OREGON HEALTH & SCIENCE UNIVERSITY

OHSU Board of Directors Meeting

February 15, 2011
SON – 358/364
1:00 – 2:30 p.m.

OREGON HEALTH & SCIENCE UNIVERSITY
BOARD OF DIRECTORS MEETING

February 15, 2011

1:00 – 2:30 p.m.

School of Nursing, Rooms 358 & 364

1:00 p.m.	Call to Order/ Chairman's Comments	Charles Wilhoite
	President's Comments	Joe Robertson
	Approval of Minutes **(Action)**	Charles Wilhoite
1:10 p.m.	Financial Report	Lawrence Furnstahl
1:30 p.m.	Health System Annual Quality Report	Chuck Kilo Chief Medical Officer
1:55 p.m.	Integrity Program Annual Report	Gary Chiodo Chief Integrity Officer
2:10 p.m.	Briefing on Institute of Medicine Report on Future Nursing	Michael Bleich School of Nursing Dean
2:30 p.m.	Other Business; Adjournment	Charles Wilhoite

OREGON HEALTH & SCIENCE UNIVERSITY

Oregon Health & Science University
Board of Directors Meeting
November 1, 2010

Board Members in Attendance: Charles Wilhoite, Joe Robertson M.D., Jon Yunker, David Yaden, MardiLyn Saathoff, Román Hernández, Meredith Wilson

Staff Presenters: Pitt Calkin, Bridget Haggerty, Amy Wayson
Other Presenters: Drew Corrigan

Chair's Comments

Mr. Wilhoite opened the meeting by commenting that everyone should be proud of the successful fiscal year at OHSU. Healthcare reform will require that the institution achieve even more efficiency and lower costs. Management is working to stay ahead of the curve in anticipation of these pressures. OHSU received positive news regarding its bond rating, which will be detailed by Dr. Robertson. Mr. Wilhoite also noted that the Board survey results were positive, as will be outlined in more detail, but there is always room for improvement to achieve an even higher standard of excellence. Mr. Wilhoite thanked the Board members for their role in the success of OHSU.

President's Comments

Dr. Robertson opened his remarks by referencing a series of recent positive articles about OHSU in the press, reflecting a consistent theme about OHSU's partnering with others, a key part of OHSU's strategic plan to make OHSU a leader in health and science innovation. The first article was about the Life Sciences Collaborative Building that we are building with the Oregon University System on the Schnitzer Campus. Dr. Robertson met with Ted Wheeler, the State Treasurer, and remains confident that the building will go forward notwithstanding the State's financial challenges. This is because the bonds to be issued to finance that building will be in part serviced by OHSU, and the balance represents a modest investment for the State that will yield a good return. Dr. Robertson referenced the copies of the MOU between OHSU and OUS, the Ground Lease Agreement, and the Tenancy in Common Agreement related to the Life Sciences Collaborative Building project, copies of which were provided to the Board members.

A second article and editorial in *The Oregonian* related to the OHSU/PSU Task Force. The Task Force was formed following testimony by PSU President Wim Wiewel and Dr. Robertson in the last legislative session at a time when a bill was pending related to the possible merger of OHSU and PSU. Dr. Wiewel and Dr. Robertson testified that their institutions were working together collaboratively in several contexts and they asked for time to study the matter. The Task Force report outlines the principles of a continued collaboration between the institutions, termed a "strategic alliance." The report is consistent with our history of collaborating, including our current joint healthcare and MBA program, informatics, and the commitment to the OUS Building.

The Board will be provided with a calendar of events planned to celebrate the 100th anniversary of the School of Nursing. Two new grants, valued at $600,000 and $1.2 million, were awarded to the School of Nursing to assist with scholarships. This is in addition to the $10 million anonymous donation for scholarships received by the School of Medicine over the summer. Scholarships have been highlighted as an area of concentration for philanthropic giving, and these gifts are much appreciated by the students. Dr. Robertson commended Dr. Michael Bleich on receiving the "American Association of Critical Care Nurses

Doctor John McGovern Award" for his work in connection with the landmark Institute of Medicine study called "The Future of Nursing." This is the first comprehensive report on how nursing fits into the evolving healthcare system and frames the challenges and opportunities for nurses in the next 25 years.

A blue-ribbon panel co-chaired by Robert Gootee of ODS and Interim Provost David Robinson has been established to examine the future of clinical education in dentistry. Our expectation is that the didactic portion of dental education will move to the Schnitzer Campus upon completion of the OUS Life Sciences Building. The panel will evaluate the possibility of moving and updating the clinical education at the same time to leverage the onsite construction. This will require a high level of philanthropic support. Dr. Robertson congratulated Dean Clinton on being named President of the USA section of the International College of Dentists.

The Joint Commission made a surprise visit to OHSU during the last week of October. Dr. Robertson was pleased to report that it was an uneventful visit with no material concerns. The Joint Commission reported that OHSU is a "high reliability organization" that is prepared to assure the quality of patient care every day. Dr. Robertson concurs with Health System Executive Director Peter Rapp's observation that the review resulted in a demonstration of "organic excellence."

OHSU has applied for a $100 million HRSA grant that would be used as part of a $250 million expansion involving both the Doernbecher and University Hospitals. The single grant is a part of healthcare reform legislation and is to be given to one institution in the country that meets specific criteria. Our receiving it is a long shot, but OHSU submitted a strong proposal and we remain hopeful that OHSU will be the recipient. The results will be known in mid-December.

Dr. Robertson reported that he continues his involvement with the Oregon Health Policy Board. The hearings should garner additional public interest as discussions include the possibility of bringing a public option health plan to the legislature. The OHP Board is also discussing the form and format for the insurance exchange. Dr. Robertson clarified that the Oregon Health Policy Board does not enact any policies or legislation; rather, it brings recommendations to the legislature for enactment.

OHSU has had a very strong year in the area of technology transfer with 3 new start-ups, 21 patents, 93 patent applications, 115 invention disclosures, 87 industry-sponsored research agreements totaling $7.3 million in awards, 34 commercialization agreements, and 340 material transfer agreements. Two years ago, an article in the *Harvard Business Review* stated that the product development cycle in high-tech is 6 months, while in bioscience it is 14-16 years. Thus, the work being done in this area now is the "seed corn" for our success in the future.

Dr. Robertson reported that Standard & Poor's upgraded OHSU's bond rating from a "BBB+" to an "A". Dr. Robertson quoted Interim CFO Pitt Calkin as saying that in 30 years, he has never seen so substantial an upgrade. The upgrade is even more remarkable during the depths of the recession, and is an endorsement of the financial plan and the management team's ability to respond to change. The strength of the faculty and staff and the value of OHSU's mission to Oregonians contributed to the positive rating. That said, the current environment and healthcare reform will bring additional challenges and diminished margins to the clinical area. For this reason, OHSU is undergoing a comprehensive review of business and operations models. This will be discussed in more detail at the February Board meeting.

Mr. Wilhoite thanked Dr. Robertson for his remarks, noting that they reflected the accuracy of a description of OHSU he frequently uses -- that OHSU is "...a lot of smart and committed people doing a lot of good stuff."

Approval of Minutes

Mr. Wilhoite asked for approval of the minutes of the September 9, 2010 Board meeting, as included in the Board materials. Upon motion duly made and seconded, the minutes were approved on the vote of 6 members present, with Román Hernández abstaining from the vote, on the basis that he was not in attendance on September 9th.

KPMG Audit Update - Resolution 2010-11-15

Drew Corrigan of KPMG congratulated OHSU on receiving a double upgrade on its bond rating. He said that most organizations have recently experienced either no change or a downgrade, so it was phenomenal to receive a double upgrade. KPMG auditors met with the Finance and Audit Committee on October 20, 2010 to explain the financial statements and audit process in detail. Mr. Corrigan outlined the purpose and scope of the audit -- positioning KPMG to provide an opinion that the financial statements are materially correct and in accordance with GAAP. KPMG's report provided to Board members at the Board meeting covers the consolidated financial statements, including Hospital activity, University activity, Faculty Practice Plan activity and research activity. In addition, KPMG issues a number of separate reports regarding federal grant activity (A-133 audits) and other special purpose reports required by other regulations.

KPMG's review of key processes and controls each year looks at many transactions throughout the year to determine if there are deviations from policy. KPMG found no policy deviations to report. KPMG focuses on significant account balances when reviewing financial transactions and on management's areas of judgment and estimation, checking for consistency each year and evaluating the year-end conclusions. The A-133 audit activity focuses on federal grant activity in the research and development arena, student financial aid (which is reviewed every third year, this being a year of review) and federal stimulus funds.

Mr. Corrigan identified as a discussion item this year's implementation of GASB 53, the accounting and financial reporting requirement for derivative instruments which establishes the GASB framework for hedge accounting treatment. For OHSU, the implications of GASB 53 are limited primarily to interest rate swap arrangements. Now, the fair value of interest rate swaps is recorded in financial statements rather than its being merely a disclosure item.

Mr. Corrigan noted that this is the first full year of Faculty Practice Plan (FPP) activity. FPP numbers for fiscal year 2009 reflect only six months of activity.

Mr. Corrigan explained that as auditors, KPMG must disclose any errors or irregularities discovered during the course of the audit. He reported that no such errors or irregularities were found and that a clean, unqualified opinion was issued on the financial statements. The implementation of GASB 53 was the only significant accounting policy change requiring reporting and is also considered a non-routine transaction that must be disclosed to the Board. The auditors are comfortable with the consistency in management's approach in the areas of patient accounts receivable and related reserves, third-party reserves, self-insurance reserves, and investment valuation.

The only adjustment to communicate to the Board is the reversal of $1.5 million in unallocated self-insurance reserves related to employee medical benefits. It does not impact the income statement. KPMG had no disagreements with management in the conduct of its work. Mr. Corrigan commented that the audit process was smooth and that necessary information was received in a timely manner. No difficulties were encountered, as everyone involved in the audit process was helpful and cooperative. KPMG identified

no material weaknesses in the internal control structure. KPMG affirmed that they are independent of OHSU and its related entities.

Mr. Yunker commented that the Finance and Audit Committee was pleased with the results of the audit and the process itself. Mr. Wilhoite concurred, saying that a lot of information is shared during the audit process and the results affirm a sound financial year for OHSU. Dr. Robertson called attention to a notation in the Financial Statements that OHSU's Marquam Hill property is leased from the State of Oregon for renewable 99-year periods at a lease payment equal to the debt service on bonds outstanding at the time of OHSU's separation from the Oregon University System. As the debt service is relatively low, the capitalized net present value of those lease payments significantly understates the value of the included land and buildings. If the full value of the property was included, similar to other organizations, our balance sheet would be even stronger. Mr. Corrigan agreed, noting that the property is appropriately accounted for under GAAP, which does not take into account the current fair market value of the property, plant and equipment.

Responding to a question from Ms. Saathoff about whether or not KPMG discusses with management trends in accounting policies that may have future impacts for the organization, Mr. Corrigan explained that his firm tries to keep OHSU informed in this area. One such area he has discussed with management relates to significant accounting changes regarding lease accounting that are occurring in the non-governmental context, and that OHSU should consider as it moves forward with existing and future leases.

Mr. Wilhoite acknowledged the professionalism and high level of services received from KPMG and Mr. Corrigan, the partner in charge of the engagement for the last four years and involved for five years prior to that as a manager. Mr. Wilhoite commended Mr. Calkin, Ken Brown, and the entire financial team for their work during the audit and the clear and concise presentation of the results.

Mr. Wilhoite asked for approval of Resolution 2010-11-15, accepting the financial statements and the auditor's report. Upon motion duly made and seconded, the Resolution was unanimously adopted.

Financial Update

Mr. Calkin indicated that the materials provided to the Board reflect the institution's financial performance through August. He will include an update regarding September, but we do not yet have final September numbers. Referring to a slide reflecting consolidated days cash on hand, Mr. Calkin noted that August results reflect 168 days of cash compared to a budget of 162 days and a standard for an "A" bond rating of 135 days. The high actual number is driven by the high clinical volume in the Hospital and the Faculty Practice Plan. Referring to a slide setting out debt service coverage ratios, Mr. Calkin noted the fiscal year to date debt service coverage ratio is 3.1 against a budgeted ratio of 3.2 and an internal goal of 3.1. September continues with this strong performance.

The Standard & Poor's analysts were onsite August 10, 2010. In-depth presentations were given by Dr. Mark Richardson, Peter Rapp, and Dr. Dan Dorsa to detail each of the missions of OHSU. Previously, OHSU was rated as a hospital system; this year, OHSU was also evaluated as an institution of higher education. The official report and double upgrade to an "A" rating was released on September 30, 2010. Overall strengths cited in the report include a significant improvement in operating performance, solid overall financial profile, specialty adult and pediatric services with a high case mix index, healthy revenue diversity, profitable hospital operations, and a strong management team working to contain costs. They also

mentioned as strengths ongoing state support and OHSU's status as the only medical school and academic medical center in Oregon. Significantly, the upgrade was given a stable outlook.

Responding to questions from Ms. Saathoff, Mr. Calkin explained that Standard & Poor's used Government Related Entities (GRE) standard criteria in the evaluation of state support. Dr. Robertson commented that in citing state support, the rating agency looked as much to the critical role fulfilled by OHSU in the State of Oregon as to the level of financial support from the State. Ms. Saathoff added that the S & P report suggests that the other areas of revenue have to be maintained and strengthened.

Mr. Calkin said that another factor in the upgraded bond rating was the progress in getting closer to a positive margin on the University side. In 2010, the University attained a $4 million deficit compared to a budgeted $15 million deficit. This was a positive trend that showed healthy revenue diversity. Responding to a question from Mr. Yaden, Dr. Robertson explained that the demand for the medical school is high, even with the high tuition costs. Last year, there were 4,000 applicants with only 120 students admitted. Seventy-five percent of the School of Medicine students admitted are from Oregon. There are always more qualified applicants than space available in the School of Medicine.

Mr. Wilhoite added that Mr. Calkin has played an invaluable role as interim CFO. Visits from the Joint Commission and Standard & Poor's were two serious events that had positive outcomes. The upgraded bond rating will have positive financial implications as OHSU will have lower interest rates going forward. Mr. Wilhoite thanked everyone at OHSU that played a role in the upgraded bond rating. Dr. Robertson acknowledged Mr. Calkin's efforts and contributions to OHSU's success this year. Mr. Calkin's knowledge, demeanor, and confidence were instrumental during a difficult time of transition. Mr. Calkin will be missed when a permanent CFO is hired.

Governance Committee Resolution 2010-11-16

The Charter for the Governance Committee requires the committee to periodically review the corporate documents and recommend changes to the Board. Standing in for Mr. Waldron, Ms. Wayson explained that the Resolution proposes to change 3 corporate documents in a manner reflected on Exhibits attached to the Resolution. The first Exhibit is the final page of the Bylaws and is a "housekeeping" change, to simply eliminate irrelevant dates on the document. The second recommended change, outlined in Exhibit B, removes from the Finance and Audit Committee Charter text that prohibits the Board Chair or the President from being a member of the Finance & Audit Committee. This change will align the Charter with what the Governance Committee sees as best practice. Exhibit C removes text from the Governance Principles and Guidelines similarly prohibiting the Board Chair and the OHSU President from serving on the Finance & Audit Committee. Ms. Wayson noted that in Exhibit C of the Board Docket, language stating that the OHSU President will not serve on the Governance Committee is deleted in red-line; however, Ms. Wayson clarified that this deletion was an error and that the language regarding the Governance Committee should be retained in the Governance Principles and Guidelines.

Mr. Wilhoite asked for approval of Resolution 2010-11-1, updating the Bylaws, the Finance & Audit Committee Charter and the Governance Principles and Guidelines as proposed and with the correction noted by Ms. Wayson. Upon motion duly made and seconded, the Resolution was unanimously adopted. Mr. Wilhoite noted the necessary amendment to Exhibit C.

Board Survey Results

Mr. Wilhoite shared the results of the annual Board survey conducted each year. The Board has a policy making role, overseeing and providing fiduciary insight for the organization, but not making direct operational decisions. The survey was changed to focus on where the Board could make improvements.

Generally the input from Board members in the survey was positive. The Board generally has a good understanding of the mission and the financial position of OHSU. Each Board member participates in an orientation process that includes people from many areas of the organization. One area for future focus is ensuring that the Board stays focused on providing strategic direction without delving into operations.

The Board has a good understanding of its role and is comfortable with current long-term planning. When information is presented to the Board, the Board would like it to be more focused and strategically framed. The Board feels that it is effective, but would like more reporting from the Board Committees, to ensure that all Board members understand what occurs within the committees.

Regarding the composition of the Board, as in prior years, the survey indicates a desire by the Board to have someone with healthcare experience on the Board. Given that Dr. Robertson has health care experience, Mr. Wilhoite's view is that the Board would benefit from having someone on it with healthcare experience from outside of OHSU. Regarding Board meetings, the Board would like management to continue to focus on getting information delivered to Board members in a timely manner in order to allow the members to study the information and prepare questions effectively. Staff presentations to the Board received very high marks.

Regarding orientation for Board members, the Board would like to see it streamlined. Regarding the Board's role relative to executive management, the Board would like additional clarity regarding the respective roles of ELT members in order to know where questions should be directed. The Committees received high marks, with the need for improving the dissemination of information to the rest of the Board. Mr. Wilhoite suggested that briefings or summarized reports could be forward by the Committees to the rest of the Board.

Overall, the Board scored itself as a "B+". While there are always areas for improvement, Mr. Wilhoite said that each year the presentations to the Board are more focused and specific, giving him a deeper understanding of OHSU. Because the environment of the institution is constantly evolving, with issues in healthcare reform, bonds, development, and construction projects, OHSU and its Board must stay ahead of the curve and continue to plan, finding solutions that will keep the institution viable and growing.

Ms. Saathoff commented that the "B+" grade speaks highly of the Board and of the Board's high expectations of their own performance. Mr. Wilhoite concurred, saying that one should never be comfortable and should always strive to attain higher standards of performance.

ITG Update

Bridget Haggerty, Vice President and Chief Information Officer, explained that the customer base for the Information Technology Group (ITG) includes the Hospitals and Clinics, University including research, University Medical Group and the OHSU Foundation. Few sites across the nation provide this integrated level of support. Similarly complex organizations generally have three or more independent IT operations.

ITG views itself as a facilitator for excellence across the missions of OHSU. ITG is committed to partnering and to project management excellence. It seeks feedback from the mission areas and administrative functions to inform IT decisions, the development and modification of the ITG strategic plan, and the annual budgeting process. It works with key strategic vendor partners such as Epic, Oracle and Cisco to achieve best pricing, and to drive the development of integrated solutions, thereby avoiding the expenditure of resources on the creation of interfaces between applications. ITG remains positioned to implement other "best in breed" solutions where the integrated platform is not adequate. ITG is committed to service excellence and strives to continually improve the services provided to OHSU.

ITG's services encompass networks, telephones, campus operators, web support, application support, desktop support, and an Advanced Computing Center providing customized services for a fee. ITG includes 325 employees that support over 17,000 workstations, 2,000 databases, and 480 distinct applications.

ITG utilizes benchmarking standards to measure efficiency, including "Educause," a measure for education institutions, University Health System Consortium measures for healthcare providers, AAMC/Epic benchmarks for organizations that have implemented Epic, and HIMSS Analytics measures relative to Electronic Medical Record (EMR) ddoption maturity. ITG compares favorably in terms of EMR adoption scores and budget. The IT budget averages 3% of the total organizational budget, while other organizations spend up to 5% of the total budget on IT. ITG grades their performance on efficiency, reliability, and customer satisfaction. Responding to a question from Ms. Saathoff, Ms. Haggerty explained that ITG sets performance benchmarks with reference to industry standards.

One capital project that was funded this year was the secondary data center, a project critical to eliminating the single point of failure and to providing expansion capacity. ITG is working with the Tech Transfer office on patent possibilities for the unique design for the data center, and with the Energy Trust of Oregon to identify all possible resource opportunities. The site location is now being finalized, with the data center design in the last stages of engineering validation review.

Other capital projects that were funded include replacing the 20 year-old telephone system, re-wiring many older buildings, and implementing Epic Beacon, an Epic product for medical oncology services. The Hospital is implementing a new document management system that will be integrated across the institution in the future. An RFP is now in process for a clinical trials management system that will assist in meeting regulatory requirements and also optimize participation in clinical trials. We implemented Amcom's "e.Notify", allowing ITG to send out alerts to all students and employees in the event of an emergency.

ITG is involved in a variety of telemedicine contexts. Oregon Health Network is a non-profit with $20 million of FCC funds available for broadband infrastructure connecting hospitals, clinics and other sites throughout the state. There will be over 200 sites deployed by the end of the fiscal year. This facilitates the deployment of telemedicine services by establishing a strong, reliable connection. The infrastructure could also be used for medical education.

Four years ago, ITG created a proposal called "enterprise management decision support" to ensure access to information necessary for key business decisions. Due to a lack of funding, the initiative has been done in stages, beginning with healthcare. We have a pilot project in the research community, and on the academic side, we are working with the School of Medicine to create a dashboard encompassing financial information and key performance indicators. On the administrative support side, a replacement for the CFS budget product in related variance reporting is scheduled to go live in the near future.

Ms. Haggerty explained that ITG is ready to move forward with a broader governance structure that ensures the appropriate prioritization of future projects and resources and that drives consistency and accountability throughout the organization.

Growing regulations such as FERPA and HIPAA have created challenges related to compliance and information security. Cyber crime has significantly increased; this year, a virus attacked the organization requiring teams of employees to work around the clock to restore access to applications and maintain the security of data. OHSU has large infrastructure needs including buildings, the telephone system replacement, and an annual cost of $3 million in server replacement. Lean operating budgets have resulted in frustration over limitations on the services ITG can provide. For example, ITG has been unable to provide a strong intranet infrastructure that would allow employees increased access to the most relevant policies and procedures.

Mr. Wilhoite commended Ms. Haggerty and ITG for their work in an area that is critical to everyone in the organization, and inquired about top investment priorities. Ms. Haggerty said that the past year's investment in infrastructure has been important. ITG is challenged to provide the desired services, proactive business assessments, and best practices implementation given the current level of staffing. Responding to a question from Mr. Yaden, Ms. Haggerty explained that the system application training for healthcare employees is the responsibility of ITG and two Hospital funded departments called Clinical Informatics and Change Management and Learning. The Clinical Informatics teams ensure that each hospital unit understands the applications and the optimization of the applications. Dr. Robertson added that the challenge extends beyond electronic medical records, citing a faculty member's recounting having to purchase and learn 16 different software programs in the span of one month. This is not a reflection on ITG, but rather the environment that we currently live in. Ms. Haggerty concurred, saying that OHSU is a leader in the utilization of those systems.

Dr. Robertson commended Ms. Haggerty and ITG for their work in an incredibly complex IT environment. Dr. Robertson said that they did a fantastic job in quickly restoring the computer systems following the virus. Responding to a question from Mr. Yaden, Ms. Haggerty stated that there is some potential for intellectual property opportunities. The training modules that were created for our physicians are being shared with other Epic clients. The Big Brain application was created by ITG to provide a common platform for sharing education modules. There are discussions with other healthcare organizations and academic institutions about selling those modules. Dr. Robertson said that the greatest real savings potential lies in the business support functions. Dr. Robertson is looking to the business intelligence system to standardize management accounting across the institutions.

Responding to a question from a Board member about which capital projects ensure business continuity, Ms. Haggerty commented that having a second data center is of great importance in ensuring reliability and business continuity. She noted that ITG partners with the Risk Management department and the Information Security office when evaluating business continuity proposals.

Adjournment

Hearing no further business, Mr. Wilhoite adjourned the meeting.

Respectfully submitted,

Amy M. Wayson
Board Secretary

Fiscal Year 2011 Financial Report

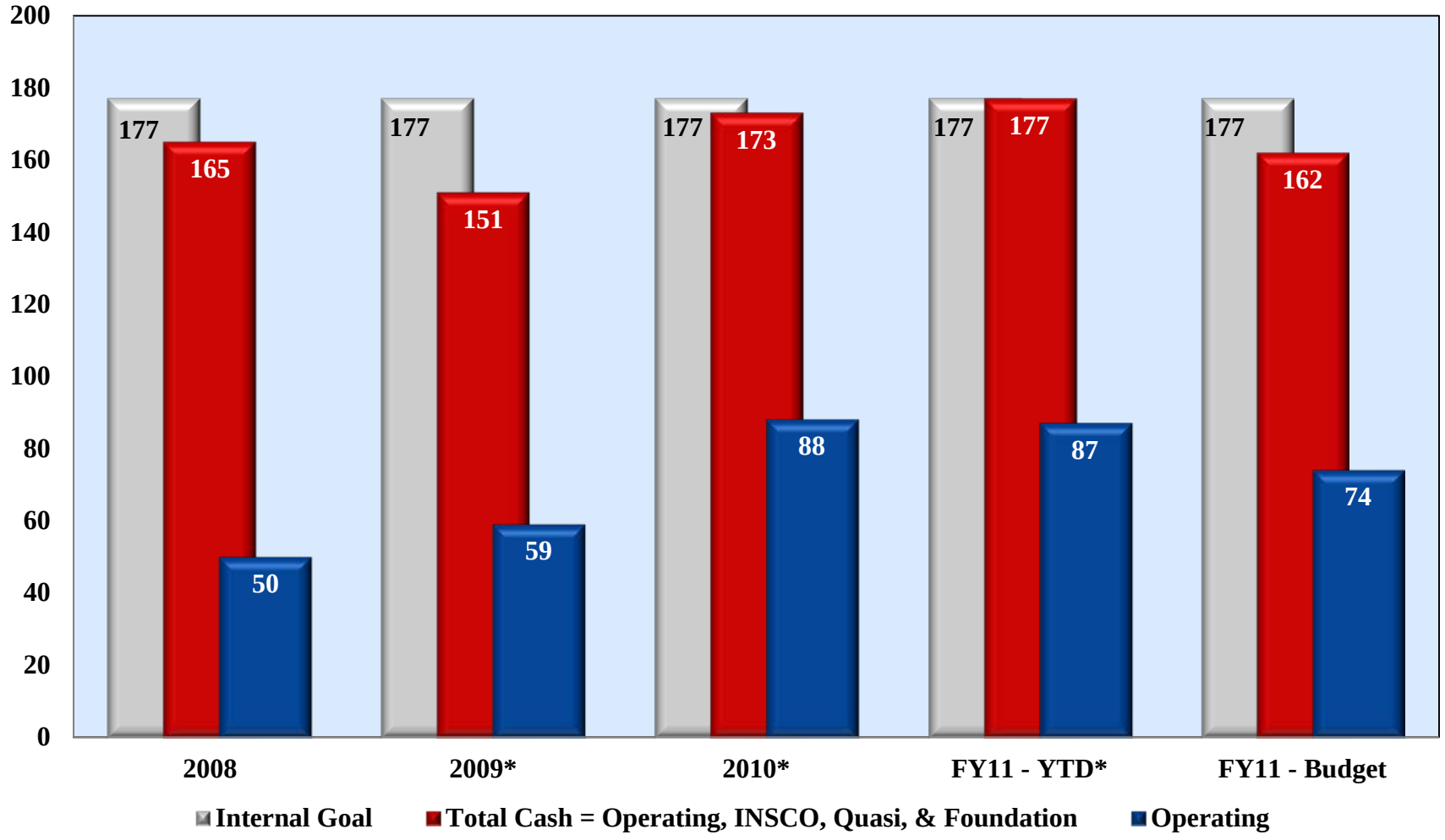
Unaudited through December 31, 2010

OREGON HEALTH & SCIENCE UNIVERSITY
OHSU

Oregon Health & Science University

Consolidated Days Cash on Hand - YTD

As of December 31, 2010

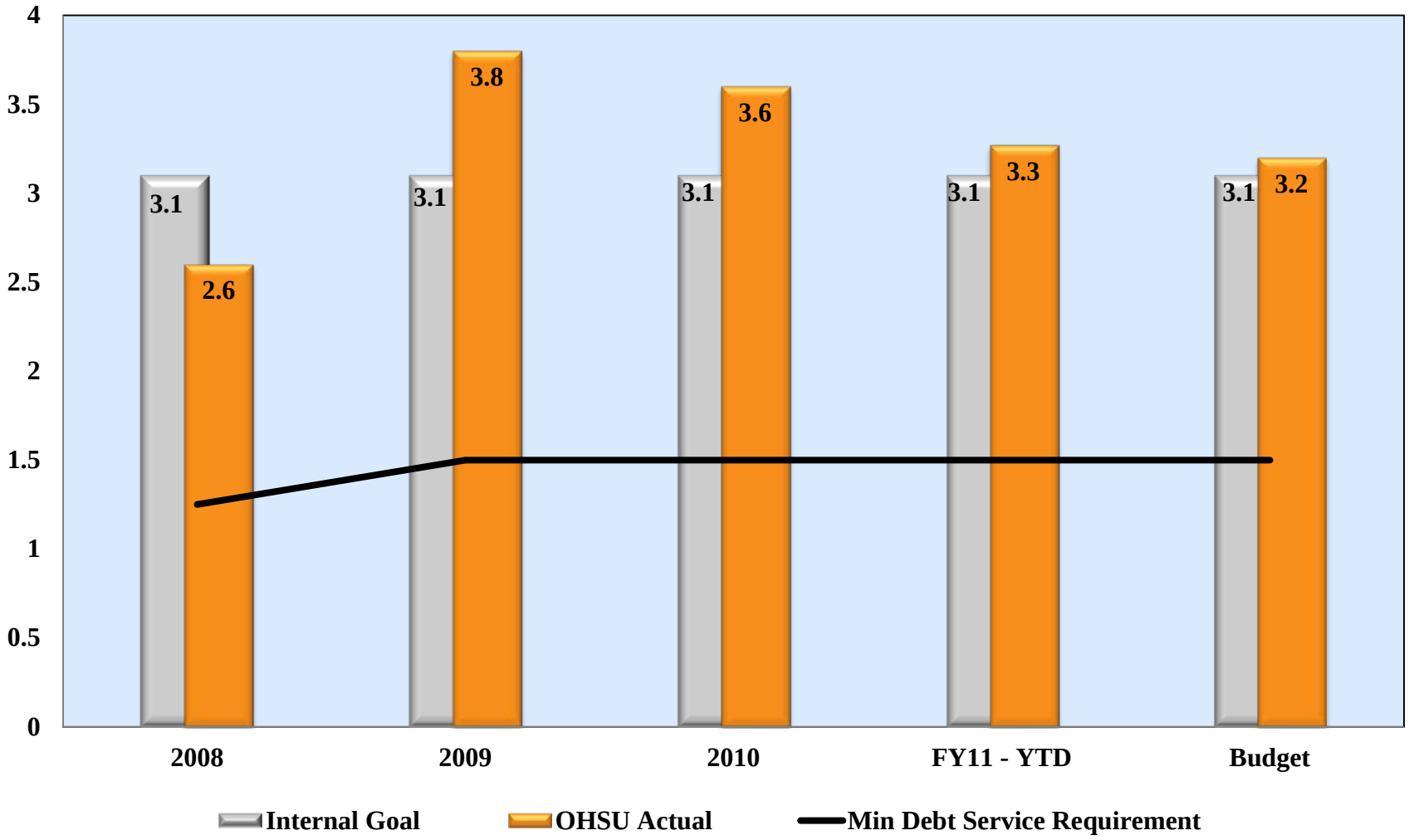


*2009 - 2011 Operating Days Cash includes FPP cash held at the Foundation

Oregon Health & Science University

Debt Service Coverage Ratio

As of December 31, 2010



Oregon Health & Science University

FY 11 Operating Statement

As of December 31, 2010

(In thousands)

UNIVERSITY	MONTH Actual	MONTH Budget	MONTH Variance	YEAR-TO-DATE Actual	YEAR-TO-DATE Budget	YEAR-TO-DATE Variance	YEAR-TO-DATE % Variance	Annual Projected for FY11	FY 2011 Budget
REVENUES:									
Net Pt. Rev. - Faculty Prac. & Other	$ 22,435	$ 21,237	$ 1,198	$ 131,617	$ 127,194	$ 4,423	3.5%	$ 260,326	$ 256,326
Student Tuition and Fees	4,884	4,103	781	23,735	23,228	507	2.2%	52,921	52,921
State Appropriations	2,793	2,965	(172)	17,531	18,208	(677)	(3.7%)	34,033	36,333
Gifts, Grants, Contracts:									
Gifts	78	90	(12)	109	623	(514)	(82.5%)	398	398
Foundation Transfers	1,780	3,170	(1,390)	11,050	17,029	(5,979)	(35.1%)	28,573	32,573
Indirect Cost Recoveries	6,402	5,974	428	33,762	35,805	(2,043)	(5.7%)	71,612	71,612
Hospital Internal Arrangements	5,552	4,930	622	31,675	29,586	2,089	7.1%	59,769	59,769
Other Gifts, Grants, & Contracts	1,281	1,489	(208)	9,796	10,782	(986)	(9.1%)	21,790	21,790
Sales/Services/Other	10,101	10,378	(277)	55,247	56,263	(1,016)	(1.8%)	111,419	111,419
Total Revenue	$ 55,306	$ 54,336	$ 970	$ 314,522	$ 318,718	$ (4,196)	(1.3%)	$ 640,841	$ 643,141
EXPENSES:									
Salaries and Wages	$ 36,399	$ 38,462	$ 2,063	$ 221,107	$ 222,554	$ 1,447	0.7%	445,565	445,565
Services and Supplies	13,628	11,911	(1,717)	77,062	77,042	(20)	(0.0%)	157,005	152,105
Depreciation	3,033	3,142	109	18,785	18,851	66	0.4%	37,703	37,703
Interest	1,451	1,640	189	8,535	9,842	1,307	13.3%	19,686	19,686
Total Expenses	54,511	55,155	644	325,489	328,289	2,800	0.9%	659,959	655,059
Net Income (Loss) from Operations	$ 795	$ (819)	$ 1,614	$ (10,967)	$ (9,571)	$ (1,396)	(14.6%)	$ (19,118)	$ (11,918)
Investment Income	$ 49	$ 400	(351)	$ 1,052	$ 2,400	(1,348)	(56.2%)	$ 1,871	$ 4,099
Unrealized Change in FV of Investments	2,764	763	2,001	7,953	4,580	3,373	73.6%	7,953	9,161
Other Non-Operative Activity	375	165	210	2,349	992	1,357	136.8%	4,459	1,985
Total Net Income (Loss)	$ 3,983	$ 509	$ 3,474	$ 387	$ (1,599)	$ 1,986	124.2%	$ (4,835)	$ 3,327
Operating Margin	1.4%	(1.5%)	2.9%	(3.5%)	(3.0%)	(0.5%)		(3.0%)	(1.9%)
Total Margin	6.9%	0.9%	6.0%	0.1%	(0.5%)	0.6%		(0.7%)	0.5%

Oregon Health & Science University

FY 11 Operating Statement

As of December 31, 2010

(In thousands)

HOSPITAL AND CLINICS	MONTH Actual	MONTH Budget	MONTH Variance	YEAR-TO-DATE Actual	YEAR-TO-DATE Budget	YEAR-TO-DATE Variance	YEAR-TO-DATE % Variance	Annual Projected for FY11	FY 2011 Budget
REVENUES:									
Net Patient Service Revenue	$ 85,803	$ 85,883	$ (80)	$ 527,814	$ 520,780	$ 7,034	1.4%	$ 1,074,686	$ 1,067,652
State Appropriations	95	104	(9)	597	624	(27)	(4.3%)	1,167	1,247
Gifts, Grants, Contracts:									
Foundation Transfers	172	51	121	202	309	(107)	(34.6%)	512	619
Sales/Services/Other	5,578	6,039	(461)	33,537	36,211	(2,674)	(7.4%)	66,543	72,467
Total Revenue	$ 91,648	$ 92,077	$ (429)	$ 562,150	$ 557,924	$ 4,226	0.8%	$ 1,142,908	$ 1,141,985
EXPENSES:									
Salaries and Wages	$ 42,224	$ 44,724	$ 2,500	$ 251,581	$ 260,448	$ 8,867	3.4%	$ 515,278	$ 526,145
Services and Supplies	41,934	41,074	(860)	243,919	246,132	2,213	0.9%	499,054	500,767
Depreciation	4,299	4,542	243	26,822	27,494	672	2.4%	53,108	54,230
Interest	1,719	1,815	96	10,048	10,888	840	7.7%	20,098	21,775
Total Expenses	90,176	92,155	1,979	532,370	544,962	12,592	2.3%	1,087,538	1,102,917
Net Income (Loss) from Operations	$ 1,472	$ (78)	$ 1,550	$ 29,780	$ 12,962	$ 16,818	129.7%	$ 55,370	$ 39,068
Investment Income	$ 1,663	$ 947	$ 716	$ 4,975	$ 5,683	(708)	(12.5%)	$ 8,260	$ 11,367
Unrealized Change in FV of Investments	(2,960)	-	(2,960)	(1,144)	-	(1,144)	0.0%	(1,144)	-
Other Non-Operating Activity	(14)	(21)	7	40	(125)	165	132.0%	(85)	(250)
Total Net Income (Loss)	$ 161	$ 848	$ (687)	$ 33,651	$ 18,520	$ 15,131	81.7%	$ 62,401	$ 50,185
Operating Margin	1.6%	(0.1%)	1.7%	5.3%	2.3%	3.0%		4.8%	3.4%
Total Margin	0.2%	0.9%	(0.7%)	5.9%	3.3%	2.6%		5.4%	4.4%

Oregon Health & Science University

FY 11 Operating Statement

As of December 31, 2010

(In thousands)

UNRESTRICTED CONSOLIDATED	MONTH Actual	MONTH Budget	MONTH Variance	YEAR-TO-DATE Actual	YEAR-TO-DATE Budget	YEAR-TO-DATE Variance	YEAR-TO-DATE % Variance	Annual Projected for FY11	FY 2011 Budget
REVENUES:									
Net Patient Service Revenue	$ 106,236	$ 105,633	$ 603	$ 648,445	$ 639,052	$ 9,393	1.5%	$ 1,315,168	$ 1,306,134
Student Tuition and Fees	4,884	4,103	781	23,735	23,228	507	2.2%	52,921	52,921
State Appropriations	2,888	3,069	(181)	18,128	18,832	(704)	(3.7%)	35,200	37,580
Gifts, Grants, Contracts:									
Gifts	78	90	(12)	109	623	(514)	(82.5%)	398	398
Foundation Transfers	1,952	3,221	(1,269)	11,252	17,338	(6,086)	(35.1%)	29,085	33,192
Indirect Cost Recoveries	6,402	5,974	428	33,762	35,805	(2,043)	(5.7%)	71,612	71,612
Hospital Internal Arrangements	(0)	(0)	0	0	0	(0)	0.0%	(2,000)	0
Other Gifts, Grants, & Contracts	1,281	1,489	(208)	9,796	10,782	(986)	(9.1%)	21,790	21,790
Sales/Services/Other	8,231	8,520	(289)	43,329	45,535	(2,206)	(4.8%)	85,055	89,136
Total Revenue	$ 131,952	$ 132,099	$ (147)	$ 788,556	$ 791,195	$ (2,639)	(0.3%)	$ 1,609,229	$ 1,612,764
EXPENSES:									
Salaries and Wages	$ 77,598	$ 82,256	$ 4,659	$ 466,697	$ 477,424	$ 10,727	2.2%	$ 949,687	$ 960,554
Services and Supplies	41,585	39,601	(1,984)	238,855	243,305	4,449	1.8%	492,695	491,665
Depreciation	7,332	7,684	352	45,607	46,345	738	1.6%	90,811	91,933
Interest	3,170	3,455	285	18,583	20,730	2,147	10.4%	39,784	41,461
Total Expenses	129,685	132,996	3,311	769,743	787,804	18,061	2.3%	1,572,977	1,585,614
Net Income (Loss) from Operations	$ 2,267	$ (897)	$ 3,164	$ 18,813	$ 3,391	$ 15,422	454.8%	$ 36,252	$ 27,150
Investment Income	$ 1,712	$ 1,347	365	$ 6,027	$ 8,083	(2,056)	(25.4%)	$ 10,131	$ 15,466
Unrealized Change in FV of Investments	(196)	763	(959)	6,809	4,580	2,229	48.7%	6,809	9,161
Other Non-Operating Activity	361	144	217	2,389	867	1,522	175.5%	4,374	1,735
Total Net Income (Loss)	$ 4,144	$ 1,357	$ 2,787	$ 34,038	$ 16,921	$ 17,117	101.2%	$ 57,566	$ 53,512
Operating Margin	1.7%	(0.7%)	2.4%	2.4%	0.4%	2.0%		2.3%	1.7%
Total Margin	3.1%	1.0%	2.1%	4.2%	2.1%	2.1%		3.5%	3.3%

Oregon Health & Science University

FY 11 Operating Statement

As of December 31, 2010

(In thousands)

Restricted[1]	MONTH Actual	MONTH Budget	MONTH Variance	YEAR-TO-DATE Actual	YEAR-TO-DATE Budget	YEAR-TO-DATE Variance	YEAR-TO-DATE % Variance	Annual Projected for FY 11	FY 2011 Budget for
Total Operating Revenue	$ 28,021	$ 30,025	(2,004)	$ 174,888	$ 180,150	(5,262)	(2.9%)	$ 343,462	$ 360,299
Total Operating Expenses	37,154	31,303	(5,851)	181,614	187,815	6,201	3.3%	353,007	375,630
Net Income/(Loss) from Operations	(9,133)	(1,278)	(7,855)	(6,726)	(7,665)	939	12.2%	(9,545)	(15,331)
Investment Income/FMV	688	209	479	2,426	1,253	1,173	93.6%	2,933	2,506
Other Non-Operating Activity	-	-	-	-	-	-		-	-
Total Net Income/(Loss)	$ (8,445)	$ (1,069)	$ (7,376)	$ (4,300)	$ (6,412)	$ 2,112	32.9%	$ (6,612)	$ (12,825)

Total Consolidated									
Total Operating Revenue	$ 159,973	$ 162,124	(2,151)	$ 963,444	$ 971,345	(7,901)	(0.8%)	$ 1,952,691	$ 1,973,063
Total Operating Expenses	166,839	164,299	(2,540)	951,357	975,619	24,262	2.5%	1,925,984	1,961,244
Net Income/(Loss) from Operations	(6,866)	(2,175)	(4,691)	12,087	(4,274)	16,361	382.9%	26,707	11,819
Investment Income/FMV	2,204	2,319	(115)	15,262	13,916	1,346	9.7%	19,873	27,133
Other Non-Operating Activity	361	144	217	2,389	867	1,522	175.5%	4,374	1,735
Total Net Income/(Loss)	$ (4,301)	$ 288	$ (4,589)	$ 29,738	$ 10,509	$ 19,229	183.0%	$ 50,954	$ 40,687

Operating Margin - Restricted	(32.6%)	(4.3%)	(28.3%)	(3.8%)	(4.3%)	0.5%		(2.8%)	(4.3%)
Total Margin - Restricted	(29.4%)	(3.5%)	(25.9%)	(2.4%)	(3.5%)	1.1%		(1.9%)	(3.5%)
Operating Margin - Consolidated	(4.3%)	(1.3%)	(3.0%)	1.3%	(0.4%)	1.7%		1.4%	0.6%
Total Margin - Consolidated	(2.7%)	0.2%	(2.9%)	3.0%	1.1%	1.9%		2.6%	2.0%

FTE's	Hospital	University	Total
Current YTD	5,861	5,751	11,612
40,359	5,535	5,594	11,129

(1) Restricted Activity includes Sponsored Projects (grants for teaching and research), Loans, Scholarships, and gifts governed by donors' wishes.

Oregon Health & Science University

FY 11 Cash Flow

As of December 31, 2010

(In thousands)

	CONSOLIDATED YEAR-TO-DATE	CONSOLIDATED YEAR-TO-DATE BUDGET
Reconciliation of operating income (loss) to net cash provided by operating activities		
Net income (loss) from Operations	$ 18,813	$ 3,391
Adjustments to reconcile operating income (loss) to net cash provided by operating activities:		
Depreciation and Amortization	45,606	46,345
Interest Expense reported as operating expense	18,583	20,730
Net change in Assets and Liabilities:	3,232	(7,000)
Net Cash provided (used) by operating activities	$ 86,234	$ 63,466
Cash flows from capital and related financing activities		
Debt (Short and Long-Term)	$ (33,231)	$ (19,395)
Fund Balance (Funding for Grant Funded Assets)	(587)	5,773
Change in Property, Plant & Equipment	(44,677)	(67,844)
Net cash provided (used) by financing activities	$ (78,495)	$ (81,466)
Cash flows from investing activities		
Investment Income	$ 12,834	$ 12,663
Quasi-Endowment Funds	(8,133)	(4,580)
Funds Held by Trustee/Board Designated	(5,803)	-
Other investments (Including Foundation contributions for Capital)	5,872	-
Net cash provided (used) by investing activities	$ 4,770	$ 8,083
Cash and equivalents, beginning of period	$ 278,385	$ 242,845
Cash and cash equivalents, end of period	$ 290,894	$ 232,928
Change in Cash	$ 12,509	$ (9,917)

(1) Due to rounding issues, there may be minor differences of up to two thousand dollars on any line item between this cash flow report and the associated P&L and Balance Sheets.

OREGON HEALTH & SCIENCE UNIVERSITY

OHSU Board Meeting, February 2011
2011 Quality Report

Charles Kilo, MD, MPH
Chief Medical Officer

Components of OHSU's Quality Program

- Quality and Safety Management
- Clinical Informatics and Health Information Management
- Medical Affairs
- Regulatory Affairs
- Clinical Risk Committee
- Graduate Medical Education
- Infection Control

OHSU Board
↑
UHS Board
↑
Professional Board

FY2011 = Foundation Building

- Hired Troy Schmit, Director of Quality and Safety and rebuilding quality management
- Hired Juni Muhota, Manager of Medical Affairs
- Hired Mike Lieberman, Assoc Chief Health Information Officer responsible for clinical reporting
- Rewrite the Professional Staff Bylaws
- Revise Professional Board, Quality Executive Council, Safety Executive Council, Physicians Committee, Clinical Risk Committee
- Adopt Lean Improvement methodologies
- Train in the “Change Acceleration Process”
- Redesign Safety Program

OREGON HEALTH & SCIENCE UNIVERSITY

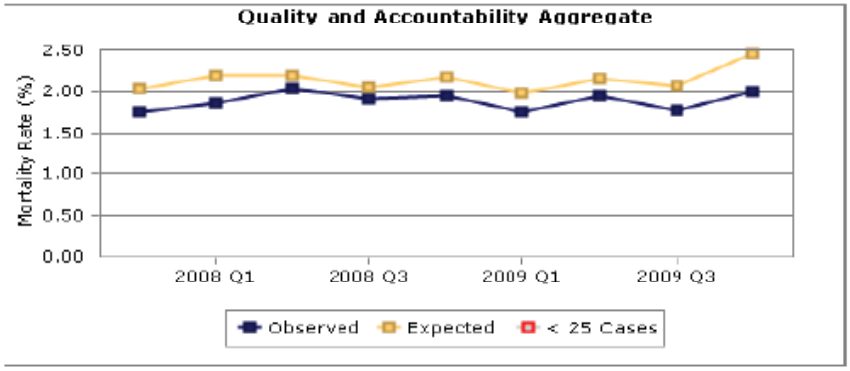
Trends in Quality

Topic	Status	OHSU Impact
The Patient Protection and Affordable Care Act	Under fire	• Multiple components, multiple strategies to prepare
Value-based Purchasing	Emerging	• Validates OHSU focus on performance improvement and adding value to those we serve.
“Meaningful Use” of Health IT	Active	• Leverage Epic and other IT investments
Accountable Care Organizations	Unclear	• Multiple ways for OHSU to engage
Governor Kitzhaber	Active	• Cuts in Medicaid followed by Medicare, PEBB/OEBB – validates aggressive cost mgmt
Comparative Effectiveness	Active	• Strength in OHSU’s Evidence-based Practice Center

OHSU Q4 '09 UHC Quality & Accountability Aggregate Mortality

	Relative Performance	Denom (Cases)	Obs/Exp Ratio	UHC Median	Rank
Current Quarter		6,848	0.80	0.85	42/106
Recent Year		27,816	0.86	0.88	50/107

	Current Quarter	Last Quarter	Recent Year
Cases (denom.)	6,848	7,051	27,816
Observed Deaths	137	125	521
Expected Deaths	169.29	146.01	604.98
Observed Mortality (%)	2.00	1.77	1.87
Expected Mortality (%)	2.47	2.07	2.17
Observed/Expected Ratio	0.80	0.85	0.86

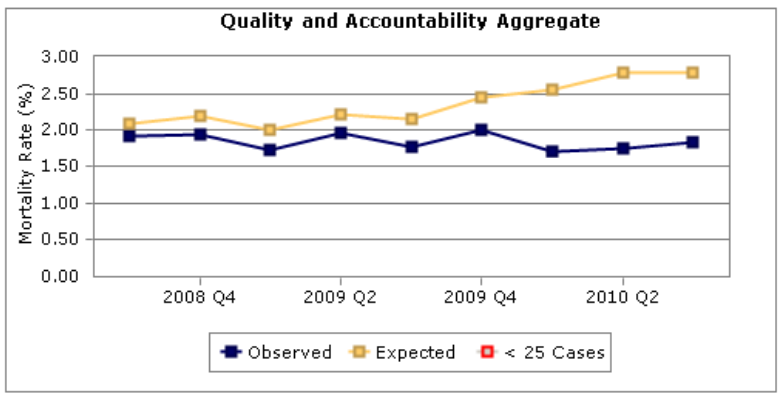


Source: UHC Clinical Outcomes Report

OHSU Jul-Sep '10 (Q3) UHC Quality and Accountability Aggregate Mortality

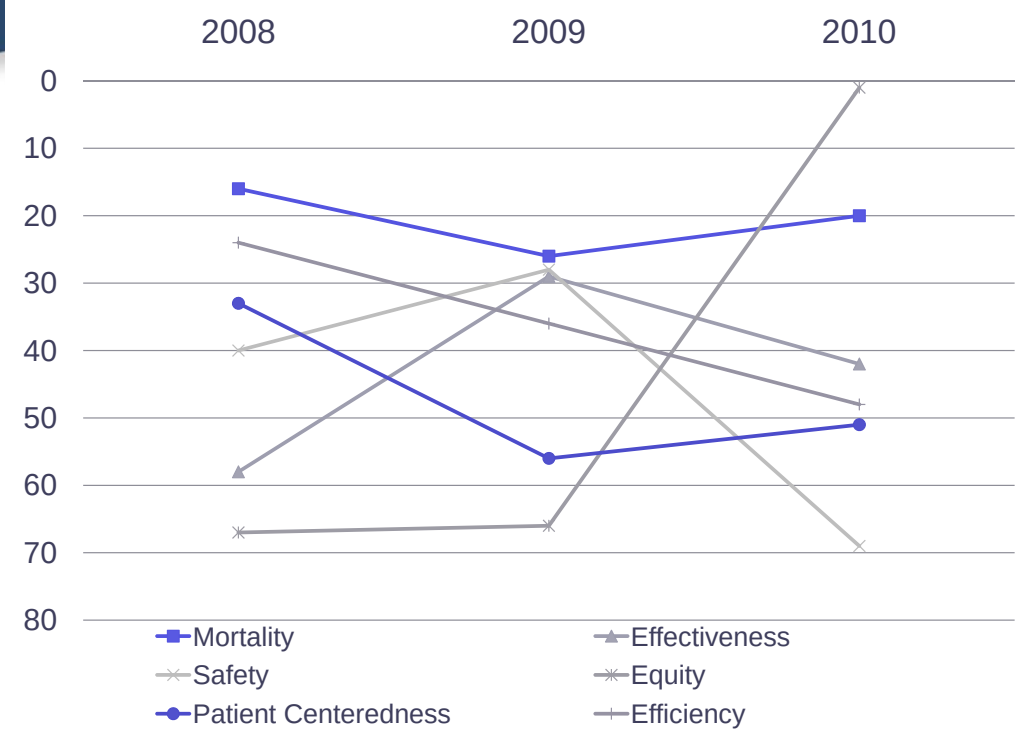
	Relative Performance	Denom (Cases)	Obs/Exp Ratio	UHC Median	Rank
Current Quarter		6,510	0.65	0.79	16/110
Recent Year		26,490	0.68	0.85	16/111

	Current Quarter	Last Quarter	Recent Year
Cases (denom.)	6,510	6,740	26,490
Observed Deaths	119	118	483
Expected Deaths	181.50	188.57	702.07
Observed Mortality (%)	1.83	1.75	1.82
Expected Mortality (%)	2.79	2.80	2.65
Observed/Expected Ratio	0.65	0.62	0.68



Source: UHC Clinical Outcomes Report

OHSU 2010 Quality and Accountability Performance Scorecard



OHSU's Regulatory & Accreditation Agencies

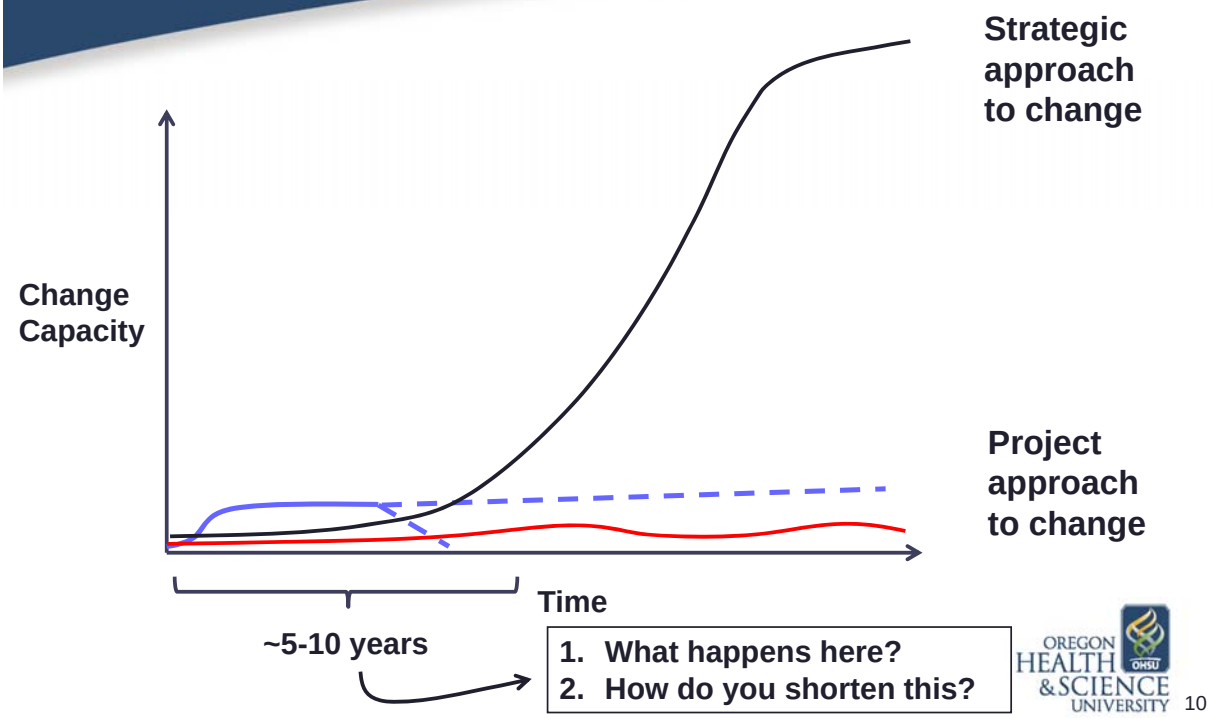
Full Re-accreditation granted via The Joint Commission!

FY11 OHSU Quality Objectives

1. Establish a planned, systematic, and organized approach to PI to improve patient care processes and outcomes.
2. Define a strategic vision for quality, set meaningful priorities for PI, and organize the improvement work and monitoring to achieve the targeted outcomes.
3. Define how quality metrics are selected and monitored.
4. Systematically aggregate and analyze data from trusted sources to identify improvement opportunities, prioritize, and monitor processes and outcomes.
5. Develop and strengthen internal capabilities for doing system-based performance improvement work throughout the organization, including the role of leaders in PI.

OREGON HEALTH & SCIENCE UNIVERSITY

Organizational Improvement Paths



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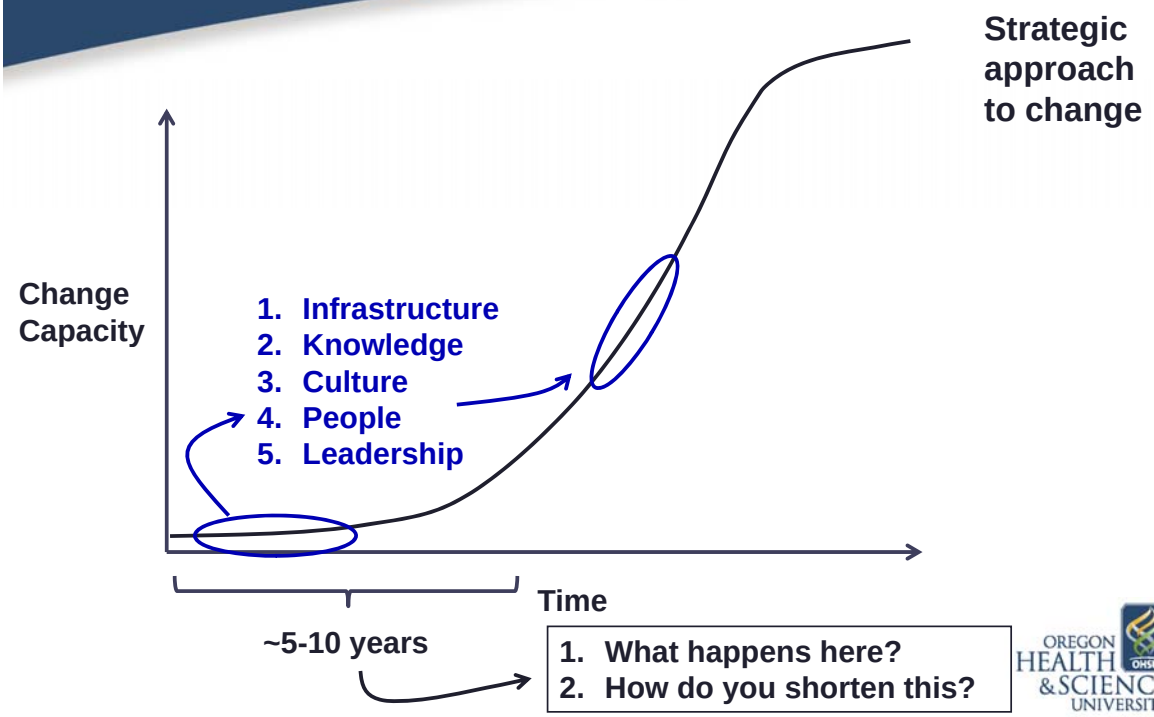
Building Effective Change Capacity



OREGON HEALTH & SCIENCE UNIVERSITY OHSU

Building Effective Change Capacity

Organizational Capacity Development

Baldrige & ANCC Magnet
↓↑
Change Acceleration Process & Lean Improvement

1:1 Leadership Coaching

Monthly PI Conference

Paths to Leadership

MBA in Healthcare Management

MS in Healthcare Management

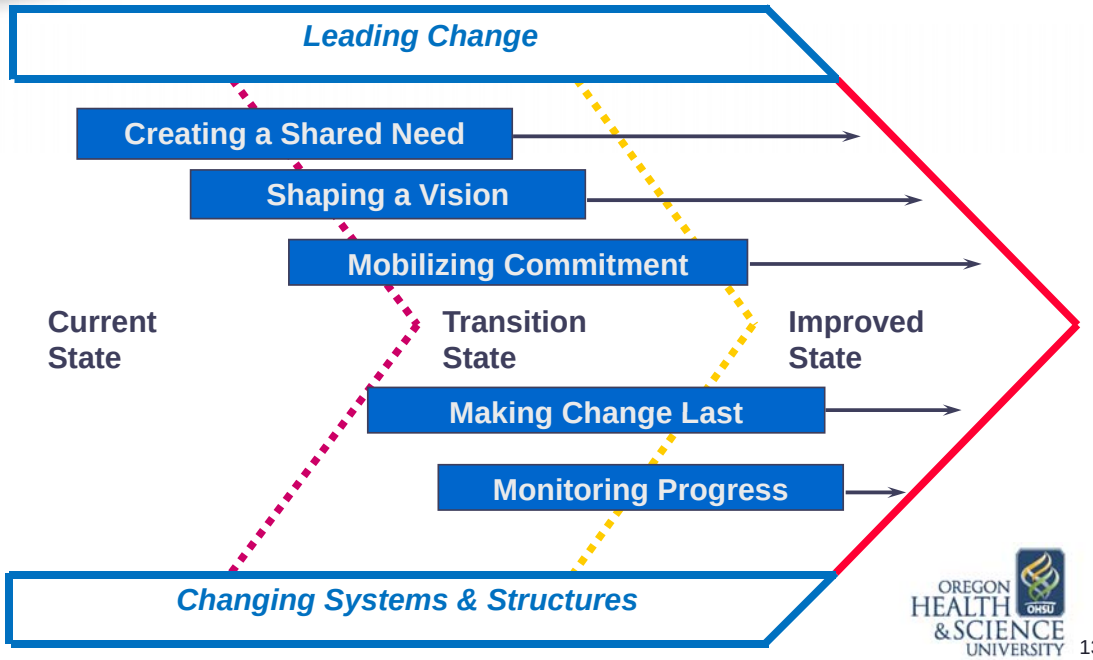
Healthcare Management Certificate

Individual Development

CAP and Lean Training

Synergistic set of learning opportunities customizable to an individual's needs… non-linear or hierarchical.

CAP: Change Acceleration Process



OREGON HEALTH & SCIENCE UNIVERSITY

What is Lean?

Five-steps:

1. **Specify value from the standpoint of the customer by "value stream" (product line).**
2. **Map all steps in the value stream eliminating steps that do not create value (waste reduction)**
3. **Make the value-creating steps occur in tight sequence so the product will flow smoothly toward the customer.**
4. **As flow is introduced, let customers pull value from the next upstream activity.**
5. **As value is specified, value streams are identified, wasted steps are removed, and flow and pull are introduced, begin the process again and continue it until a state of perfection is reached in which perfect value is created with no waste.**

Forms of Waste

To Learn More about Lean

- **Lean Enterprise Institute - www.lean.org**
- **Lean Thinking by Womack and Jones**
- **The Machine that Changed the World by Womack, Jones, and Roos**
- **Do a site visit – Siltronics, Leatherman Tools, Virginia Mason, Denver Health, Beth Israel Deaconess (Boston)**
- **Healthcare Value Leaders - www.healthcarevalueleaders.org**
- **Second Annual Lean Healthcare Transformation Summit, Seattle June 8-9, 2011**

OHSU Healthcare
FY11 Quality and Performance Improvement Plan

Purpose
Aligned with Mission and Vision of OHSU Healthcare, this Quality and Performance Improvement Plan documents the infrastructure and processes that support, assure, and improve the quality of care and services provided to our patients.

Vision
Our vision is to become a leading, nationally-recognized healthcare performance improvement organization. We continually strive to achieve the following objectives:

- Achieve top 10% performance in all trusted datasets in which we participate: UHC, VON, NSQIP, and STS
- Meet the triple aim of:
    - Improving the health of the population
    - Enhancing the patient experience of care (quality, access, and reliability)
    - Reduce the cost of care
- Create a culture of continuous performance improvement and high reliability in all of our work and continually seek best practices

Guiding Principles for Quality and Performance Improvement at OHSU

1. The words "performance improvement" (PI) are used to describe the primary work of the Quality Management Department (QM).
2. PI domains include clinical quality, the patient experience, and cost management within the clinical enterprise in addition to work productivity, efficiency, and patient safety.
3. QM enables PI throughout OHSU Healthcare by providing expertise, training, consultation, and support to hospital and clinical departments.
4. PI responsibility resides primarily within individual hospital and clinical departments with QM serving as a resource to their PI efforts. QM drives PI in those areas that cut across the institution such as patient flow, medication management, care coordination, patient safety, and blood product management.

Structure
OHSU governance of quality ultimately rests with the University Health System Board. The routine oversight of clinical quality lies with the OHSU Professional Board and Administrative Team. These three bodies comprise the governance structure that approves the clinical quality agenda annually: those activities intended to measure, monitor, report, and improve clinical quality throughout the healthcare enterprise. The Quality Executive Council (QEC) of the Professional Board is specifically tasked with the

development and regular monitoring of OHSU's annual and on-going clinical quality agenda.

Overall responsibility for performance improvement activities reside within the QM department, the Administrative team, each hospital and clinical department, and the Faculty Practice Plan.

FY11 Objectives

1. Establish a planned, systematic, and organized approach to PI to improve patient care processes and outcomes.
2. Define a strategic vision for quality, set meaningful priorities for PI, and organize the improvement work and monitoring to achieve the targeted outcomes.
3. Define how quality metrics are selected and monitored.
4. Systematically aggregate and analyze data from trusted sources to identify improvement opportunities, prioritize, and monitor processes and outcomes.
5. Develop and strengthen internal capabilities for doing system-based performance improvement work throughout the organization, including the role of leaders in PI.

FY11 Approach

To build a sustainable, effective PI infrastructure and capability at OHSU we will deploy the following strategies in FY11.

1. **QM Personnel**: Hire Quality Management and PI professionals to provide support, training, and consultation to the clinical and hospital departments in addition to managing large, interdisciplinary PI projects. QM will develop deep PI expertise by training personnel in specific techniques and establishing resources for more sophisticated quality measurement.

2. **Clinical Reporting**: QM will be working directly with OHSU's Clinical Informatics Department to establish the reporting capabilities necessary to support PI. Efforts will be made to provide periodic and timely performance data that is actionable and tied to our organizational priorities and PI activities.

   In addition, OHSU will strive to be more transparent, both internally and externally, with regards to its performance on quality and safety performance. Work will begin in early 2011 to establish an approach to becoming more transparent.

3. **Methodology**: It is recognized that over time, a variety of PI approaches will be needed to fully address the quality agenda. In FY11 we will introduce and deploy Lean methodology and begin applying these tools and techniques to our

work on the organizational priorities. In tandem with Lean, the Change Acceleration Process (CAP) framework will be deployed to facilitate adoption of performance improvement solutions.

4. **Training**: Training sessions on Lean and CAP will be offered in FY11. The plan is to offer training for two Lean cohorts and four CAP cohorts. Participants for this training will be selected based on their involvement and connection to strategically important organizational and/or departmental PI work. In addition starting in the spring, QM will be organizing a monthly PI conference focused on discussing advanced PI methods, showcasing OHSU PI work, sharing PI learning across the organization, and planning for PI initiatives.

5. **Department PI Planning and Capacity**: In FY12, hospital and clinical departments will be required to submit an annual PI plan and dashboard and provide progress reports on a quarterly basis. QM will support the departments in the development of these plans and help facilitate the reporting and monitoring. QEC will provide the oversight and periodic review of these plans. The current PI plan template will be revised and work will begin in early 2011 to develop the FY12 PI Plans.

   In addition in FY12 each department will develop a newly formatted departmental Annual Performance Improvement Plan that will be combined with a single consolidated departmental IA agreement. These plans will be developed with input from Hospital Administration, QM, the QEC, and the SOM FPP.

6. **Leadership**: Workshops and training sessions will be provided to OHSU leaders for them to gain deeper understanding of PI methodologies and their role in leading PI. PI topics, presentations, and discussions will be included as standing agenda items on various committee and team meetings.

7. **Strategic Projects**: Projects will be strategically selected and chartered as leverage points to expand PI understanding and capacity and to address select critical priorities for FY11. The learning that occurs with these initial projects will assist the organization in gaining capability more quickly as it builds its PI culture.

   In addition, a "project funneling" process will be developed for staff and departments to request PI assistance and for these project requests to be vetted, scoped, and prioritized.

8. **Priority Setting**: Priority setting will begin in January for the upcoming fiscal year. Based on progress against existing QEC and institutional priorities and a broad data analysis from OHSU's trusted data sources, PI priorities will be generated and vetted by Hospital Administration and the QEC with final approval

determined by the QEC. The priority list will then be presented to the Professional Board and the UHS Board for approval.

9. **Safety Program**: Working with the Safety Executive Council, QM will establish a formal OHSU Safety Program narrowing the breath but deepening the domain-specific expertise of our safety personnel. The Root Cause Analysis process will be revised along with this sharpened focus. We will also continue to align our Safety Program and our Clinical Risk Committee toward the goals of clinical risk mitigation and risk reduction.

FY11 Evaluation Plan and Metrics

FY11 QEC quality objectives and metrics for adult and pediatric hospital services are noted below. Additional metrics reflecting our emphasis on building deep PI capabilities within OHSU include:

- Achieve top quartile performance in all trusted datasets in which we participate – specifically UHC, VON, and NSQIP
- Improve patient experience based on Press Ganey Scores
- Develop and strengthen hospital and clinical department PI capacity as measured by the number of specific departmental resources dedicated to PI, the number of PI projects, and the number of OHSU staff trained in PI methods

QEC FY11 Priorities

Adult

1. Surpass 90% in Core Measure Composite for Pneumonia
2. Achieve VTE rate < 10 per 1,000 surgical discharges
3. Rank in the top quartile of UHC 30-day readmission rate
4. Standardize Glycemic Control
   - Achieve greater than 70% glycemic patient-days in control
   - Achieve patient-day-weighted mean glucose < 165 mg/dl
   - Reduce % patient days with glucose < 60 to under 5% in the ICU, and under 1.5 % in the non-ICU setting.
5. Improve Infection Control
   - Achieve 100% compliance on hand hygiene
   - Rank in the top quartile of NHSN for CLABSI rate
   - Surpass NSQIP benchmarking data for rate of postoperative UTIs
   - Rank in top quartile of NHSN for Hip and Knee Prosthetic Infection rate
6. Improve Pain Management
   - Rank in top quartile for the HCAHPS “Percent of patients who reported that their pain was ‘Always’ well controlled.”
   - Achieve a 75% reduction in adverse events associated with over-sedation
   - Decrease percent of patients on opiates who receive a reversal agent

Pediatric

1. Rank in the top quartile of UHC 30-day readmission rate
2. Improve Infection Control
   - Achieve 100% compliance on hand hygiene
   - Rank in the top quartile of NHSN for CLABSI rate
   - Rank in top quartile of Vermont Oxford Neonatal Nosocomial Bacterial Infections
3. Green Dot for UHC Surgical Pediatric Safety Indicators
   - Accidental puncture or laceration
   - Post-op hemorrhage or hematoma
4. Rank in top quartile for Vermont Oxford Neonatal Indicators
   - Retinopathy of Prematurity Stage 3
   - Overall Mortality
5. 90% of pediatric patients with Asthma receive optimal care as defined by the American Academy of Pediatrics guidelines
6. >90% of pediatric patients are offered influenza immunization
7. Optimize family satisfaction with care
   - >95% of families report that the "Staff worked together to care for you"
   - >80% of all pediatric visits and hospitalizations have a completed After Visit Summary (AVS)

Implementation Plan (January -June 2011)

MONTH	ACTIVITY
JANUARY	• Begin prioritization process • Begin Visioning process • Begin transparency work • Revise PI Plan templates • Develop Project Funnel • Identify Projects for Lean Training • CAP Workshop #1
FEBRUARY	• Continue prioritization process • Finalize Vision • Continue transparency work • Finalize PI Plan template – orient departments to requirements • Lean Workshop #1 – Part 1 • CAP Workshop for Leaders

MONTH	ACTIVITY
MARCH	• Continue prioritization process • Continue transparency work • Continue departmental PI Plan orientation • Lean Workshop #1 – Part 2 • Offer first PI Conference
APRIL	• Finalize priorities • Continue transparency work • Continue departmental PI Plan development • CAP Workshop #2 • PI Conference • Finalize transparency work
MAY	• Continue departmental PI Plan development • PI Conference
JUNE	• Finalize departmental PI Plans • Evaluate FY11 Performance • CAP Workshop #3 • PI Conference

OHSU INTEGRITY OFFICE ANNUAL REPORT

to the

OHSU BOARD OF DIRECTORS

Calendar Year 2010

Presented February 15, 2011

CONTENTS

Introduction to Calendar Year 2010
OHSU Integrity Office Annual Report

In this Annual Report to the OHSU Board of Directors, we present information related to current national interest in all Integrity Program areas, how the OHSU Integrity Program has responded to those areas, and other integrity initiatives at OHSU. For easy reference, there is a **Glossary of Acronyms** beginning on page 12 of the report.

I. National Picture
Integrity Issues of Current Focus

A. Recovery Audit Contractors

1. The Centers for Medicare and Medicaid Services (CMS) recovery audit contractor (RAC) audit program was made permanent on January 1, 2009 and the program continues with increased audit activity across the U.S. The OHSU Clinical Integrity Program receives and processes all RAC audit requests. This annual report to the Board will provide an update of RAC activities to-date.

B. Clinical Research Billing

1. Medicare fraud has become a focus of the current administration in its efforts to reform health care. The Patient Protection and Affordable Care Act designated $1.5 billion to specifically target this issue. Clinical research billing compliance remains on the radar of RAC audits in an effort to identify improper Medicare payments and institutions continue to be scrutinized and fined. Most recently, Tenet Healthcare in California (doing business as USC Norris Cancer Center) was fined $1.9 million as a result of its receiving government reimbursement for items and services: (1) paid for by clinical research sponsors or grants; (2) intended to be free of charge as stated in the informed consent document; (3) for research purposes only; and (4) otherwise not covered under the Medicare Clinical Trial Policy. CMS considers such claims to be false or fraudulent and institutions are devoting increasing amounts of personnel and resources to address these risks. In addition to fines, penalties can include the imposition of a corporate integrity agreement and debarment from participation in Medicare for the institution and/or specific providers. Finally, changes in reimbursement for patients covered by Medicare Advantage plans went into effect on January 1, 2011 and add both complexity and risk when billing for these patients who receive treatment in clinical trials.

C. OHSU Initiatives

1. RAC Audit Work. CMS has contracted with the vendor HealthDataInsights (HDI) to audit all hospitals participating in the Medicare program in the State of Oregon. Since July 2008, we have continued to work internally with our multi-department RAC Task Force that has reviewed the RAC findings and citations from other states and the demonstration audits conducted from 2005 to 2007. In addition, our internal billing monitoring and auditing program looks for potential exposure in all areas.

As of January 3, 2011, we received 50 automated denial notifications and 408 complex inpatient requests. Automated denials of payments are generated by the auditor's review of electronic billing data and do not require submission of documentation unless OHSU challenges the denial. Complex reviews require the patient charts and all documentation to be submitted to the RAC. We have appealed nine of the automated denials and won all nine. The complex reviews resulted in 35 denials, 26 underpaid cases, 253 that upheld our billing, and 94 charts not yet reviewed by HDI. Of the 35 denials we have successfully appealed one and are in the process of appealing several others.

2. MAC Audit Work. In addition to the RAC audits of Medicare claims we have also been involved with 62 Medicare claims being reviewed by our Medicare Area Contractor (MAC) auditor (Noridian). All of these were complex audits related to immunosuppressant drugs and the audits were received by OHSU between July and October 2010. Because the MAC audit process is not held to the same time-lines as the RAC audits, these reviews are still in-process.

3. RAC Managed Care Audits. The latest audit activity to begin under the RAC program is Medicare managed care audits. Currently HDI has initiated seven complex audits of Medicare managed care claims that are specific and limited to patients in managed care plans. We are coordinating these audits through the RAC Task Force to track, review, and respond timely to all requests.

4. Audit Tracking. The Clinical Integrity Program implemented commercial software to assist in tracking claims that are reviewed via the RAC, MAC, and other auditing processes through all levels of appeal, if necessary. The software product tracks the status of each claim, generates reports related to the type of audit activity, and communicates to multiple departments that must assist in responding to the claims. We have developed a RAC Response Team and a RAC Appeals Team to coordinate all audit activities and ensure that our responses are within the mandated timelines.

5. Clinical Research Billing. In 2010, OHSU engaged nationally-recognized experts, Meade & Roach, to help develop a clinical research billing compliance "roadmap." The resulting Clinical Research Billing Initiative includes hiring additional personnel and implementing additional technology to ensure all billing for clinical services on clinical trials is done in accordance with relevant federal rules and regulations. The creation of a Clinical Research Billing Office has been completed and is working closely with other units at OHSU that have responsibility for clinical research.

II. Clinical Integrity

A. National Picture

1. **OIG Work Plan:** The Fiscal Year 2011 Work Plan, published by the Office of the Inspector General (OIG) in October 2010 provides insight into the clinical compliance risk areas that will receive governmental scrutiny. The FY11 Work Plan identifies risk areas that will be the focus of the OIG's investigations and inquiries. Many key areas of interest were also on the 2010 Work Plan and include:

   a. Hospital admissions with conditions coded "Present on Admission";
   b. Hospital Readmissions;
   c. Adverse Events (any event that causes harm to the patient as a result of medical care);
   d. Payments for non-physician outpatient services under the inpatient payment system;
   e. Duplicate graduate medical education payments;
   f. Observation Services during outpatient visits;
   g. Physician reassignment of benefits;
   h. "Cloned" notes, in which identical documentation is provided across various services;
   i. Place of service errors; and
   j. Evaluation and management services in surgical global periods.

1. **Medicaid Audits**

   In 2010, the Patient Protection and Affordable Care Act included a section on RAC-type audits for State Medicaid programs. In 2011, the State of Oregon will have a plan for these audits with an estimated go live date for such audits in mid-2011. Because each state will have its own plan, OHSU will need to respond to multiple Medicaid RAC auditors as we have patients from surrounding states.

B. OHSU Initiatives

1. **Response to National Picture**
   a. Addressing the OIG Work Plan**:** Because the Annual OIG Workplans are a source of information for potential audits by the RAC auditors, the Clinical Integrity Program has included the Workplan's key areas of interest related to billing issues in its RAC preparation activities.
   b. Response to MAC Audits: We are utilizing the same RAC Task Force, software programs, and departmental organization to respond to MAC audits. Because OHSU is the largest Medicaid provider in the state, we continue to work with the Medicaid Program to make sure they receive all the documents requested.

2. **Other Initiatives**
   a. Centralized Coding: In November 2008, the Clinical Integrity Program began assisting the Health Information Management Department in centralizing outpatient coding responsibilities for the Hospital. This effort has centralized coding for the Emergency Department facility and professional fees, Family Medicine Resident Clinic, Infusion Clinics, and several other OHSU clinics.

b. Professional Fee Billing: The Professional Fee Billing component of the Integrity Office continues its program of conducting reviews of documentation and coding activity in School of Medicine departments. The purpose of the reviews is to ensure that documentation and coding of services billed is in full compliance with state and federal regulations and with billing rules for third party payers. The reviews also provide an opportunity for continuing education at the department level.

III. Research Integrity

A. National Picture

1. Human Subjects Research:

a. Oversight of research repositories (both tissue and data banks) continues to be an area of national interest and discussion and recent case law has elevated public awareness and interest in this issue. Variations in federal and state laws and the existence of genetic privacy acts in a few states have clouded this issue. In 2008, the Office for Human Research Protection (OHRP) issued new guidance on research involving coded private information or biological specimens. In addition, the Health Information Technology for Economic and Clinical Health (HITECH) Act proposes changes that will affect the consent and authorization process for protected health information that is banked for future research.

b. The new director of OHRP is working rapidly to revise old and confusing regulatory guidance and issue new guidance that is specifically attuned to the current research environment. Examples include new guidance on continuing review processes and contingent approvals. These new rules allow more flexibility for processes and provide clarification and examples for contingent approval.

2. Animal Subjects Research:

The Association for the Assessment and Accreditation of Laboratory Animal Care, International (AAALACi) site inspectors performed a site visit at OHSU's Central/Waterfront Campus and West Campus in the summer of 2010. Following their extensive review of the animal research protection program and facilities, they granted continued full accreditation of the program. OHSU's Central Campus animal research protection program has had continuous AAALACi accreditation since 1966.

B. OHSU Initiatives

1. Responses to National Picture

a. Human Subjects Research: The OHSU Research Repository policy was launched in June of 2010 and a one-year initiative is in progress to ensure that the policy is thoroughly socialized and implemented. The program will identify the multiple OHSU databases and repositories so that tissues and data can be shared for research in the most effective and efficient manner. Additionally, the OHSU Institutional Review Board Chair is serving on the national Newborn Screening and Translational Research Network Bioethics and Regulatory Oversight Committee, which is focusing on issues with stored tissue samples.

b. OHRP Guidance: OHSU policies and procedures have been modified to comply with new guidance regarding timelines for continuing reviews and tracking contingent approvals.

c. Animal Subjects Research: OHSU has hired a new Research Integrity Officer for the Central/Waterfront Campus. Dr. Bill Dale comes to us from University of Missouri and brings a wealth of experience to the OHSU program. Dr. Dale is an AAALACi site inspector and will contribute to our maintaining best practices and highest standards in the animal research programs.

IV. Institutional BioSafety

A. National Picture

1. **Select Agents and Other Infectious Agent Research:** Research with Select Agents (infectious agents and toxins that have the potential to pose a severe threat to public health and safety) and other agents that are associated with serious or lethal human disease (Biosafety Level 3 agents) continues to be a hot topic of national discussion. Bills pending debate in Congress include proposals for additional layers of government oversight for this research.

   Currently, all organisms used in research are assigned a biosafety or "BSL" level by the Centers for Disease Control and Prevention (CDC) and NIH. These agencies also publish guidance describing the appropriate containment and handling practices to be followed at each of four BSL levels, BSL-4 being the highest containment (OHSU has no BLS-4 research). A national accreditation program for biosafety labs is in development.

B. OHSU Initiatives

1. OHSU maintains an active program of research involving Select Agents and Biosafety Level 3 agents. Recent research awards and other events indicate that the volume of this type of research will continue to increase. The following table illustrates the number of approved research projects involving infectious agents or recombinant DNA (genetic material that has been modified in the laboratory) at OHSU during the past three years.

Biosafety level	2008	2009	2010
BSL-2	144	174	172
ABSL-2	63	80	85
BSL-2+/BSL-3	14	26	27
ABSL-2+/ABSL-3	9	15	17
Select Agent	7	7	9
Total projects	186 approved	275 approved	294 approved

2. OHSU was selected for a site visit by the NIH Office of Biotechnology Activities (OBA), the office that oversees federal regulations for recombinant DNA research. The site visit occurred on September 20, 2010. The final report from OBA was quite positive but listed three "possible deficiencies" related to administrative issues, such as details in meeting minute taking. These have been addressed.

V. Conflicts of Interest

A. National & Oregon Picture

1. **NIH Requirements for Conflict of Interest in Research:** In 2009, the NIH proposed substantial revisions to the regulations related to financial conflicts of interest in research. These proposed amendments of the NIH regulations come after much public attention to conflict of interest issues in science and medicine. The current regulations have been in place and unchanged since 1995. The NIH final rules are expected in April of 2011.

2. **Oregon State Ethics Law:** In 2009, the Oregon Legislature passed additional changes to the Oregon State Ethics Law including restrictions on gifts to public officials. The basic elements of the law including the $50 annual limit on gifts to public officials and the application of the law to family members of public officials remain unchanged.

3. **Industry Relationships:** The Patient Protection and Affordable Care Act includes a provision requiring transparency in provider-industry relationships. As a result, several pharmaceutical companies have already created publicly accessible web sites identifying amounts paid by them to individual and institutional providers.

4. **Transparency:** Both the Patient Protection and Affordable Care Act and the proposed NIH regulatory revisions include a requirement for institutions to maintain publically-accessible web pages disclosing industry payments to individuals. This transparency initiative is intended to allow patients, students, and others to enter a provider name and review all industry payments for consulting, speaking, research, and other arrangements.

B. OHSU Initiatives

1. **Response to National & State Picture:**

   a. Conflict of Interest in Research: The OHSU Conflict of Interest in Research committee (CoIRC) has standardized its review and management processes and policies. The group has been functioning for so long and the national awareness of this issue is so high among scientists that compliance is very high. The NIH proposed changes to its regulations related to conflicts of interest in research were posted for public comment and OHSU joined many other academic health centers in providing comments on the proposed changes. Because of the volume of comments, the NIH is re-drafting the proposed changes.

   b. Industry Gifts: OHSU policy has a zero-dollar gift limit for all persons at OHSU who may influence a business decision related to the giver of the gift. Additionally, OHSU's policies incorporate a number of the recommendations from national guidance issued by professional associations and regulatory agencies on the topic of industry relationships, including:

      i. A conflict of interest (CoI) review process for those involved in purchasing decisions;
      ii. A clinical CoI review process for clinicians;
      iii. Restrictions on the ability of industry to bring food to OHSU;
      iv. A ban on trinkets with industry logos; and

v. A requirement for OHSU faculty serving as speakers at industry-sponsored events to have control over the content of their lectures.

VI. Information Privacy & Security

A. National & State Picture

The total number of privacy complaints received by the Office for Civil Rights (OCR) from April of 2003 through December of 2009 is 48,869 with an 80% resolution rate. The top five complaints investigated by OCR continue to be impermissible uses and disclosures of protected health information (PHI), lack of safeguards for PHI, restricting access by patients to their own PHI, disclosing more than the minimum necessary PHI, and poor resolution of an individual's complaint to a covered entity.

Since September 2009 and as required by the HITECH Act, 218 breaches of unsecured PHI affecting 500 individuals or more have been reported to the Secretary of Health and Human Services. Of the 218 reports, 85 (39%) involved lost or stolen laptops or portable devices. AvMed from Florida (laptop) and Blue Cross Blue Shield of Tennessee (hard drives) had the largest reported breaches, each affecting more than one million patients. Two reports are from Oregon. Both involved stolen laptops and affected 4,000 and 4,328 patients respectively. None were from OHSU.

In Oregon, there is increasing activity to promote efficient exchange of electronic health information. The legislature and other statewide organizations are evaluating the current status of existing capabilities to exchange electronic health information and are striving to establish standards and principles for safe and appropriate use of technology in that process. A recent state survey shows Oregon has a high electronic health record (EHR) adoption rate with 65% of clinicians in a practice with an EHR. The highest adoption rate is in the Portland Metro area with northwest and central/southern regions of Oregon having the lowest adoption rates. Practices with fully implemented systems being actively and effectively used by their clinicians may qualify for Medicare/Medicaid incentives by demonstrating "meaningful use" of their EHR.

B. OHSU Initiatives

1. In response to the national and state areas of interest, the OHSU Integrity Office:
   a. In collaboration with OHSU's Information Technology Group, implemented the OHSU Information Security Initiative by:
      i. Actively implementing encryption of laptops and desktop computers effective January 2011;
      ii. Activating security controls on handheld devices accessing OHSU information;
   b. Reviewed and helped establish compliance with security and privacy requirements for the HITECH Act and meaningful use of OHSU's electronic health record;
   c. Continued to refine documentation and reporting of OHSU privacy and security incidents to promote effective risk mitigation;
   d. Coordinated privacy and security incident investigations and risk mitigation among OHSU stakeholders;
   e. Implemented other appropriate controls for information security based on the risk assessments; and

f. Provided privacy and security advisory services to OHSU.

VII. Audit & Advisory Services

A. National Picture

1. **Higher Education Audits:** Federal agencies continue to emphasize the importance of effective internal audit programs. In cases where institutions have been fined or sanctioned for compliance failures, the requirements of corporate integrity agreements imposed by the government include internal audit capacity and function. Current "hot topics" identified by audit organizations and federal agencies include:
   a. Research compliance (human and animal subjects, grant compliance);
   b. Information technology and security issues;
   c. Employee relationships that may trigger conflict of interest issues;
   d. Procurement card use and oversight;
   e. HIPAA/information privacy issues;
   f. Controlled substance records;
   g. Student financial aid;
   h. Hospital and clinical billing receivables; and
   i. Fraud risk assessments

B. OHSU initiatives

1. **Response to National Picture**
   a. Audit Areas: OHSU's Audit and Advisory Services program is completing its seventh year of incorporation into the Integrity Office. In calendar year 2010, Audit and Advisory Services participated in 27 projects, several of which relate to the above items of national interest. The process of developing an annual plan for subsequent year audits includes careful analysis of information from the national picture, review of areas that A&AS has audited within the past two years, internal assessments of the risk environment, and judicious allocation of audit resources by the Audit and Advisory Services Committee.

2. **Other Initiatives**
   a. Continuous Auditing: An evolving regulatory environment has made the implementation of electronic audit systems essential for an effective audit program. Audit and Advisory Services will fully deploy such a software program by March 2011 to perform audit analytics and continuous auditing techniques. This program is designed to identify errors and potential fraud and analyze entire data populations for anomalies, control deficiencies, and emerging risks. The benefits of implementing continuous auditing are realized through timely identification and correction of errors, increasing the efficiency of limited audit staff resources, and the creation of a stronger internal control environment across the OHSU enterprise.
   b. Staffing: The department ended calendar year 2010 with 3.0 FTE (down from 5.5 FTE in CY08). We anticipate adding an additional Senior Auditor in July of 2011. In addition, the Audit Manager will return from military duty in 2012. All current auditors hold multiple certifications, including Certified Internal Auditor, Certified Fraud Examiner, and Certified Public Accountant.

VIII. Integrity Education

A. National Picture

1. **Periodic Education:** The Office of the Inspector General, the Office for Civil Rights, the National Institutes of Health, and other federal agencies have continued to study and define the elements of an effective compliance program. While education is an essential element, these groups have made it clear that such education must be continuous, effective, and documented. Past approaches of delivering education modules via web-based or other computerized methods are being questioned. The NIH now requires a minimum of eight hours of live classroom education for the receipt of certain types of grants.

B. OHSU Initiatives

1. **Response to National Picture**
   a. Periodic Education: In 2010 the OHSU Integrity Office implemented significant updates to the periodic integrity education module (first deployed in 2008). The 2010 revisions include the addition of modules on biosafety and animal research. Completion of the module is required of all employees and students. Completion rates are currently 91% for employees and 75% for students within 90 days of assignment. The OHSU Research Development and Administration Office has taken the lead in addressing the new NIH requirements for live education and several education efforts in Integrity Program areas now include live approaches.

2. **Other Initiatives**
   a. To address education requirements by the Occupational Safety and Health Administration (OSHA) and the CDC, the Integrity Office developed and deployed the Bloodborne Pathogens Training for Research Personnel.

IX. Environmental Health & Radiation Safety

A. National & State Picture

1. The Joint Commission: The Joint Commission (TJC) conducts a thorough triennial survey of OHSU Healthcare operations for compliance with regulatory standards. The survey team includes a Life Safety Specialist focused specifically on the Life Safety and Environment of Care chapters. This focus is directly related to the increased attention to fire and life safety issues from the CMS. Inspection results validate current practices as well as direct immediate and long term improvement plans.

2. State Fire Marshal: The Oregon State Fire Marshal's Office has recently created a healthcare-specific deputy position in alignment with the increased CMS focus.

B. OHSU Initiatives

1. Response to National & State Picture: TJC survey visitors arrived at OHSU the week of October 25, 2010 for a full survey. The Environment of Care team actively participated in all aspects of the survey, including sessions reviewing the Emergency Management program, the Environment of Care program, the Statement of Conditions, and

facility/utility documentation. In addition, the Life Safety Specialist spent two days inspecting inpatient care areas for compliance with Environment of Care and Life Safety standards. The survey team showed an interest in performance improvement efforts, risk assessment processes, and employee competency. The high level of preparation, knowledge and collaboration, and ongoing performance improvement efforts of the program were acknowledged throughout the week.

Surveyors were very complimentary about OHSU's team and programs. Survey findings indicated in the final report included:

a. Minor facility issues that were resolved before the conclusion of the survey involving exit signs, a rolling fire door, and fire barrier integrity;
b. A finding for placing specialty fire extinguishers in operating room suites – this "best practice" improvement effort was already underway related to a recent multidisciplinary evacuation exercise;
c. Concern about patient room locks in the psychiatric crisis unit, which was resolved with additional explanation of process; and
d. Discussion about inpatient suite exiting design that was addressed through demonstrating equivalent fire protection features.

X. Reporting to OHSU Leadership

An effective integrity program reports to leadership on a regular basis. At OHSU, the Integrity Program has been designed to include this reporting relationship in several ways. On a quarterly basis, integrity issues, including significant regulatory developments and internal compliance issues are brought to the Integrity Program Oversight Council ("IPOC"), a committee chaired by MardiLyn Saathoff, and including Amy Wayson, Dan Dorsa, Lawrence Furnstahl, Mark Richardson, Peter Rapp, and Ronald Marcum. The purpose of the IPOC is to position leadership to understand and monitor all significant integrity related concerns and to provide a forum for discussion of risk mitigation by leadership. I also provide annual reports to the Finance and Audit Committee and the Governance Committee. In addition, on a quarterly basis I brief Dr. Robertson on any significant integrity-related developments. If an issue requires a more immediate response from leadership, I work directly with the involved executive leader and/or arrange for discussions in the Executive Leadership Team setting.

XI. Glossary of Acronyms

AAALACi: Association for the Assessment and Accreditation of Laboratory Animal Care, International. This is one of several national associations that oversee compliance with animal research regulations.

CDC: U.S. Centers for Disease Control and Prevention

CMS: Centers for Medicare and Medicaid Services

CoI: Conflict of Interest. The term is used to refer to actual, potential, or apparent conflicts of interest. OHSU Integrity Programs review and manage CoIs related to research, outside activities, clinical activities, and executives.

CoIR: Conflict of Interest in Research. OHSU has a standing committee to review and manage CoIR disclosures.

EHR: Electronic Health Record. OHSU uses the Epic system for this.

HDI: HealthDataInsights. This is the vendor that has contracted with the Centers for Medicare and Medicaid Services to perform all hospital billing audits under the recovery audit contractor (RAC) program.

HIPAA: The Health Insurance Portability and Accountability Act. HIPAA is divided into three rules related to information privacy, information security, and transaction and code sets.

HITECH: Health Information Technology for Economic and Clinical Health

IPOC: Integrity Program Oversight Council

MAC: Medicare Area Contractor. This is the vendor that has contracted with the Centers for Medicare and Medicaid Services to perform all hospital billing audits under the Medicare Audit Contractor (MAC) program.

NIH: National Institutes of Health

OBA: The Office of Biotechnology Activities. This is an office within the NIH that is responsible for guidance related to the use and storage of select agent and toxins and recombinant DNA.

OCR: Office for Civil Rights. This is the federal office that oversees compliance with the Health Insurance Portability and Accountability Act (HIPAA).

OHRP: Office for Human Research Protections. This is the primary federal office that oversees human subjects research compliance.

OIG: Office of Inspector General of the U.S. Department of Health and Human Services.

RAC: Recovery Audit Contractor. This is the program initiated by the Centers for Medicare and Medicaid Services to contract with private audit firms to perform audits of hospital and professional fee billing.

TJC: The Joint Commission. This was formerly called the Joint Commission on Accreditation of Healthcare Organizations or JCAHO.

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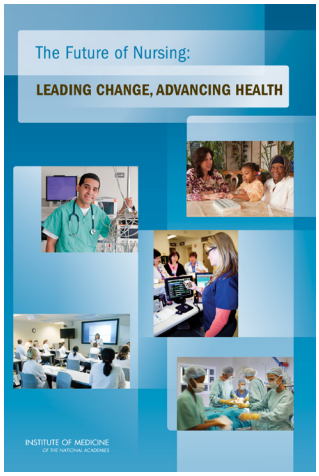
The Future of Nursing
Leading Change, Advancing Health



With more than 3 million members, the nursing profession is the largest segment of the nation's health care workforce. Working on the front lines of patient care, nurses can play a vital role in helping realize the objectives set forth in the 2010 Affordable Care Act, legislation that represents the broadest health care overhaul since the 1965 creation of the Medicare and Medicaid programs. A number of barriers prevent nurses from being able to respond effectively to rapidly changing health care settings and an evolving health care system. These barriers need to be overcome to ensure that nurses are well-positioned to lead change and advance health.

In 2008, The Robert Wood Johnson Foundation (RWJF) and the Institute of Medicine (IOM) launched a two-year initiative to respond to the need to assess and transform the nursing profession. The IOM appointed the Committee on the RWJF Initiative on the Future of Nursing, at the IOM, with the purpose of producing a report that would make recommendations for an action-oriented blueprint for the future of nursing.

Nurses practice in many settings, including hospitals, schools, homes, retail health clinics, long-term care facilities, battlefields, and community and public health centers. They have varying levels of education and competencies—from licensed practical nurses, who greatly contribute to direct patient care in nursing homes, to nurse scientists, who research and evaluate more effective ways of caring for patients and promoting health. The committee considered nurses across roles, settings, and education levels in its effort to envision the future of the profession. Through its deliberations, the committee developed four key messages that structure the recommendations presented in this report:

A number of barriers prevent nurses from being able to respond effectively to rapidly changing health care settings and an evolving health care system. These barriers need to be overcome to ensure that nurses are well-positioned to lead change and advance health.

1) Nurses should practice to the full extent of their education and training.

While most nurses are registered nurses (RNs), more than a quarter million nurses are advanced practice registered nurses (APRNs), who have master's or doctoral degrees and pass national certification exams. Nurse practitioners, clinical nurse specialists, nurse anesthetists, and nurse midwives all are licensed as APRNs.

Because licensing and practice rules vary across states, the regulations regarding scope-of-practice—which defines the activities that a qualified nurse may perform—have varying effects on different types of nurses in different parts of the country. For example, while some states have regulations that allow nurse practitioners to see patients and prescribe medications without a physician's supervision, a majority of states do not. Consequently, the tasks nurse practitioners are allowed to perform are determined not by their education and training but by the unique state laws under which they work.

The report offers recommendations for a variety of stakeholders—from state legislators to the Centers for Medicare & Medicaid Services to the Congress—to ensure that nurses can practice to the full extent of their education and training. The federal government is particularly well suited to promote reform of states' scope-of-practice laws by sharing and providing incentives for the adoption of best practices. One sub-recommendation is directed to the Federal Trade Commission, which has long targeted anti-competitive conduct in the health care market, including restrictions on the business practices of health care providers, as well as policies that could act as a barrier to entry for new competitors in the market.

High turnover rates among new nurses underscore the importance of transition-to-practice residency programs, which help manage the transition from nursing school to practice and help new graduates further develop the skills needed to deliver safe, quality care. While nurse residency programs sometimes are supported in hospitals and large health systems, they focus primarily on acute care. However, residency programs need to be developed and evaluated in community settings.

2) Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.

To ensure the delivery of safe, patient-centered care across settings, the nursing education system must be improved. Patient needs have become more complicated, and nurses need to attain requisite competencies to deliver high-quality care. These competencies include leadership, health policy, system improvement, research and evidence-based practice, and teamwork and collaboration, as well as competency in specific content areas including community and public health and geriatrics. Nurses also are being called upon to fill expanding roles and to master technological tools and information management systems while collaborating and coordinating care across teams of health professionals.

Nurses must achieve higher levels of education and training to respond to these increasing demands. Education should include opportunities for seamless transition into higher degree programs—from licensed practical nurse (LPN)/licensed vocational nurse (LVN) diplomas; to the associate's (ADN) and bachelor's (BSN) degrees; to master's, PhD, and doctor of nursing practice (DNP) degrees. Nurses also should be educated with physicians and other health professionals both as students and throughout their careers in lifelong learning opportunities. And to improve the quality of patient care, a greater emphasis must be placed on making the nursing workforce more diverse, particularly in the areas of gender and race/ethnicity.

To ensure the delivery of safe, patient-centered care across settings, the nursing education system must be improved. Patient needs have become more complicated, and nurses need to attain requisite competencies to deliver high-quality care.

3) Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.

Efforts to cultivate and promote leaders within the nursing profession—from the front lines of care to the boardroom—will prepare nurses with the skills needed to help improve health care and advance their profession. As leaders, nurses must act as full partners in redesign efforts, be accountable for their own contributions to delivering high-quality care, and work collaboratively with leaders from other health professions.

Being a full partner involves taking responsibility for identifying problems and areas of system waste, devising and implementing improvement plans, tracking improvement over time, and making necessary adjustments to realize established goals. In the health policy arena, nurses should participate in, and sometimes lead, decision making and be engaged in health care reform-related implementation efforts. Nurses also should serve actively on advisory boards on which policy decisions are made to advance health systems and improve patient care.

In order to ensure that nurses are ready to assume leadership roles, nursing education programs need to embed leadership-related competencies throughout. In addition, leadership development and mentoring programs need to be made available for nurses at all levels, and a culture that promotes and values leadership needs to be fostered. All nurses must take responsibility for their personal and professional growth by developing leadership competencies and exercising these competencies across all care settings.

4) Effective workforce planning and policy making require better data collection and an improved information infrastructure.

Planning for fundamental, wide-ranging changes in the education and deployment of the nursing workforce will require comprehensive data on the numbers and types of health professionals—including nurses—currently available and required to meet future needs. Once an improved infrastructure for collecting and analyzing workforce data is in place, systematic assessment and projection of workforce requirements by role, skill mix, region, and demographics will be needed to inform changes in nursing practice and education.

The 2010 Affordable Care Act mandates the creation of both a National Health Care Workforce Commission to help gauge the demand for health care workers and a National Center for Workforce Analysis to support workforce data collection and analysis. These programs should place a priority on systematic monitoring of the supply of health care workers across professions, review of the data and methods needed to develop

accurate predictions of workforce needs, and coordination of the collection of data on the health care workforce at the state and regional levels. All data collected must be timely and publicly accessible.

Conclusion

The United States has the opportunity to transform its health care system, and nurses can and should play a fundamental role in this transformation. However, the power to improve the current regulatory, business, and organizational conditions does not rest solely with nurses; government, businesses, health care organizations, professional associations, and the insurance industry all must play a role.

The recommendations presented in this report are directed to individual policy makers; national, state, and local government leaders; payers; and health care researchers, executives, and professionals—including nurses and others—as well as to larger groups such as licensing bodies, educational institutions, philanthropic organizations, and consumer advocacy organizations. Working together, these many diverse parties can help ensure that the health care system provides seamless, affordable, quality care that is accessible to all and leads to improved health.

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The Future of Nursing: Leading Change, Advancing Health

Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine

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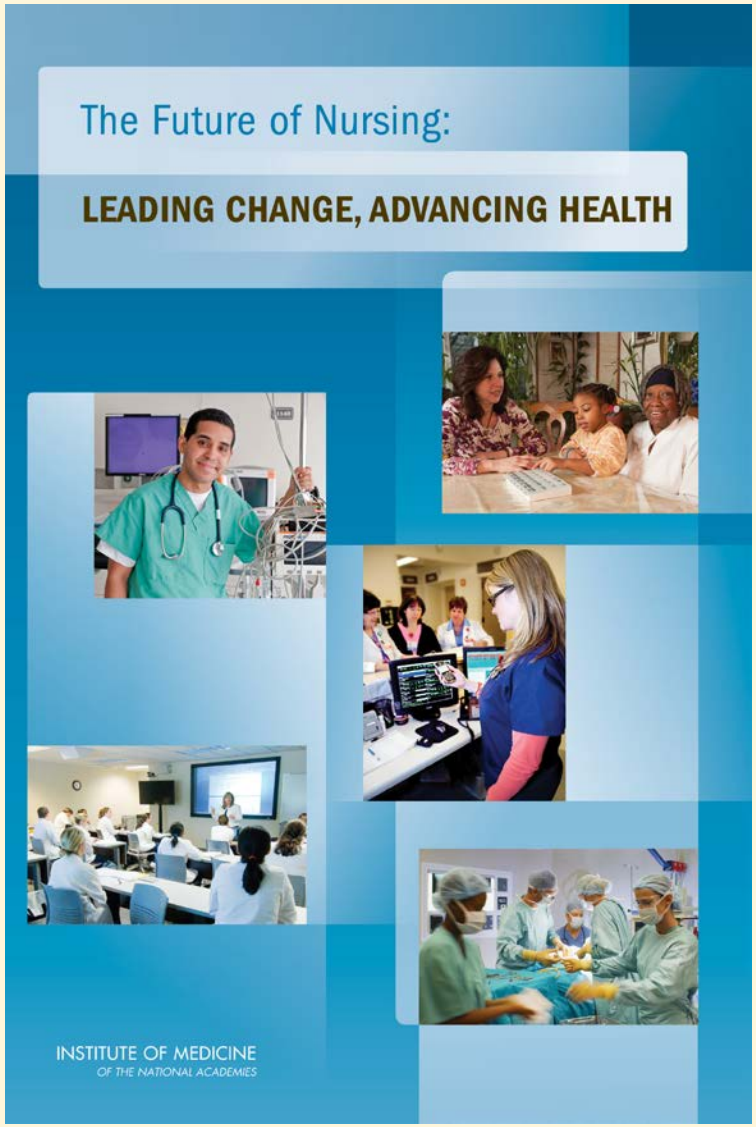

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Background and Context

- With more than 3 million members, the nursing profession is the largest segment of the nation's health care workforce.
- Working on the front lines of patient care, nurses can play a vital role in helping realize the objectives set forth in the 2010 Affordable Care Act.
- Legislation enacted will provide insurance coverage to health care for 32 million more Americans; the implications of this new demand on the nation's health care system are significant.

Background and Context

- The Robert Wood Johnson Foundation (RWJF) and the Institute of Medicine (IOM) partnered to assess and respond to the need to transform the nursing profession.

- The committee was tasked with producing a report containing recommendations for an action-oriented blueprint for the future of nursing, including changes in public and institutional policies at the national, state, and local levels.

Committee's Vision

The committee envisions a future system that makes quality care accessible to the diverse populations of the United States, intentionally promotes wellness and disease prevention, reliably improves health outcomes, and provides compassionate care across the lifespan. In this envisioned future, primary care and prevention are central drivers of the health care system.

Committee's Vision (continued)

Interprofessional collaboration and coordination are the norm. Payment for health care services rewards value, not volume of services, and quality care is provided at a price that is affordable for both individuals and society. The rate of growth of health care expenditures slows. In all these areas, the health care system consistently demonstrates that it is responsive to individuals' needs and desires through the delivery of truly patient-centered care.

Nurses' Role in This Vision

- Nurses are at the front lines in ensuring that care is delivered safely, effectively, and compassionately.

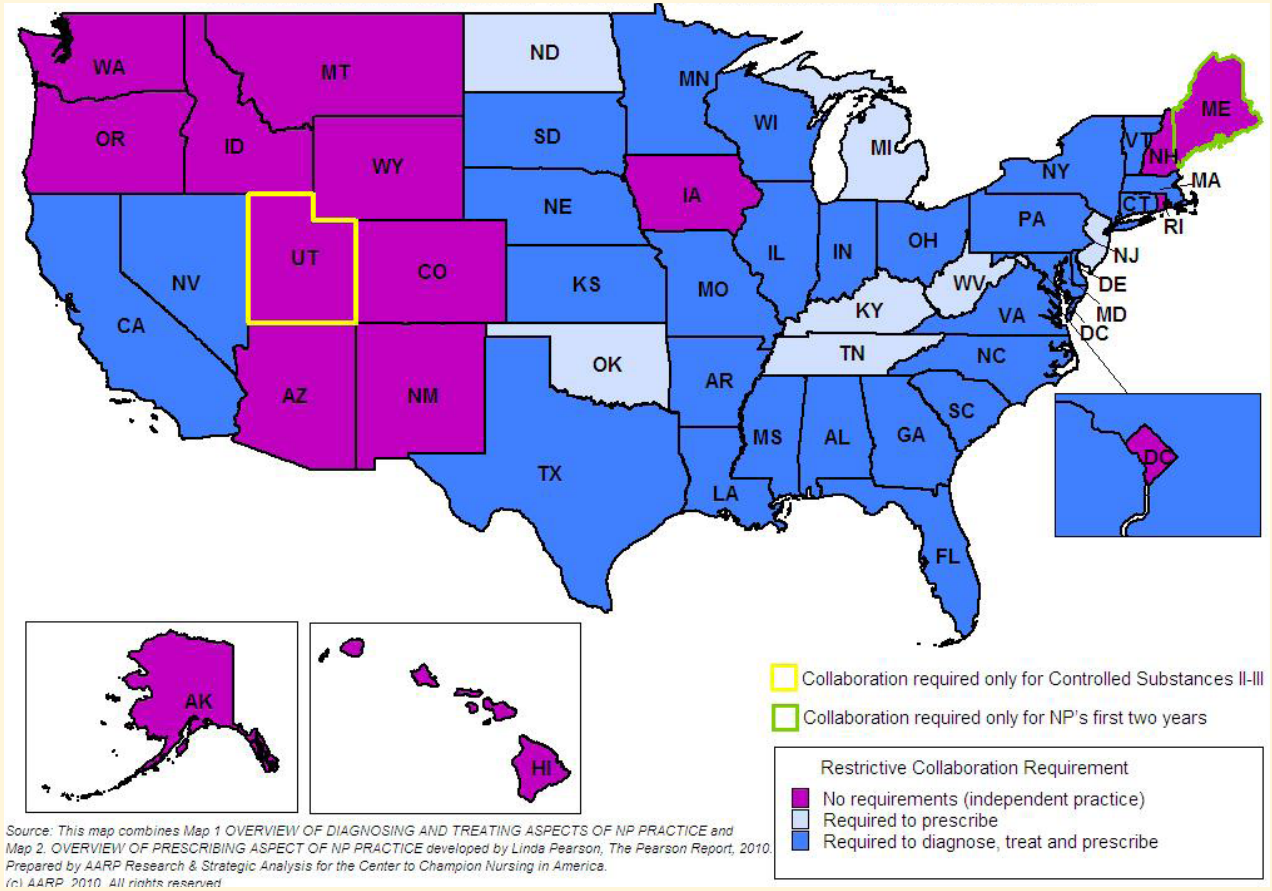
- Because of their regular, close proximity to patients and their scientific understanding of care processes, nurses have a considerable opportunity to act as full partners with other health professionals and to lead in the improvement and redesign of the health care system and its practice environment.

Key Messages

1. Nurses should practice to the full extent of their education and training.
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
3. Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.
4. Effective workforce planning and policy making require better data collection and an improved information infrastructure.

Key Message #1. **Nurses should practice to the full extent of their education and training.**

- The variability of scope-of-practice regulations across states may hinder advanced practice nurses from giving care they were trained to provide and contributing to innovative health care delivery solutions.
- Although some states have regulations that allow nurse practitioners to see patients and prescribe medications without a physician's supervision, a majority of states do not.
- The federal government is well suited to promote reform of states' scope-of-practice laws by sharing and providing incentives for the adoption of best practices.



Requirements for physician–nurse collaboration, by state, as a barrier to access to primary care.

NOTE: Collaboration refers to a mutually agreed upon relationship between nurse and physician.

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Key Message #2. **Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.**

- To ensure the delivery of safe, patient-centered care across settings, an improved nursing education system is critical.
- To respond to changing patient needs and an evolving health care systems, nurses must achieve higher levels of education and training.
- Education should include opportunities for seamless transition into higher degree programs.

Key Message #3. **Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.**

As leaders, nurses must:

- Act as full partners with other health care professionals
- Be accountable for their responsibility to deliver high-quality care
- Work collaboratively with leaders from other health professions
- Identify and propose solutions to problems in care environments
- Devise and implement plans for improvement
- Participate in health policy decision-making

Key Message #4: **Effective workforce planning and policy making require better data collection and an improved information infrastructure.**

- Planning for changes in the education and deployment of the nursing workforce will require comprehensive data on the numbers and types of health care providers currently available and required to meet future needs.

- Once an infrastructure for collecting and analyzing workforce data is in place, systematic assessment and projection of nursing workforce requirements will be needed to inform necessary changes in nursing practice and education.

- A priority should be placed on systematic monitoring of the supply of health care workers across profession, review of the data, and methods needed to develop accurate predictions of future workforce needs.

Recommendation # 1
Remove Scope of Practice Barriers

Advanced practice registered nurses should be able to practice to the full extent of their education and training. To achieve this goal, the committee recommends actions for the following entities:

- Congress
- State Legislatures
- Centers for Medicare and Medicaid Services
- Office of Personnel Management
- Federal Trade Commission and Antitrust Division of the Department of Justice

Recommendation # 2
Expand opportunities for nurses to lead and diffuse collaborative improvement efforts

Private and public funders, health care organizations, nursing education programs, and nursing associations should expand opportunities for nurses to lead and manage collaborative efforts with physicians and other members of the health care team to conduct research and to redesign and improve practice environments and health systems. These entities should also provide opportunities for nurses to diffuse successful practices.

Recommendation # 3
Implement nurse residency programs

State boards of nursing, accrediting bodies, the federal government, and health care organizations should take actions to support nurses' completion of a transition-to-practice program (nurse residency) after they have completed a prelicensure or advanced practice degree program or when they are transitioning into new clinical practice areas.

Recommendation # 4
Increase the proportion of nurses with a baccalaureate degree to 80 percent by 2020

Academic nurse leaders across all schools of nursing should work together to increase the proportion of nurses with a baccalaureate degree from 50 to 80 percent by 2020. These leaders should partner with education accrediting bodies, private and public funders, and employers to ensure funding, monitor progress, and increase the diversity of students to create a workforce prepared to meet the demands of diverse populations across the lifespan.

Recommendation # 5
Double the number of nurses with a doctorate by 2020

Schools of nursing, with support from private and public funders, academic administrators and university trustees, and accrediting bodies, should double the number of nurses with a doctorate by 2020 to add to the cadre of faculty and nurse researchers, with attention to increasing diversity.

Recommendation # 6
Ensure that nurses engage in lifelong learning

Accrediting bodies, schools of nursing, health care organizations, and continuing competency educators from multiple health professions should collaborate to ensure that nurses and nursing students and faculty continue their education and engage in lifelong learning to gain the competencies needed to provide care for diverse populations across the lifespan.

Recommendation # 7
Prepare and enable nurses to lead change to advance health

Nurses, nursing education programs, and nursing associations should prepare the nursing workforce to assume leadership positions across all levels, while public, private, and governmental health care decision makers should ensure that leadership positions are available to and filled by nurses.

Recommendation # 8
Build an infrastructure for the collection and analysis of interprofessional health care workforce data

The National Health Care Workforce Commission, with oversight from the Government Accountability Office and the Health Resources and Services Administration, should lead a collaborative effort to improve research and the collection and analysis of data on health care workforce requirements. The Workforce Commission and the Health Resources and Services Administration should collaborate with state licensing boards, state nursing workforce centers, and the Department of Labor in this effort to ensure that the data are timely and publicly accessible.

Summary

- Nurses are committed to delivering high-quality care under current regulatory, business, and organizational conditions.
- The power to change those conditions to deliver better care does not rest primarily with nurses.
- Responsibility also lies with governments, businesses, health care institutions, professional organizations and other health professionals, and the insurance industry.

Summary (continued)

- The committee's recommendations are directed to policy makers; national, state, and local government leaders; payers; researchers; executives; and professionals, including nurses; licensing bodies; educational institutions, and philanthropic and consumer advocacy organizations.
- Together, these groups have the power to transform the health care system to provide seamless, affordable, quality care that is accessible to all, patient centered, evidence based and leads to improved health outcomes.