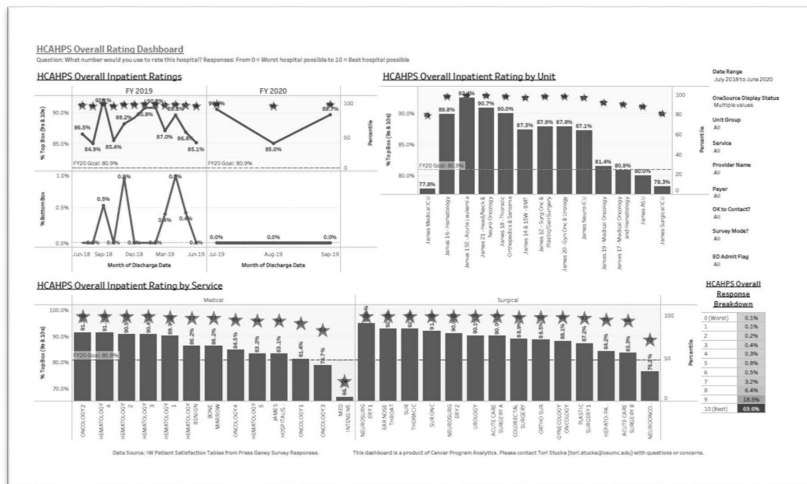


Figure 12 Patient Satisfaction Portal

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 on-going development and implementation of a curriculum for quality, safety and service for all staff, employees, clinicians, patients, and students. There are a variety of forums and venues utilized to enhance the education surrounding quality and patient safety including, but not limited to:

- Online videos
- Quality & Patient Safety Simulcasts
- Newsletters
- Classroom forums
- Simulation training
- Computerized Based Learning Modules (e-learning/CBLs)
- 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: The Vizient, The US News Report, and the Ohio Department of Health, Press Ganey, and National Database of Nursing Quality Indicators.

Innovation, Design, Evaluation

A new process can be initiated by innovative staff and leaders, and design of a new process is brought about by The James' ambition, mission, vision, values, priorities, and sound practices. Evaluation is an integral part of all existing processes and certainly key in any new innovation or design.

The design or redesign of a process comes from:

- Surveillance of data which indicates a variance that is not desired
- Patients, faculty, staff, or payers perception of a change being necessary
- Information and updates from both within the organization and from other organizations about potential risks to patient safety
- Sentinel or significant events
- Review and analysis of data and/or review of available literature confirming a need for change.

Performance Based Physician Quality & Credentialing See Figure 13

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

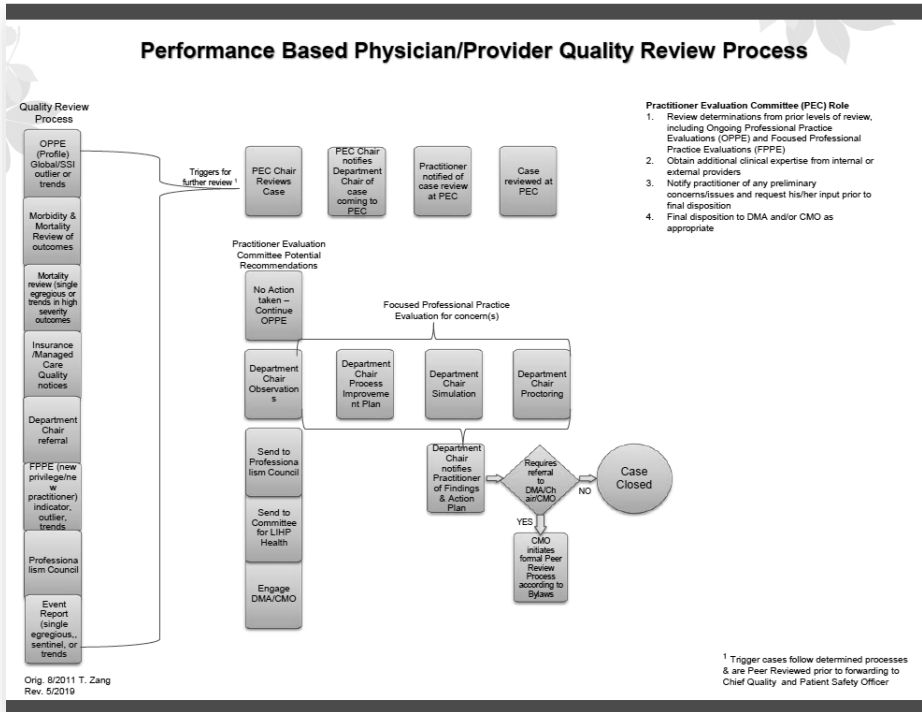


Figure13 Process for Provider Evaluations

Annual and on-going evaluations

The James Quality, Patient Safety and Reliability Plan is approved annually by The James Quality and Patient Safety Committee and QPAC. The annual evaluation includes a review of the program activities and an evaluation of the effectiveness of the structure.

Attachment A outlines the annual quality goals for FY22

Attachment B outlines the annual patient safety goals for FY22.

Attachment C examples of Shared Service metrics and annual review

Attachment A: FY 2022 James Annual Clinical Quality Goals

July 1 2021 through June 30 2022



FY22 Goals

- **Translational Research**
 - In conjunction with Pathology, the following goal has been determined for FY22: To increase the efficiency and effectiveness of Tissue Archive Services in fulfilling research requests.
 - This will be an inter-disciplinary goal

- **Just Culture[®] education & implementation** – a multi-year goal
 - Working together to improve the culture of safety by implementing the Just Culture[®] program which allows us to examine events through a lens that provides accountability to the organization and individuals, with joint responsibility to improve systems and patient safety
 - This goal is a multi-disciplinary plan

- **Serious Illness Conversation - continued**
 - A program designed to prepare front-line clinicians to have greater ease and comfort in discussing goals of care with patients along the trajectory of the continuum of care.
 - This goal is a multi-disciplinary plan.

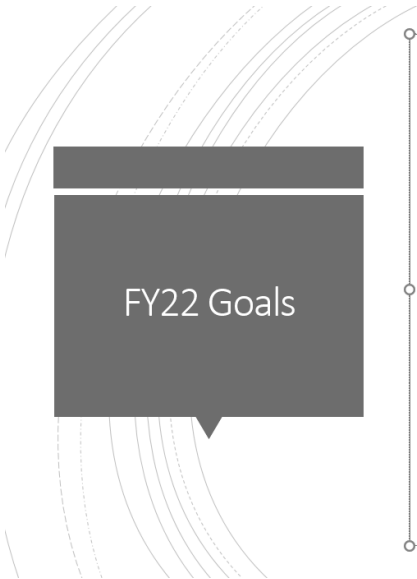
- **Plan of Care – Patient Education**
 - A goal designed to improve the quality, quantity and documentation of education to all of our patients, in both ambulatory and inpatient settings.
 - This goal is a multi-disciplinary plan.



FY22 Goals

Attachment B: FY2022 James Annual Patient Safety Goals

July 1 2021 through June 30 2022



ELIMINATE HARM! GO FOR ZERO!

Reduce or eliminate harm related to:

- Hospital Acquired Conditions (HAC)
- Pressure Injuries – Any Stage
- PSI-90 Indicators
- Mortality
- CAUTI
- CLABSI
- MRSA
- Cdiff
- SSI-Colon
- SSI-Hysterectomy

Safety Indicators such as:

- Falls with injury (any level)
- Hand hygiene compliance

Attachment C: FY2022 Sample documents for Shared Services

July 1 2021 through June 30 2022

2020 Evaluation of Contract Services: The James

Name:

Department: Date Eval. Completed: 2/28/2020

Contract Services from OSUWMC to The James: X Department

		YES	NO
1.	Are there any known outstanding requirements for improvement issued by the accrediting body for this organization?		X
2.	Do you monitor key quality and performance indicators for the service? Describe how and how often you monitor these indicators (e.g. direct observation, audits, incident reports, efficiency, satisfaction reports, etc.) Percentage of clinical nutrition consults completed within 24 hrs is monitored, this data is received twice annually and provides a monthly breakdown of completion rates. Patient satisfaction scores for James Ambulatory RD team and patient food services is also monitored monthly.	X	
3.	Does the contracted service provide the organization with performance/efficiency / quality data? If so, describe indicator, analysis, and frequency of data. Yes, department scorecard is updated monthly to include the above metrics	X	
4.	Is there a process in place to carry out improvement efforts if a problem area is identified? Explain briefly. Yes, department has a quarterly QAPI meeting to discuss scorecard and any needed corrective plans	X	
5.	Were any improvements made in the past year? Describe briefly. Validated malnutrition screening tool (MST) added to EMR in November of 2019	X	
6.	Has the organization (or any staff of the organization) providing the contracted service ever been sanctioned by CMS?		X
7.	If the contract is terminated, do you have continuity plans developed for the services provided? Please describe.		X

2020 OSUWMC to The James Evaluation Report

Internal Contract Evaluation Summary: 2020							
Evaluation Criteria: <i>All questions were answered by contract manager at OSUCCC</i>	Are there any known outstanding requirements for improvement issued by the accrediting body for this organization?	Do you monitor key quality and performance indicators for the service?	Does the contracted service provide the organization with performance/efficiency / quality data?	Is there a process in place to carry out improvement efforts if a problem area is identified?	Were any improvements made in the past year?	Has the organization (or any staff of the organization) providing the contracted service ever been sanctioned by CMS?	If the contract is terminated, do you have continuity plans developed for the services provided?
	Laboratory Services	N	Y	Y	Y	Y	Y
Medical Information Management Services	N	Y	Y	Y	Y	N	N
Security	N	Y	Y	Y	N	N	N
Nutrition	N	Y	Y	Y	Y	N	N
Credentialing	Not yet received						
Respiratory	N	Y	Y	Y	N	N	N
Pharmacy Services	N	Y	Y	Y	N	N	N
Heart and Vascular	Not yet received						
Rehabilitation Services	N	Y	Y	Y	Y	N	N
Central Sterile Processing Services	N	Y	Y	Y	Y	N	N
Radiological Services	N	Y	Y	Y	Y	N	N
Pastoral Care	N	Y	Y	Y	Y	N	Y
Radiological Technical Services	N	Y	Y	Y	Y	N	N
Interventional Radiology Call Services	N	Y	Y	Y	Y	N	N

ATTACHMENT XI



Approvals:
MSAC- June 9, 2021
QPAC- July 27, 2021
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 REHABILITATION 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 UNIVERSITY WEXNER MEDICAL CENTER (OSUWMC) MISSION, VISION AND VALUES

Mission Statement:

To improve health in Ohio and across the world through innovations and transformation in research, education, patient care, and community engagement.

Vision Statement:

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

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 (e.g. patient rights, patient assessment, patient care, patient and family education, coordination of care, and discharge planning) and organizational support functions (e.g. 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 (QAPI) 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 NURSING OFFICER, HEALTH SYSTEM

The Chief Nursing Officer, Health System 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 CNO Health System 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 CNO Health System leads quality, safety, and innovation initiatives in partnership with the Chief Quality and Patient Safety Officer. The CNO Health System ensures the vision, strategic direction, and the advancement of the profession of Nursing at OSU Wexner Medical Center.

The Chief Nursing Officer, Health System 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, HOSPITAL

The Chief Nursing Officer, Hospital 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, Hospital supports and facilitates an interdisciplinary team approach to the overall delivery of care to patients, families, and the community. The CNO, Hospital leads quality, safety, and innovation initiatives in partnership with the Hospital Executive Directors.

The CNO, Hospital 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, Hospital ensures the vision, strategic direction, and the advancement of the profession of Nursing at OSUWMC under the direction of the Chief Nursing Officer, Health System.

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 Officer of the Health System, CNO of the Hospital 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, AWHONN, 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, HIV/AIDS status, military status, national origin, race, religion, sex, gender, sexual orientation, pregnancy, protected veteran status or any other basis under the law.
- 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 (QAPI) plan. Departments utilize the QAPI plan and cascade the hospital's goals to service line quality plans to ensure proper alignment to support the overall hospital quality goals.

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.
CENTRAL STERILE SUPPLY (CSS)	Responsible for supporting all instrument cleaning and sterilization needs across the Health System. In addition, CSS is responsible for providing case carts to the operating rooms which contain all of the instrumentation and disposable supply needs for each surgical case.
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.

DEPARTMENT	SERVICE
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 & RESOURCES	Provides and promotes ongoing development and training experiences to all member of the OSU Wexner Medical Center community; provides staff enrichment programs, 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.

DEPARTMENT	SERVICE
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 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, Ultrasonography. 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

DEPARTMENT	SERVICE
	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.



Approvals: MSAC: 7/16/2021 QPAC: 7/27/2021 Wexner Medical Center Board:
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Title: Arthur G. James Cancer Hospital and Richard J. Solove Research Institute Plan for Patient Care Services

The Arthur G. James Cancer Hospital and Richard J. Solove Research Institute's Plan for Providing Patient Care Services describe herein the integration of departments and personnel who provide comprehensive care, treatment and services to patients with a cancer diagnosis and to 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 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, and distinguishes The Arthur G. James Cancer Hospital and Richard J. Solove Research Institute as one of the nation's premier comprehensive cancer centers.

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 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 community needs;
 - Planning and designing from the hospital leadership, involving the communities to be served;
 - Providing individualized care, treatment and services appropriate to the scope and level required by each patient based on professional assessments 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;; communications through management and 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 the philosophical foundation based on the values of The James Cancer Hospital and Richard J. Solove Research Institute.

Hospital Leadership

The hospital leadership is defined as the governing board, the University President, the Chancellor, administrative staff, faculty, physicians, nurses, clinical, and operational leaders in both appointed and elected positions. The hospital's leadership team is responsible for producing 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, assessment, care, safety, patient and family education, coordination of care, and discharge planning) and organizational support functions (information management, human resource management, infection control, quality, the environment of care, and the improvement of organization performance).

The hospital leadership team works collaboratively with all operational and clinical leaders to ensure 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 the patients 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 throughout the 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.

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 the organization;
 - 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.

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.

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.

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 of operation if other than 24 hours a day/7 days 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.

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. Registered Nurses, 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 cancerpatient 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 patient 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 patient satisfaction.
- 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.

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

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 11) 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.

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.

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.

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.

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 outside normal 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 day on 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.

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.
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-initiated projects, 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.
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.

ATTACHMENT XIII

2020 Contracted Services Evaluation

Person Completing Evaluation	Name of the Contracted Service	Contract Category	Contract Description
Sheryl Burtch	American Kidney Stone Management	Direct Patient Care	Provider of lithotripsy services
Jill Hannah	AMN Healthcare	Direct Patient Care	Float pool nurses
Elizabeth Bell	AMN Healthcare	Direct Patient Care	Float pool nurses
Jeffrey S. Miller	ASIST Translation Services, Inc.	Direct Patient Care	Translation and interpretation services
Bonnie Meyer	Chaplaincy Services	Direct Patient Care	Contracted chaplaincy services
Jeffrey S. Miller	Deaf Service Center	Direct Patient Care	ASL interpreting services
Trish Neel-Wilson	Fairfield Medical Center	Direct Patient Care	Provides rehab locally for OSUWMC LVRS patients
Sheryl Burtch	Fortec	Direct Patient Care	ForTec technicians assisting with laser surgical cases using ForTech equipment
Trish Neel-Wilson	Genesis HealthCare System	Direct Patient Care	Provides rehab locally for OSUWMC LVRS patients
Trish Neel-Wilson	Hardin Health System	Direct Patient Care	Provides rehab locally for OSUWMC LVRS patients
Trish Neel-Wilson	Kettering Medical Center	Direct Patient Care	Provides rehab locally for OSUWMC LVRS patients
Jeffrey S. Miller	Language Line Services, Inc.	Direct Patient Care	Interpreting, translation services, localization, and interpreter training. Connect to a professional interpreter 24/7
Trish Neel-Wilson	Mary Rutan	Direct Patient Care	Provides rehab locally for OSUWMC LVRS patients
Beth Haselwood	MedCare	Direct Patient Care	Ambulance transportation services
John Lindaman	MedFlight of Ohio	Direct Patient Care	Not-for-profit, air and ground critical care transportation company
Trish Neel-Wilson	Memorial Health System	Direct Patient Care	Provides rehab locally for OSUWMC LVRS patients
Beth Haselwood	Midwest Ambulance Transport	Direct Patient Care	Ambulance transportation services
Coranita Burt	Nationwide Children's Hospital	Direct Patient Care	Graduate Medical Education; funds flow bi-directional based on residents learning needs / location
Armin Rahmani / Steven Turner	Nuvasive Clinical Services Monitoring	Direct Patient Care	Intraoperative Neurological monitoring
Coranita Burt	Ohio Health	Direct Patient Care	Graduate Medical Education; funds flow bi-directional based on residents learning needs / location
Trish Neel-Wilson	Ohio Health Marion General Hospital	Direct Patient Care	Provides rehab locally for OSUWMC LVRS patients
Trish Neel-Wilson	Southeastern Ohio Regional Medical Center	Direct Patient Care	Provides rehab locally for OSUWMC LVRS patients
Trish Neel-Wilson	Southwest General Health Center	Direct Patient Care	Provides rehab locally for OSUWMC LVRS patients
Trish Neel-Wilson	University Hospital Health System	Direct Patient Care	Provides rehab locally for OSUWMC LVRS patients
Jeffrey S. Miller	US Together	Direct Patient Care	Local interpretation service
Rick Sargent	AHC, Inc	Patient Impact Service	Licensed asbestos abatement and mold remediation, clean up
Rick Sargent	Air Force One	Patient Impact Service	HVAC contractor
Rick Sargent	Bruner Corp	Patient Impact Service	HVAC and Mechanical solutions contractor
Rick Sargent	Chem Aqua	Patient Impact Service	Water treatment solutions
Michelle Zieber	Crothall	Patient Impact Service	Environmental services main campus through 3/31/2021
Sarah Miller	EDMXpress	Patient Impact Service	Cleaning services/EVS at EEI and JCSMI
Stacie Geese	Epic Systems Corporation	Patient Impact Service	Healthcare software company for medical record management
Angela Adkins	Follett	Patient Impact Service	Repair parts, ice machines, freezers
Angela Ferguson	Franklin County Department Job & Family Services	Patient Impact Service	Works with our uninsured and underinsured patients evaluating and helping them to apply for government resources for which they may be eligible. FCDJFS, provides case managers that help OSUWMC patients to apply for assistance
Rick Sargent	FX Facility	Patient Impact Service	Construction, renovation and facilities maintenance projects
Rick Sargent	Hina Environmental	Patient Impact Service	Environmental company focusing on Testing and Abatement of Asbestos, Lead-Based Paint, Radon, Meth Clean-up and Mold Remediation
Rick Sargent	HMPC	Patient Impact Service	HVAC contractor
Anita Cygnor	Innovative Medical Systems	Patient Impact Service	Infant security system
Heidi Pieper	Intuitive Surgical, INC	Patient Impact Service	Manufacturer of the da Vinci surgical system; provides robotic assisted technologies
Rick Sargent	JL Erlich	Patient Impact Service	Pest control
Rick Sargent	Limbach	Patient Impact Service	Mechanical solutions including in-house Design Engineering, Sheet Metal Fabrication and Installation, HVAC Piping, Plumbing, HVAC Service & Maintenance, Controls
Amanda Zeid	LindeGas North America LLC	Patient Impact Service	Supplier of medical gases
Rick Sargent	Mid-American Cleanings	Patient Impact Service	Cleaning services/EVS at various ambulatory locations
Rick Sargent	Mid-West Elevator	Patient Impact Service	Full service elevator contractor
Rick Sargent	Pro-Flow	Patient Impact Service	Modular Fluid System used for flow in HVAC systems
Thomason Smith	SHAW-DAVIS FUNERAL HOME	Patient Impact Service	Decedent cremation and body transport (through Jan 2021)
Michelle Zieber	STERICYCLE INC	Patient Impact Service	Medical Waste
Rick Sargent	The Kings	Patient Impact Service	Cleaning services/EVS at various ambulatory locations

2020 Contracted Services Evaluation

Person Completing Evaluation	Name of the Contracted Service	Contract Category	Contract Description
Michael Dorne	Towne Park - Valet Services	Patient Impact Service	Valet services
Services OSUWMC Purchases from The James			
Person Completing Evaluation	Name of Contracted Service	Contract Category	Contract Description
James Baldwin	Apherisis Nursing Services	Direct Patient Care	On call, emergency Apherisis services for patients based on need
Cassandra England	Chemotherapy Nurse Float Pool Services	Direct Patient Care	Patients receiving chemotherapy outside of The James
Erin Farrell	Emergency Oncology Services	Direct Patient Care	Oncology nurses, PCA, UCA, Patient Flow Coordinators, SANE nurses for ED oncology pod on 24/7 basis
Traci Mignery	Infusion Services	Direct Patient Care	Infusion administration on weekends and holidays and as needed
Kerri Walker	Interventional Radiology Call Services	Direct Patient Care	Radiologic services based on need outside of normal business hours
Kerri Walker	Interventional Radiology Nursing Float Pool Services	Direct Patient Care	Nursing services through The James float pool IR
Kerri Walker	Interventional Radiology Tech Services	Direct Patient Care	Radiologic services based on need
Amy Gallatin	Laboratory Services	Direct Patient Care	Lab services as defined by the Test Catalog of The James laboratories; Emergency Laboratory Services
Jennifer Watson	Nutrition Services	Direct Patient Care	Provide meals to patients, staff, and visitors
Laura Stillion / Kevin Shively	Pastoral Care Services	Direct Patient Care	0.10 FTE Chaplain and 0.40 FTE residents providing direct pastoral / spiritual support to patients and families of OSUWMC
Erin Farrell / James Baldwin	Pharmacy Services	Direct Patient Care	Administrative and operational support; clinical pharmacist support and Quality and Safety Support
Julie Meddles	Radiologic Services	Direct Patient Care	MR, CT, X-ray, Fluoroscopy, Interventional Radiology, Ultrasound, Nuclear Medicine at The James or Spielman Breast Center
Vanessa Jamison	Wound Ostomy Services	Direct Patient Care	Evaluate, assess, and treat patients in collaboration with OSUWMC Wound Ostomy Team
Hanci Newbery	Materials Management	Patient Impact	Supplies acquisitions and inventory control; software execution; supply rooms for Critical Care, Progressive Care and Emergency Department
Vanessa Jamison	Officer of the Day	Patient Impact	Review surgical case movement on a daily basis; review predictable pattern to better utilize OR for main campus pavilions
Robert Weber / Ben Lopez	Perioperative Policy and Procedure Support Services	Patient Impact	Research, edit, update and educate on perioperative policies and procedures

ATTACHMENT XIV

Contracted Services

	Person Completing Evaluation	Name of the Contracted Service	Contract Category	Contract Description
1	Sheryl Burtch	American Kidney Stone Management	Direct Patient Care	Provider of lithotripsy services
2	Jill Hannah	AMN Healthcare	Direct Patient Care	Float pool nurses
3	Elizabeth Bell	AMN Healthcare	Direct Patient Care	Float pool nurses
4	Jeffrey S. Miller	ASIST Translation Services, Inc.	Direct Patient Care	Translation and interpretation services
5	Bonnie Meyer	Chaplaincy Services	Direct Patient Care	Contracted chaplaincy services
6	Jeffrey S. Miller	Deaf Service Center	Direct Patient Care	ASL interpreting services
7	Trish Neel-Wilson	Fairfield Medical Center	Direct Patient Care	Provides rehab locally for OSUWMC LVRS patients
8	Sheryl Burtch	Fortec	Direct Patient Care	ForTec technicians assisting with laser surgical cases using ForTech equipment
9	Trish Neel-Wilson	Genesis HealthCare System	Direct Patient Care	Provides rehab locally for OSUWMC/The James LVRS patients
10	Trish Neel-Wilson	Hardin Health System	Direct Patient Care	Provides rehab locally for OSUWMC/The James LVRS patients
11	Trish Neel-Wilson	Kettering Medical Center	Direct Patient Care	Provides rehab locally for OSUWMC/The James LVRS patients
12	Jeffrey S. Miller	Language Line Services, Inc.	Direct Patient Care	Interpreting, translation services, localization, and interpreter training. Connect to a professional interpreter 24/7
13	Trish Neel-Wilson	Mary Rutan Hospital	Direct Patient Care	Provides rehab locally for OSUWMC/The James LVRS patients
14	Beth Haselwood	MedCare	Direct Patient Care	Ambulance transportation services

15	John Lindaman	MedFlight of Ohio	Direct Patient Care	Not-for-profit, air and ground critical care transportation company
16	Trish Neel-Wilson	Memorial Health System	Direct Patient Care	Provides rehab locally for OSUWMC LVRS patients
17	Beth Haselwood	Midwest Ambulance Transport	Direct Patient Care	Ambulance transportation services
18	Coranita Burt	Nationwide Children's Hospital	Direct Patient Care	Graduate Medical Education; funds flow bi-directional based on residents learning needs / location
19	Armin Rahmanian / Steven Turner	Nuvasive Clinical Services Monitoring	Direct Patient Care	Intraoperative Neurological monitoring
20	Coranita Burt	Ohio Health	Direct Patient Care	Graduate Medical Education; funds flow bi-directional based on residents learning needs / location
21	Trish Neel-Wilson	Ohio Health Marion General Hospital	Direct Patient Care	Provides rehab locally for OSUWMC/The James LVRS patients
22	Trish Neel-Wilson	Southeastern Ohio Regional Medical Center	Direct Patient Care	Provides rehab locally for OSUWMC/The James LVRS patients
23	Trish Neel-Wilson	Southwest General Health Center	Direct Patient Care	Provides rehab locally for OSUWMC/The James LVRS patients
24	Trish Neel-Wilson	University Hospital Health System	Direct Patient Care	Provides rehab locally for OSUWMC/The James LVRS patients
25	Jeffrey S. Miller	US Together	Direct Patient Care	Local interpretation service
26	Rick Sargent	AHC, Inc	Patient Impact Service	Licensed asbestos abatement and mold remediation, clean up
27	Rick Sargent	Air Force One	Patient Impact Service	HVAC contractor
28	Rick Sargent	Bruner Corp	Patient Impact Service	HVAC and Mechanical solutions contractor

29	Rick Sargent	Chem Aqua	Patient Impact Service	Water treatment solutions
30	Michelle Zieber	Crothall	Patient Impact Service	Environmental services main campus through 3/31/2021
31	Sarah Miller	EDMXpress	Patient Impact Service	Cleaning services/EVS at EEI and JCSMI
32	Stacie Gecse	Epic Systems Corporation	Patient Impact Service	Healthcare software company for medical record management
33	Angela Adkins	Follett	Patient Impact Service	Repair parts, ice machines, freezers
33	Angela Ferguson	Franklin County Department Job & Family Services	Patient Impact Service	Works with our uninsured and underinsured patients evaluating and helping them to apply for government resources for which they may be eligible. FCDJFS, provides case managers that help OSUWMC/The James patients to apply for assistance
34	Rick Sargent	FX Facility	Patient Impact Service	Construction, renovation and facilities maintenance projects
35	Rick Sargent	Hina Environmental	Patient Impact Service	Environmental company focusing on Testing and Abatement of Asbestos, Lead-Based Paint, Radon, Meth Clean-up and Mold Remediation
36	Rick Sargent	HMPC	Patient Impact Service	HVAC contractor
37	Anita Cygnor	Innovative Medical Systems	Patient Impact Service	Infant security system
38	Heidi Pieper	Intuitive Surgical, INC	Patient Impact Service	Manufacturer of the da Vinci surgical system; provides robotic assisted technologies

39	Rick Sargent	JL Erlich	Patient Impact Service	Pest control
40	Rick Sargent	Limbach	Patient Impact Service	Mechanical solutions including in-house Design Engineering, Sheet Metal Fabrication and Installation, HVAC Piping, Plumbing, HVAC Service & Maintenance, Controls
41	Amanda Zeid	LindeGas North America LLC	Patient Impact Service	Supplier of medical gases
42	Rick Sargent	Mid-American Cleanings	Patient Impact Service	Cleaning services/EVS at various ambulatory locations
43	Rick Sargent	Mid-West Elevator	Patient Impact Service	Full service elevator contractor
44	Rick Sargent	Pro-Flow	Patient Impact Service	Modular Fluid System used for flow in HVAC systems
45	Thomason Smith	SHAW-DAVIS FUNERAL HOME	Patient Impact Service	Decedent cremation and body transport (through Jan 2021)
46	Michelle Zieber	STERICYCLE INC	Patient Impact Service	Medical Waste
47	Rick Sargent	The Kings	Patient Impact Service	Cleaning services/EVS at various ambulatory locations
48	Michael Dorne	Towne Park - Valet Services	Patient Impact Service	Valet services

Services The James has purchased from OSUWMC

[Note: for the purposes of The James MSAC review, we are required to assess the adequacy of services provided by OSUWMC as an external entity. The converse process has already occurred at UH MSAC]

Person Completing Evaluation	Name of Contracted Service	Contract Category	Contract Description
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1	Andrea Scurria	Acute Hemodialysis Nurse Services	Direct Patient Care	As ordered by a nephrologist, Acute Hemodialysis Services are provided to The James' patients on a daily basis during normal business hours; Emergency Acute Hemodialysis Services are available, via on call
2	Shannon Thompson	Central Sterile Supply	Patient Impact	All duties related to cleaning and decontamination of general and specialty surgical instruments, power equipment, endoscopes, as well sterilization, preparation & packaging, and delivery of surgical instruments and supplies to the James operating room
3	Penny Moore	Clinical Engineering Services	Patient Impact	Assurance of the accuracy, safety, and proper performance of electrical and non-electrical medical equipment
4	Michelle Ross	Employee Health Services	Direct Patient Care	Provide new hire screening, faculty and staff injuries, manage blood and body fluid exposures, annual vaccinations
5	Megan Mooney	Fetal and Uterine Nurse Monitoring Services	Direct Patient Care	Fetal and Uterine Monitoring Services include, but are not limited to, fetal movement assessment, auscultation, electronic fetal monitoring, non-stress test, contraction stress test, fetal biophysical profile, and modified biophysical profile
6	Shannon Thompson	Interventional Radiology Call Services	Direct Patient Care	Provide a call team, consisting of one (1) IR nurse and one (1) IR Technician, to cover all of The James' after hours calls and services
7	Shannon Thompson	Interventional Radiology Technician Services	Direct Patient Care	Confirm and review order from an authorized practitioner; manage supplies; assist in preparation for procedures, obtain radiographic procedural imaging for patients
8	Michelle Ross	Legal Services	Patient Impact Service	On-call legal and risk management consultative services; provision of legal consultation and legal review of new-risk related policies and policy changes for The James.
9	Andrea Scurria	Nursing Float Pool Services	Direct Patient Care	Provide RNs in the event of unexpected surges in case volume or low staff numbers

10	Megan Mooney	Pastoral Care Services	Patient Impact Service	0.30 FTE staff member shall be dedicated to providing Pastoral Care Services
11	Michelle Ross	Physician Advisor Services	Patient Impact Service	Provide second-level medical necessity of review of appropriate level of care cases
12	Shannon Thompson	Radiologic Services	Patient Impact Service	Supply diagnostic and therapeutic radiology services to The James
13	Mike Callahan	Registration Services	Patient Impact Service	Provide a complete registration for The James' patients in OSUWMC's and The James' joint EMR system according to organizational guidelines
14	Andrea Scurria	Rehabilitation Services	Direct Patient Care	Oversees James Acute Rehab team
15	Shannon Thompson	Operating Room Nurse Float Pool Services	Direct Patient Care	Provide RNs and/or surgical technicians to offset unexpected surges in case volume or low staff numbers due to vacancies or use of benefit time

ATTACHMENT XV



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

July 8, 2021

Jeremy Young, MD
Division of Infectious Disease
The Ohio State University Wexner Medical Center
1581 Dodd Dr
4th Floor
Columbus, OH-43210-1267

Dear Dr. Young,

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, MBA
Chief Clinical Officer
Senior Vice President for Health Services

Robert J. Weber, PharmD
Administrator, Pharmacy

ATTACHMENT XVI

The James



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

June 21, 2021

Zeinab El Boghdadly, MBBCh
Division of Infectious Disease
OSUCCC-The James
460 West 10th Ave. 5th floor
Columbus, OH-43210-1267

Dear Dr. El Boghdadly,

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,

A handwritten signature in black ink, appearing to read 'David E Cohn'.

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

A handwritten signature in black ink, appearing to read 'Robert Weber'.

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



A Comprehensive Cancer
Center Designated by the
National Cancer Institute

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