ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR CHANGE OF OWNERSHIP EXEMPTION

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

RECEIVED
JUL 27 2020
HEALTH FACILITIES & SERVICES REVIEW BOARD

Facility/Project Identification

Facility Name:	Memorial Hospital-East		
Street Address:	1404 Cross Street		
City and Zip Code:	Shiloh, IL 62269		
County: St. Clair	Health Service Area: XI	Health Planning Area: F-01	

Legislators

State Senator Name:	Christopher Belt
State Representative Name:	LaToya Greenwood

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name:	Metro-East Services, Inc. d/b/a Memorial Hospital-East
Street Address:	1404 Cross Street
City and Zip Code:	Shiloh, IL 62269
Name of Registered Agent:	Illinois Corporation Service Company
Registered Agent Street Address:	801 Adlai Stevenson Drive
Registered Agent City and Zip Code:	Springfield, IL 62703
Name of Chief Executive Officer:	Michael McManus
CEO Street Address:	4500 Memorial Drive
CEO City and Zip Code:	Belleville, IL 62226
CEO Telephone Number:	618/257-5642

Type of Ownership of Applicants

X Non-profit Corporation
☐ For-profit Corporation
☐ Limited Liability Company
☐ Partnership
☐ Governmental
☐ Sole Proprietorship
☐ Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court, Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

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Exact Legal Name:	Protestant Memorial Medical Center, Inc. d/b/a Memorial Hospital-East
Street Address:	4500 Memorial Drive
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State Representative Name:	LaToya Greenwood

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name:	Memorial Regional Health Services, Inc.
Street Address:	4500 Memorial Drive
City and Zip Code:	Belleville, IL 62226
Name of Registered Agent:	Illinois Corporation Service Company
Registered Agent Street Address:	801 Adlai Stevenson Drive
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Name of Chief Executive Officer:	Michael McManus
CEO Street Address:	4500 Memorial Drive
CEO City and Zip Code:	Belleville, IL 62226
CEO Telephone Number:	618/257-5642

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County: St. Clair	Health Service Area: XI	Health Planning Area:	F-01

Legislators

State Senator Name:	Christopher Belt
State Representative Name:	LaToya Greenwood

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name:	BJC Health System d/b/a BJC HealthCare
Street Address:	4901 Forest Park Avenue
City and Zip Code:	St. Louis, MO 63108
Name of Registered Agent:	CSC-Lawyers Incorporating Service Company
Registered Agent Street Address:	221 Bolivar Street
Registered Agent City and Zip Code:	Jefferson City, MO 65101
Name of Chief Executive Officer:	Richard J. Liekweg
CEO Street Address:	4901 Forest Park Avenue, Suite 1200
CEO City and Zip Code:	St. Louis, MO 63108
CEO Telephone Number:	314/286-2030

Type of Ownership of Applicants

X	Non-profit Corporation	☐	Partnership	
☐	For-profit Corporation	☐	Governmental	
☐	Limited Liability Company	☐	Sole Proprietorship	☐
	Other			

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
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Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

Additional Contact [Person who is also authorized to discuss the Application]

Name:	None
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

Post Exemption Contact
[Person to receive all correspondence subsequent to exemption issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960]**

Name:	Michael McManus
Title:	President
Company Name:	Memorial Hospital-East
Address:	1404 Cross Street Shiloh, IL 62269
Telephone Number:	618/257-5642
E-mail Address:	Michael.McManus@bjc.org
Fax Number:	

Site Ownership after the Project is Complete
[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Protestant Memorial Medical Center, Inc.
Address of Site Owner:	4500 Memorial Drive Belleville, IL 62226
Street Address or Legal Description of the Site:	1404 Cross Street Shiloh, IL 62269
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.	
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Current Operating Identity/Licensee
[Provide this information for each applicable facility and insert after this page.]

Exact Legal Name:	Metro-East Services, Inc. d/b/a Memorial Hospital-East
Address:	1404 Cross Street Shiloh, IL 62269

- X Non-profit Corporation
- ☐ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

Operating Identity/Licensee after the Project is Complete

[Provide this information for each applicable facility and insert after this page.]

Exact Legal Name:	Protestant Memorial Medical Center, Inc.
Address:	4500 Memorial Drive Belleville, IL 62226

X	Non-profit Corporation	☐	Partnership	
☐	For-profit Corporation	☐	Governmental	
☐	Limited Liability Company	☐	Sole Proprietorship	☐
	Other			

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Narrative Description

In the space below, provide a brief narrative description of the change of ownership. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site.

The applicants propose to change the licensee of Memorial Hospital-East from Metro-East Services, Inc. ("Metro-East") to Protestant Memorial Medical Center, Inc. ("PMMC").

BJC Health System d/b/a BJC HealthCare holds "final control" over both Metro-East and PMMC.

The transition is anticipated to take place on or about January 1, 2021.

A Certificate of Exemption is being sought as a result of the intended change of Memorial Hospital-East's licensee.

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes X No

Purchase Price: $_______________

Fair Market Value: $_______________

Project Status and Completion Schedules

Outstanding Permits: Does the facility have any projects for which the State Board issued a permit that is not complete? Yes X__ No __. If yes, indicate the projects by project number and whether the project will be complete when the exemption that is the subject of this application is complete.

Project 17-069 addresses the construction of the second phase of a medical clinics building on the campus of Memorial Hospital-East. The project has been obligated, and the applicants anticipate that the December 31, 2020 completion date will be met. As such, the potential exists that the project will not be completed, per the HFSRB's definition of "completion", prior to the completion of the proposed change to the hospital's licensee.

Anticipated exemption completion date (refer to Part 1130.570): _on or about January 1, 2021__

State Agency Submittals

Are the following submittals up to date as applicable:

X Cancer Registry

X APORS

X All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted

X All reports regarding outstanding permits

Failure to be up to date with these requirements will result in the Application being deemed incomplete.

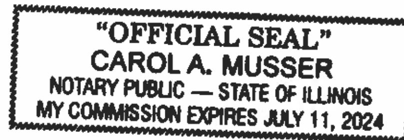
CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of __Metro-East Services, Inc. d/b/a Memorial Hospital-East__ in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.

[signature]	[signature]
SIGNATURE	SIGNATURE
MICHAEL MCMANUS	Jane K. Gusmano
PRINTED NAME	PRINTED NAME
PRESIDENT	Vice President
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 16th day of July, 2020	Notarization: Subscribed and sworn to before me this 15th day of July, 2020
Carol A. Musser	Carol A. Musser
Signature of Notary	Signature of Notary
Seal	Seal



*Insert the EXACT legal name of the applicant

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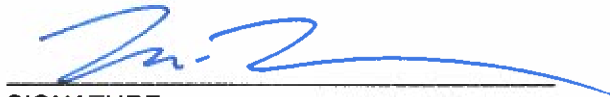


SIGNATURE

MICHAEL MCMANUS

PRINTED NAME

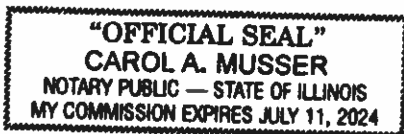
PRESIDENT

PRINTED TITLE

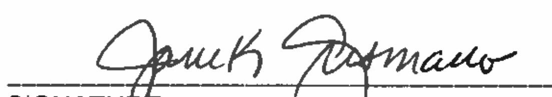
Notarization:
Subscribed and sworn to before me
this 16th day of July, 2020

Signature of Notary

Seal



"OFFICIAL SEAL"
CAROL A. MUSSER
NOTARY PUBLIC — STATE OF ILLINOIS
MY COMMISSION EXPIRES JULY 11, 2024



SIGNATURE

Jane K. Gusmano

PRINTED NAME

Vice President

PRINTED TITLE

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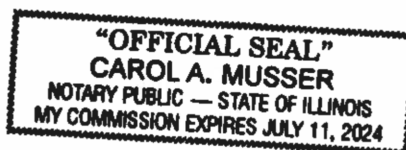
Subscribed and sworn to before me
this 16th day of July, 2020

Signature of Notary

Seal



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*Insert the EXACT legal name of the applicant

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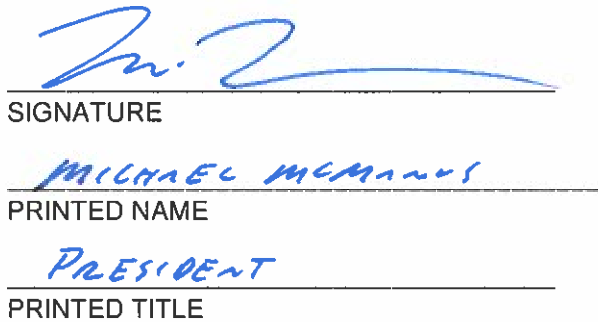
This Application is filed on the behalf of __Memorial Regional Health Services, Inc._ in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.



SIGNATURE

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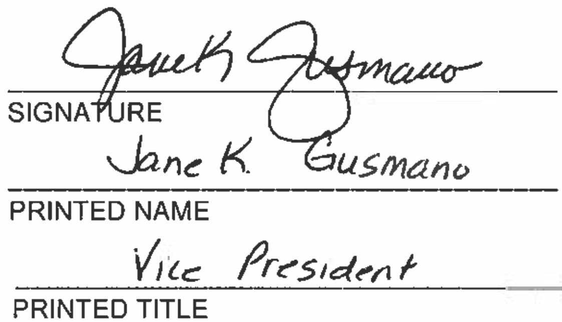

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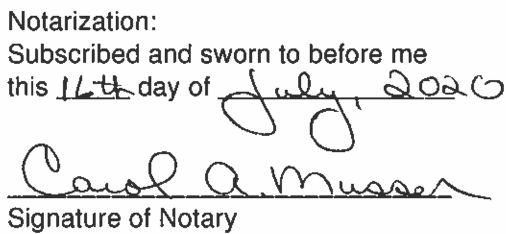
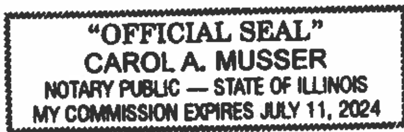


Signature of Notary

Seal



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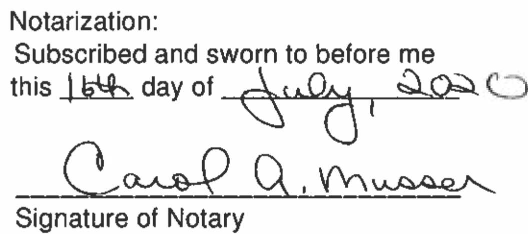

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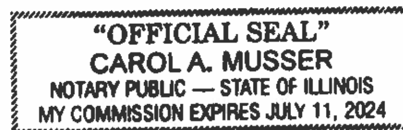

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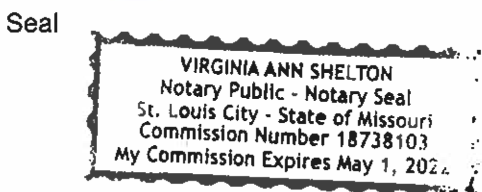
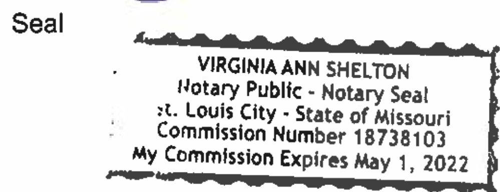
SIGNATURE	SIGNATURE
Joan Magruder PRINTED NAME	David R. Aplington PRINTED NAME
Group President PRINTED TITLE	Senior V. P. PRINTED TITLE
Notarization: Subscribed and sworn to before me this 21 day of July 2020	Notarization: Subscribed and sworn to before me this 21 day of July 2020
Virginia Shelton Signature of Notary	Virginia Shelton Signature of Notary
Seal	Seal





*Insert the EXACT legal name of the applicant

SECTION II. BACKGROUND.

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.

2. A listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.

3. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application. Please provide information for each applicant, including corporate officers or directors, LLC members, partners and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.

4. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**

5. If, during a given calendar year, an applicant submits more than one Application, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 5.

SECTION III. CHANGE OF OWNERSHIP (CHOW)

Transaction Type. Check the Following that Applies to the Transaction:

☐ Purchase resulting in the issuance of a license to an entity different from current licensee.

☐ Lease resulting in the issuance of a license to an entity different from current licensee.

☐ Stock transfer resulting in the issuance of a license to a different entity from current licensee.

☐ Stock transfer resulting in no change from current licensee.

X Assignment or transfer of assets resulting in the issuance of a license to an entity different from the current licensee.

☐ Assignment or transfer of assets not resulting in the issuance of a license to an entity different from the current licensee.

☐ Change in membership or sponsorship of a not-for-profit corporation that is the licensed entity.

☐ Change of 50% or more of the voting members of a not-for-profit corporation's board of directors that controls a health care facility's operations, license, certification or physical plant and assets.

☐ Change in the sponsorship or control of the person who is licensed, certified or owns the physical plant and assets of a governmental health care facility.

☐ Sale or transfer of the physical plant and related assets of a health care facility not resulting in a change of current licensee.

X Change of ownership among related persons resulting in a license being issued to an entity different from the current licensee

☐ Change of ownership among related persons that does not result in a license being issued to an entity different from the current licensee.

☐ Any other transaction that results in a person obtaining control of a health care facility's operation or physical plant and assets and explain in "Narrative Description."

1130.520 Requirements for Exemptions Involving the Change of Ownership of a Health Care Facility

1. Prior to acquiring or entering into a contract to acquire an existing health care facility, a person shall submit an application for exemption to HFSRB, submit the required application-processing fee (see Section 1130.230) and receive approval from HFSRB.

2. If the transaction is not completed according to the key terms submitted in the exemption application, a new application is required.

3. READ the applicable review criteria outlined below and **submit the required documentation (key terms) for the criteria:**

APPLICABLE REVIEW CRITERIA	CHOW
1130.520(b)(1)(A) - Names of the parties	X
1130.520(b)(1)(B) - Background of the parties, which shall include proof that the applicant is fit, willing, able, and has the qualifications, background and character to adequately provide a proper standard of health service for the community by certifying that no adverse action has been taken against the applicant by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois against any health care facility owned or operated by the applicant, directly or indirectly, within three years preceding the filing of the application.	X
1130.520(b)(1)(C) - Structure of the transaction	X
1130.520(b)(1)(D) - Name of the person who will be licensed or certified entity after the transaction	
1130.520(b)(1)(E) - List of the ownership or membership interests in such licensed or certified entity both prior to and after the transaction, including a description of the applicant's organizational structure with a listing of controlling or subsidiary persons.	X
1130.520(b)(1)(F) - Fair market value of assets to be transferred.	X
1130.520(b)(1)(G) - The purchase price or other forms of consideration to be provided for those assets. [20 ILCS 3960/8.5(a)]	X
1130.520(b)(2) - Affirmation that any projects for which permits have been issued have been completed or will be completed or altered in accordance with the provisions of this Section	X
1130.520(b)(3) - If the ownership change is for a hospital, affirmation that the facility will not adopt a more restrictive charity care policy than the policy that was in effect one year prior to the transaction. The hospital must provide affirmation that the compliant charity care policy will remain in effect for a two-year period following the change of ownership transaction	X
1130.520(b)(4) - A statement as to the anticipated benefits of the proposed changes in ownership to the community	X
1130.520(b)(5) - The anticipated or potential cost savings, if any, that will result for the community and the facility because of the change in ownership;	X

1130.520(b)(6) - A description of the facility's quality improvement program mechanism that will be utilized to assure quality control;	X
1130.520(b)(7) - A description of the selection process that the acquiring entity will use to select the facility's governing body;	X
1130.520(b)(9)- A description or summary of any proposed changes to the scope of services or levels of care currently provided at the facility that are anticipated to occur within 24 months after acquisition.	X

APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION V. CHARITY CARE INFORMATION

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 10.

Memorial Hospital-East

CHARITY CARE			
	2017	**2018**	**2019**
Net Patient Revenue	**$69,203,000**	**$76,347,000**	**$75,820,000**
Amount of Charity Care (charges)	$3,198,132	$4,623,131	$6,094,524
Cost of Charity Care	$1,225,734	$696,863	$696,368

APPEND DOCUMENTATION AS ATTACHMENT 10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

File Number 2998-217-1

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

PROTESTANT MEMORIAL MEDICAL CENTER, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON AUGUST 04, 1947, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 6TH *day of* APRIL *A.D.* 2020 .

Authentication #: 2009704834 verifiable until 04/06/2021
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

File Number 6997-719-7

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

MEMORIAL REGIONAL HEALTH SERVICES, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON MAY 14, 2015, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

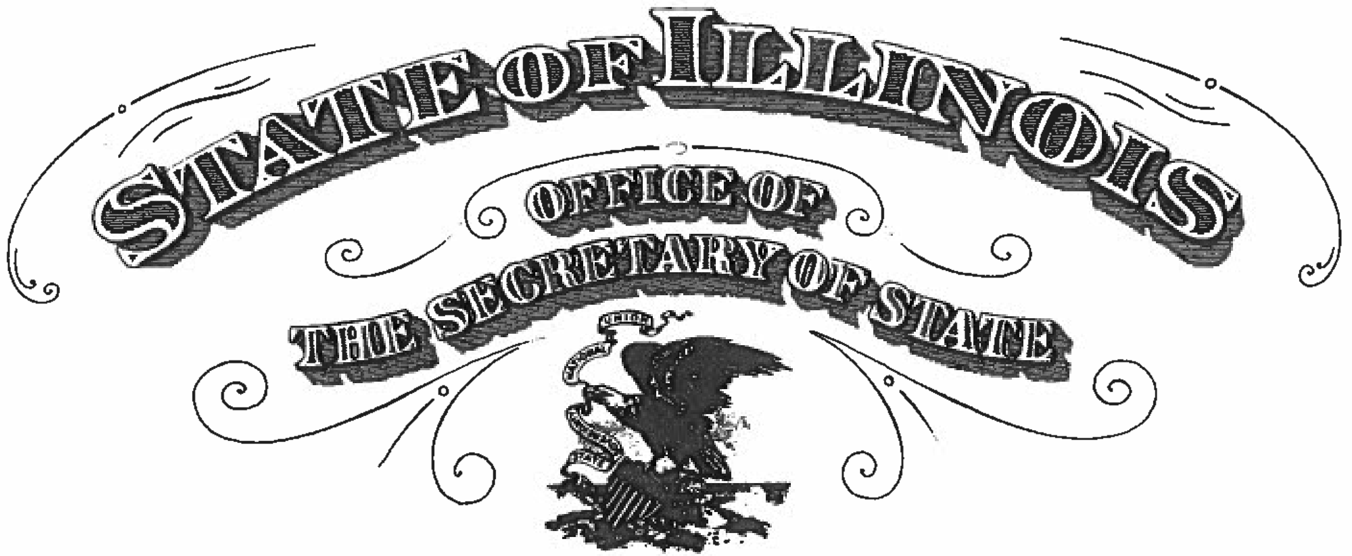
In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 8TH *day of* JULY *A.D.* 2020 .

Authentication #: 2019001964 verifiable until 07/08/2021
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

File Number 6775-531-6



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

METRO-EAST SERVICES, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON MARCH 17, 2011, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 6TH *day of* APRIL *A.D.* 2020 .

Authentication #: 2009704870 verifiable until 04/06/2021
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

STATE OF MISSOURI

John R. Ashcroft
Secretary of State

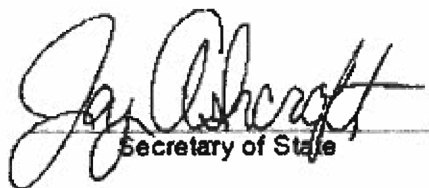
CORPORATION DIVISION
CERTIFICATE OF GOOD STANDING

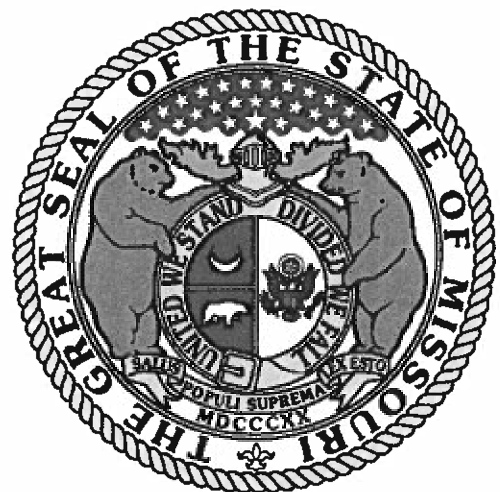
I, JOHN R. ASHCROFT, Secretary of State of the State of Missouri, do hereby certify that the records in my office and in my care and custody reveal that

BJC HEALTH SYSTEM
N00045883

was created under the laws of this State on the 11th day of May, 1992, and is in good standing, having fully complied with all requirements of this office.

IN TESTIMONY WHEREOF, I hereunto set my hand and cause to be affixed the GREAT SEAL of the State of Missouri. Done at the City of Jefferson, this 6th day of April, 2020.





Certification Number: CERT-04062020-0221

ATTACHMENT 1

July 20, 2020

Ms. Courtney Avery
Administrator
Illinois Health Facilities and
Services Review Board
525 West Jefferson
Springfield, Illinois

To Whom It May Concern:

This letter is being provided as confirmation that, following the proposed change of ownership/change of control, Protestant Memorial Medical Center, Inc. will own the Memorial Hospital-East site.

Sincerely,

Michael T. McManus
President
Memorial Hospital - Belleville and Memorial Hospital - East

Notarized:

ATTACHMENT 2

BJC HealthCare

File Number 2998-217-1

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

PROTESTANT MEMORIAL MEDICAL CENTER, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON AUGUST 04, 1947, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

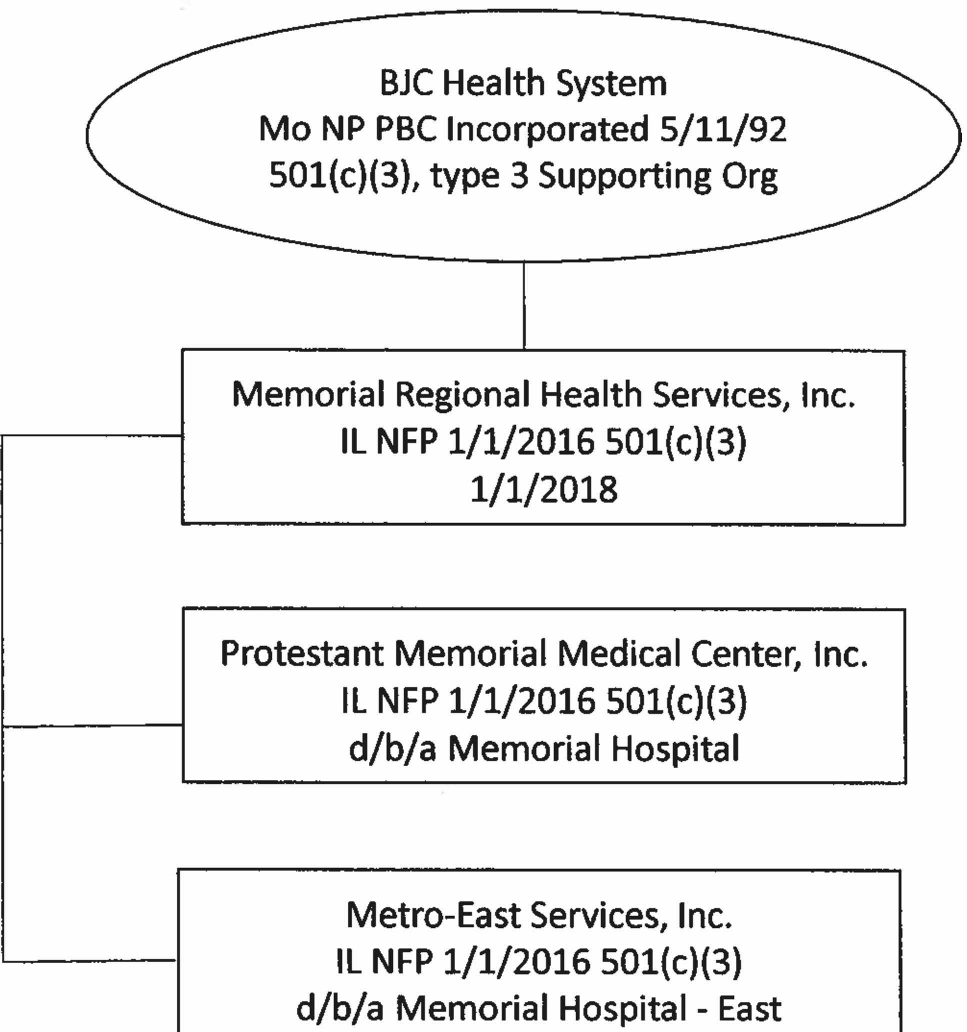
In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 6TH *day of* APRIL *A.D.* 2020 .

Authentication #: 2009704834 verifiable until 04/06/2021
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

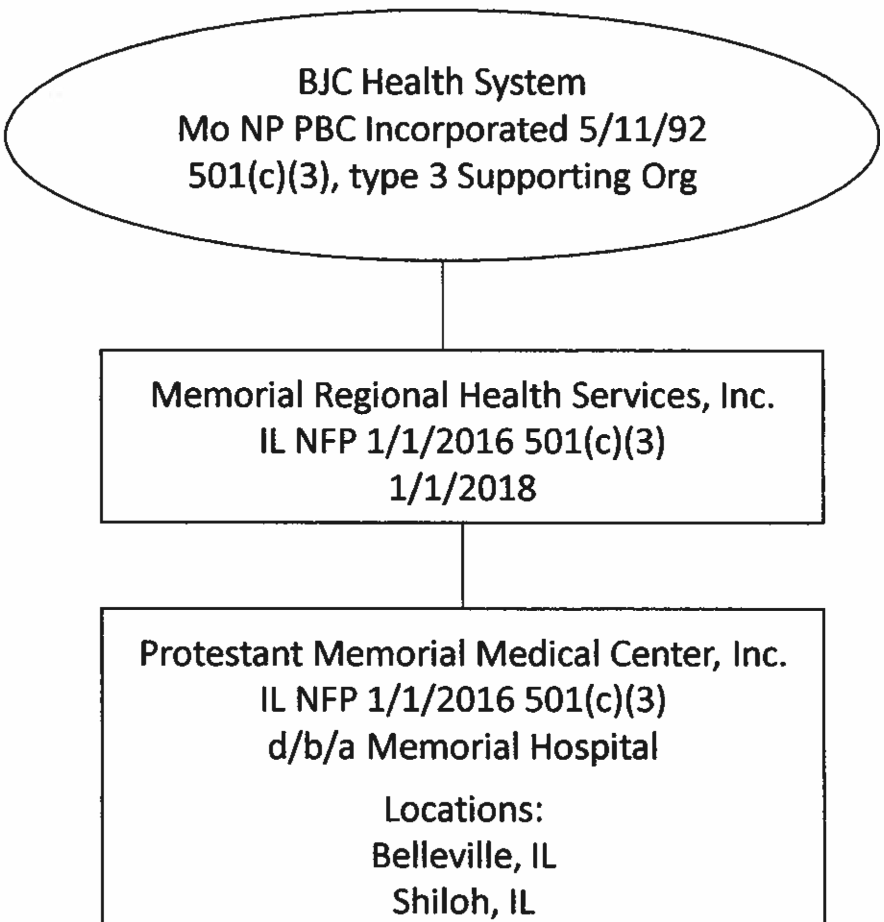
ATTACHMENT 7

Current



ATTACHMENT 4

As of: 1/1/2021



ATTACHMENT 4

BACKGROUND

BJC HealthCare holds "final control" over the following Illinois licensed health care facilities:

1. Protestant Memorial Medical Center, Inc. d/b/a Memorial Hospital, located in Belleville
2. Metro-East Services, Inc. d/b/a/ Memorial Hospital-East, located in Shiloh
3. Alton Memorial Hospital, located in Alton

No BJC HealthCare corporate officers, directors, LLC members, or partners own a 5%+ control interest in any licensed health care facility in Illinois.

Illinois Department of PUBLIC HEALTH

HF 119879

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

Ngozi O. Ezike, M.D.
Director

Issued under the authority of the Illinois Department of Public Health

4/11/2021 0006049

General Hospital

Effective: 04/12/2020

Metro-East Services Inc
dba Memorial Hospital East
1404 Cross Street

Shiloh, IL 62269

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #19-403-001 10M 9/18

DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 4/11/2021

Lic Number 0006049

Date Printed 2/10/2020

Metro-East Services Inc
dba Memorial Hospital East
1404 Cross Street
Shiloh, IL 62269

FEE RECEIPT NO.

ATTACHMENT 5

#5

BJC HealthCare

July 17, 2020

Ms. Courtney Avery
Illinois Health Facilities
And Services review Board
525 West Jefferson
Springfield, IL 62761

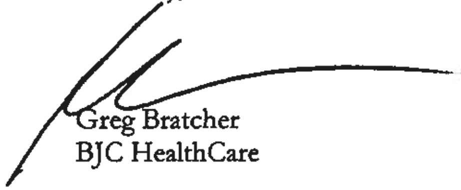
Dear Ms. Avery:

In accordance with Review Criterion 1110.230.b, Background of the Applicant, we are submitting this letter assuring the Illinois Health Facilities and Services Review Board that:

1. BJC HealthCare has not had any adverse actions taken against any facility owned and operated by it during the three (3) year period prior to the filing of this application, and
2. BJC HealthCare authorizes the State Board and Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1110.230.b or to obtain any documentation or information which the State Board or Agency finds pertinent to this application.

If we can in any way provide assistance to your staff regarding these assurances or any other issue relative to this application, please do not hesitate to call me at 314-323-1231.

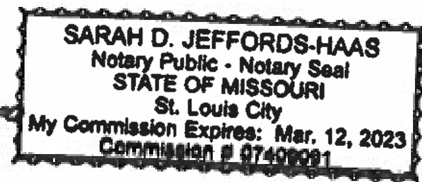
Sincerely,



Greg Bratcher
BJC HealthCare

Date: July 21st, 2020

Notarized:



BJC The world's best medicine. Made better.

ATTACHMENT 5

SECTION V
CHANGE OF OWNERSHIP (CHOW)

Applicable Review Criteria

Criterion 1130.520(b)(1)(A) Names of the parties
The parties named as an applicant are:

1. Metro-East Services, Inc. d/b/a Memorial Hospital-East ("the hospital"), the hospital's current license holder.
2. Protestant Memorial Medical Center, Inc., the entity that will become the hospital's license holder.
3. BJC Health System (d/b/a BJC HealthCare) the entity which currently meets the IDPH definition of "final control" found in Section 1130.140, and the entity that holds, and will maintain "final control" over the hospital.
4. Memorial Regional Health Services, Inc., an entity named on past CON and COE applications relating to Memorial Hospital-East.

Criterion 1130.520(b)(1)(B) Background of the parties
Provided in ATTACHMENT 1 are Certificates of Good Standing for each applicant identified above. Provided in ATTACHMENT 5 are:

1. Listings of Illinois Health Care Facilities owned by the applicants
2. A certification from the applicants that no adverse actions have been taken against any facility owned and/or operated in Illinois by the applicant during the past three years.
3. The applicants' authorization permitting HFSRB and IDPH access to documents necessary to verify the information submitted.

Criterion 1130.520(b)(1)(C) Structure of transaction
BJC HealthCare currently has "final control", per Section 1130.140, over Metro-East Services, Inc. d/b/a Memorial Hospital-East through its "final control" of Memorial Regional Health Services, Inc. Memorial Hospital-East is located in Shiloh.

BJC HealthCare also, through Memorial Regional Health Services, Inc., currently has "final control" over Protestant Memorial Medical Center, Inc. d/b/a Memorial Hospital, located in Belleville.

The proposed change of ownership and control resulting from the merger of the corporate entities, will result in Memorial Hospital-East becoming an additional location and d/b/a of Protestant Memorial Medical Center, Inc., along with Memorial Hospital. The two hospitals will operate under a single license, Memorial Hospital's current license (IDPH #1461). BJC HealthCare will continue to have "final control" over Memorial Regional Health Services, Inc. and Protestant Memorial Medical Center, Inc., and thereby continue to have "final control" over the two hospitals.

ATTACHMENT 6

Criterion 1130.520(b)(1)(D) Name of the person who will be licensed or certified entity after the transaction

As described in the section above, upon the completion of the proposed transaction, and under the "two hospital/one license" framework, there will no longer be a separate Memorial Hospital-East license. Memorial Hospital-East's license will be held by Protestant Memorial Medical Center, Inc.

Criterion 1130.520(b)(1)(E) List of the ownership or membership interests in such licensed or certified entity both prior to and after the transaction, including a description of the applicant's organization structure with a listing of controlling or subsidiary persons.

BJC HealthCare currently has, and will continue to have "final control" over Memorial Hospital-East and its Shiloh, Illinois location.

Current control is the result of BJC HealthCare's "final control" over Memorial Regional Health Services, Inc.'s subsidiary Metro-East Services, Inc. d/b/a Memorial Hospital-East. Upon the completion of the proposed transaction, BJC HealthCare will maintain "final control" over Memorial Hospital-East as a result of its "final control" over Protestant Memorial Medical Center, Inc.

Criterion 1130.520(b)(1)(F) Fair market value of assets to be transferred

Memorial Hospital-East's value, per its April 30, 2020 balance sheet, is $157,543,413. This amount is identified as the hospital's fair market value for purposes of this Certificate of Exemption application, exclusively.

Criterion 1130.520(b)(1)(G) The purchase price or other forms of consideration to be provided for those assets

There will not be an exchange of money as a result of the proposed change of ownership and control, and therefore this criterion is not applicable.

Criterion 1130.520(b)(2) Affirmation that any projects for which Permits have been issued have been completed or will be completed or altered in accordance with the provisions of this Section.

As of the time of this Certificate of Exemption application filing, the applicants have one Certificate of Need Permit (Permit) pending. That Permit addresses the construction of the second phase of a medical clinics building on the campus of Memorial Hospital-East. The project has been obligated, and the completion date is December 31, 2020. The applicable Permit holders include Metro-East Services, Inc. and BJC HealthCare.

In addition, Metro East Services, Inc. and BJC HealthCare are among the co-applicants for Project 19-021, The Rehabilitation Institute of Southern Illinois. That project is scheduled to be heard by the HFSRB on September 22, 2020. Consistent with Section 1130.520.e, as noted below, the applicants affirm that, following approval, Project 19-021 will be completed as approved, or as subsequently altered, consistent with applicable requirements.

e) Completion of Projects with Outstanding Permits

1) A permit or exemption cannot be transferred.

2) *In connection with a change of ownership, the State Board may approve the transfer of an existing permit without regard to whether the permit to be transferred has yet been obligated, except for permits establishing a new facility or a new category of service.* (see 20 ILCS 3960/6(b).)

3) If the requirements of this subsection (e) are not met, any outstanding permit will be considered a transfer of the permit and results in the permit being null and void.

By its respective signatures on the Certification Pages of this Certificate of Exemption application, the applicants affirm that the Certificate of Need Permits identified above will be completed, consistent with rules of the Illinois Health Facilities and Services Review Board.

Criterion 1130.520(b)(3) If the ownership change is for a hospital, affirmation that the facility will not adopt a more restrictive charity care policy than the charity care policy that was in effect one year prior to the transaction. The hospital must provide affirmation that the compliant charity care policy will remain in effect for a two-year period following the change of ownership transaction.

By their signatures on the Certification Pages of this Certificate of Exemption application, the applicants affirm that the hospital's charity care policy will not become more restrictive for a minimum of two years following the closing of the change of ownership transaction. A copy of BJC HealthCare's Financial Assistance Policy, under which both of the hospitals currently operate, and will continue to operate, is attached.

Criterion 1130.520(b)(4) A statement as to the anticipated benefits of the proposed changes in ownership to the community

The primary purposes of the proposed change of ownership/control are to improve the hospitals' operating efficiencies in consolidating services so as to create Centers of Excellence for its primary and secondary service areas, to further benefit the community, and to simplify the organizational structure and Board-level control. It is not anticipated that the community will experience any material changes to manner in which services are provided, including diminished access to services.

Criterion 1130.520(b)(5) The anticipated or potential cost savings, if any, that will result for the community and facility because of the change in ownership.

While operating efficiencies will result from the transaction, substantive savings are not anticipated to be realized because Memorial Hospital and Memorial Hospital-East have operated under common leadership, with common purchasing plans, etc., and have been diligent in the consolidation of unnecessarily-duplicative services, as practical, since the opening of Memorial Hospital-East.

Criterion 1130.520(b)(6) A description of the facility's quality improvement mechanism that will be utilized to ensure quality control

The applicants place great importance in quality control, incorporating best practices models, peer review protocols, and other mechanisms designed to monitor and improve quality of care, which are shared throughout BJC HealthCare. No changes to the hospital's *Quality*

ATTACHMENT 6

Improvement Program are anticipated to occur as a direct result of the proposed change of control.

A copy of the program is attached.

Criterion 1130.520(b)(7) A description of the selection process that the acquiring entity will use to select the facility's governing body
It is anticipated that the hospitals' current Board leadership will participate in and lead a joint nominating committee to establish a new composition for the Memorial Board to take effect in in 2021. Such Board composition will conform with the current Protestant Memorial Medical Center, Inc.'s bylaws, which limits Board membership to fifteen individuals.

Criterion 1130.520(b)(9) A description or summary of any proposed changes to the scope of services or levels of care currently provided at the facility that are anticipated to occur within 24 months after acquisition.
Consideration is being given to the consolidation of Memorial Hospital's obstetrical services with those of Memorial Hospital-East, with the consolidated service to be located at Memorial Hospital-East. If the decision is made to proceed with the consolidation of that service, a Certificate of Exemption to discontinue the service at Memorial Hospital will be sought from the HFSRB.

Financial Assistance Policy

BJC wants to help patients who do not have health insurance or who need help paying their hospital bills. As a nonprofit health care organization, BJC and our member hospitals and health service organizations care about the patients and communities we serve through better health and better health care.

Our staff can help you:

- Apply for health insurance through the new Marketplace
- Apply for Medicaid assistance
- Determine if you qualify for financial assistance from BJC

BJC Financial Assistance

First and foremost, your financial circumstances will not affect your care. All patients are treated with respect and fairness. Patients who meet certain income guidelines may qualify for BJC Financial Assistance, including reduced hospital charges and long-term, interest-free payment plans. Patients who are eligible for financial assistance will be billed less than the amounts generally billed to individuals who have insurance covering such care. Information regarding amounts generally billed and its calculation is available by calling 314-362-8400 or 855-362-8400 or at www.bjc.org.

If you are insured and have questions about your coverage or your level of benefits, please contact your insurance provider. Patients without insurance will automatically receive a 40 percent discount on the billed charges and will be considered for assistance. Depending on the type of service and level of financial assistance, a partial payment may be required. We can give you a Financial Assistance Policy Income and Discount chart that shows the payment amounts upon request.

Financial assistance approval will be in effect for 12 months from the date of approval. Patients who have services within this time period should inform us of the visit by calling 314-362-8400 or 855-362-8400 so that financial assistance may be applied.

Exceptions to the financial assistance qualification criteria will be considered on an individual basis.

Applying for Financial Assistance

You may apply for Financial Assistance at any time – before, during or after your care, up to 240 days after your initial bill. We will send information with your bill about how to apply for assistance. Applications are also available upon request at any BJC facility, on our websites and at www.bjc.org. The application requires proof of income such as an income tax return or paycheck stub. Examples of documents which may be used as proof of income can be found on the application form.

Patients who have been enrolled in Medicaid or who are deemed eligible for Gateway to Better Health in the last six months automatically qualify for Financial Assistance for medical services that are not covered by Medicaid. (The only exception is if the previous Medicaid enrollment was due to pregnancy. In that case, you can still apply for Financial Assistance.)

In addition, patients may be approved for financial assistance based on the use of a standard analytic approach which estimates the patient's financial and/or socio-economic position. Eligibility for this type of assistance does not automatically qualify the patient for assistance on future accounts.

Medical Qualifications for Financial Assistance

BJC hospitals will provide, without exception, care for emergency medical conditions to all patients seeking such care, regardless of ability to pay or to qualify for financial assistance, in accordance with the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA).

Financial assistance is available only for emergency and medically necessary services. It does not apply to elective procedures such as cosmetic surgery. It also does not apply to the portion of your services that have been paid for by a third party such as an insurance company or government program.

Financial Assistance is available to patients who live in Missouri and Illinois.

A listing of providers who are not included under BJC's financial policy is available by calling 314-362-8400 or 855-362-8400 or electronically at www.bjc.org.

Income Guidelines for Financial Assistance

The amount of financial assistance you receive is based on Federal Poverty Level information set by the U.S. government each year. To be eligible for a discount, your family income must not be more than three times the Federal Poverty Level (300 percent). We can give you a Financial Assistance Policy Income and Discount chart that shows these income levels upon request. In addition to your income, the discount will also take into account the size of your family. Patients with family income over $100,000 a year are not eligible for BJC Financial Assistance, regardless of family size. Uninsured Illinois residents receiving services at Alton Memorial Hospital may be eligible for additional discounts under the Illinois Hospital Uninsured Patient Discount Act.

Income Guidelines for Catastrophic Events

In the case of a catastrophic medical event, patients who may not ordinarily qualify for Financial Assistance will be granted aid. Under these special circumstances, patient payment responsibilities in a 12-month period will not be more than 25 percent of annual family income.

Learn more

You can get more information about the BJC Financial Assistance Policy and an application, or make a request to receive written notice or communication electronically by speaking with a Patient Services representative or by calling **314-362-8400 or toll free 855-362-8400.** Information and application forms are also available at **www.bjc.org**. Please feel free to ask about Financial Assistance. We are here to help.

BJC HealthCare

ATTACHMENT 6

BJC Financial Assistance
Income and Discount Schedule

Table I: Family Income Ranges for Financial Assistance

Family Size	100% FPL	150% FPL	200% FPL	250% FPL	300% FPL
1 Person	$12,760	$19,140	$25,520	$31,900	$38,280
2 People	$17,240	$25,860	$34,480	$43,100	$51,720
3 People	$21,720	$32,580	$43,440	$54,300	$65,160
4 People	$26,200	$39,300	$52,400	$65,500	$78,600
5 People	$30,680	$46,020	$61,360	$76,700	$92,040
6 People	$35,160	$52,740	$70,320	$87,900	$100,000
7 People	$39,640	$59,460	$79,280	$99,100	$100,000
8 People	$44,120	$66,180	$88,240	$100,000	$100,000

- Family Size: For each additional family member over 8 members, add $4,480 to income. Patients with family income over $100,000 will not be eligible for financial assistance, regardless of family size.
- FPL: "Federal Poverty Level" is determined yearly by the US Department of Health and Human Services.

Table II: Amount of Discount and Patient Responsibility

Patient's Household Income	Less than 100% FPL	101-150% FPL	151-200% FPL	201-250% FPL	251-300% FPL
Patient's Discount:	100%	95%	90%	80%	75%
Patient Pays:	0%	Co-pay + 5%	Co-pay + 10%	Co-pay + 20%	Co-pay + 25%

Co-pays:

Hospitals	BJC Medical Group	Home Care Services
Inpatient: $300 per stay	Office Visit: $50 per visit	Home Care: $50 per visit
Outpatient: $25 per visit	Office Procedure: $75 per visit	Home Infusion: $50 per visit
Emergency: $100 per visit	Inpatient Visit: $100 per stay	Medical Equipment: $25 per piece
Therapy: $10 per visit	Outpatient Visit: $25 per visit	

CATASTROPHIC FINANCIAL ASSISTANCE

In the case of a catastrophic medical event, patients who may not ordinarily qualify for Financial Assistance will be granted aid. Under these special circumstances, patient payment responsibilities will not be more than 25 percent of annual family income.
Patients must inform the hospital of subsequent visits within a 12-month period in order to receive catastrophic financial assistance.

BJC HealthCare

ATTACHMENT 6

CS_462800_1/20

Illinois Hospital Uninsured Discount Act Schedule

Table III: Family Income Ranges for Financial Assistance

(Uninsured Illinois Residents at Alton Memorial Hospital, Memorial Hospital Belleville and Memorial Hospital East ONLY)

Family Size	200% FPL	600% FPL
1 Person	$25,520	$76,560
2 People	$34,480	$103,440
3 People	$43,440	$130,320
4 People	$52,400	$157,200
5 People	$61,360	$184,080
6 People	$70,320	$210,960
7 People	$79,280	$237,840
8 People	$88,240	$264,720

- Family Size: For each additional family member over 8 members, add $4,480 to income.
- Patients who have been enrolled in the following programs over the last six months automatically qualify for BJC Financial Assistance: WIC, SNAP, Illinois Free Lunch and Breakfast Program, LIHEAP and other medical grant assistance.
- FPL: "Federal Poverty Level" is determined yearly by the U.S. Department of Health and Human Services.

Table IV: Amount of Discount and Patient Responsibility

(Uninsured Illinois Residents at Alton Memorial Hospital, Memorial Hospital Belleville and Memorial Hospital East ONLY)

Patient's Household Income	Less than 200% FPL	201-600% FPL
Patient's Discount:	100%	135% Cost to Charge Ratio
Patient Pays:	No Co-pay	Co-pay + Cost Share

Co-Pays:	Alton Memorial Hospital, Memorial Hospital Belleville and Memorial Hospital East
Inpatient:	Lesser of charges or $300 per stay
Outpatient:	Lesser of charges or $300 per visit
Emergency:	Lesser of charges or $300 per visit
Therapy (PT/OT/Speech):	Lesser of charges or $300 per visit

CATASTROPHIC FINANCIAL ASSISTANCE

In the case of a catastrophic medical event, patients who may not ordinarily qualify for Financial Assistance will be granted aid. Under these special circumstances, patient payment responsibilities will not be more than 25 percent of annual family income.
Patients must inform the hospital of subsequent visits within a 12-month period in order to receive catastrophic financial assistance.

ATTACHMENT 6

CS_462800_1/20

Memorial Hospital East
Shiloh, IL

QUALITY IMPROVEMENT PLAN

I. PURPOSE

Memorial Hospital East (MHE) shall demonstrate through the Quality Improvement and Patient Safety Plan a systematic, organization wide approach to ensuring patient safety, delivering optimal patient centered care and service to patients in keeping with its mission, values and strategic plan.

II. MISSION STATEMENT

Memorial Hospital East's mission is to provide exceptional healthcare and compassionate service.

III. GUIDING PRINCIPLES

Memorial Hospital East's foundation for the Quality Improvement and Patient Safety program are established on the following guiding principles:

- **Relationship Based Care**: Involve patient, families, and caregivers in care design and decision making that meets their needs and preferences.
- **Accountability of Interdisciplinary Teams**: Provide care teams with goal defined responsibilities and support them with dedicated staff, resources, data collection, analysis and monitoring.
- **Transparency of Information**: Provide easily accessible, meaningful information with open communications among leadership, caregivers and patients regarding expectations and performance
- **Strive for Culture of Safety**: Promote open and accepting reporting of errors by the staff and foster change to enhance the culture of quality and safety.
- **Leadership and Innovation**: Create an environment that provides resources that support and foster change to enhance the culture of quality and safety
- **Aims for Improvement**: The quality and patient safety improvement activities are structured around the Institutes of Medicine's (IOM) six key dimensions of care delivery assessed by collecting and analyzing data related to one or more of the following aims for improvement:
  Safe – avoiding injuries to patients from the care that is intended to help them;
  Effective – providing services based on scientific knowledge to those who would benefit, and refraining from providing services to those not likely to benefit;
  Patient centered – providing care that is respectful of, and responsive to, individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions;
  Timely – reducing waits and potentially harmful delays;
  Efficient – avoiding waste, including waste of equipment, supplies, ideas and energy;
  Equitable – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

IV. LEADERSHIP RESPONSIBILITY

Memorial Hospital East's quality improvement and patient safety structure includes the Board of Directors, Quality Improvement Committee, Quality Management Council, Patient Safety Committee, Medication Safety Committee, and Medical Staff Quality Improvement Committee.

A. BOARD OF DIRECTORS

Memorial Hospital East's Board of Directors bears the ultimate responsibility for assuring that high quality, safe and effective care is provided to patients. The Board delegates the responsibility for implementing the Quality Improvement and Patient Safety Plan through the board level Quality Improvement Committee, the Quality Management Council and to the hospital's executive leadership team.

The Board of Directors provides leadership for the quality improvement and patient safety program as follows:

- Establish a hospital-wide quality improvement and patient safety program that reflects the complexity of the hospital's organization and services and involves all hospital departments and services including those services furnished under contract or arrangement.
- Set clear expectations for patient safety and focus on performance indicators related to improved health outcomes and the prevention and reduction of medical errors.
- Provide adequate resources to implement the quality improvement program.
- Approve the written quality improvement and patient safety plan on an annual basis.
- Receive and act upon the annual quality improvement and patient safety program evaluation.

QUALITY IMPROVEMENT COMMITTEE (BOARD LEVEL)
The Quality Improvement Committee of the board provides leadership, guidance, authority and accountability for quality improvement and patient safety throughout the organization. Members are appointed by the MHE board of directors. The committee's composition includes a maximum of six Directors; two shall be elected, and four may be elected or honorary; President, two medical staff members from different departments, Vice President of Medical Affairs, three additional officers, Quality Improvement Coordinator and ad hoc members from among department heads as necessary.

The Quality Improvement Committee oversees and guides the Quality Improvement and Patient Safety program to ensure high quality patient care, eliminate preventable harm to patients, minimize risk to the patients, employees, and the organization and promote cost effectiveness.
To carry out its responsibility, the Quality Improvement Committee provides for the effective functioning of quality improvement and patient safety activities as follows:

- Establish priorities for improved quality of care and patient safety annually;
- Approve the number of distinct improvement projects and specify the frequency and detail of quality improvement and patient safety data collection on an annual basis; (Appendix A and B)
- Receive and act upon reports from the Quality Management Council quality improvement and patient safety summary findings that monitor the effectiveness and safety of service;
- Report and make recommendations to the full Board quarterly.

The Quality Improvement Committee meets on a quarterly basis.

B. QUALITY MANAGEMENT COUNCIL (HOSPITAL)
The Quality Management Council is comprised of the executive leadership team and the following individuals: Chairperson Medical Staff Quality Improvement Committee, nursing/clinical directors, patient advocate, infection prevention coordinator, quality improvement coordinator and department managers from Radiology and Pharmacy, and other managers as necessary on an ad-hoc basis.

The Quality Management Council is responsible to facilitate integration and coordination of quality improvement and patient safety into operations. The council provides leadership and oversight, identifies improvement opportunities and prioritizes the use of resources for quality improvement and patient safety activities. The Quality Management Council will:

- Ensure high quality patient care, eliminate preventable harm to patients, minimize risk to the patients, employees, and the organization, and promote cost effectiveness.
- Provide guidance to the Quality Improvement and Patient Safety Program to ensure important processes and quality improvement and patient safety activities are measured, assessed and improved systematically throughout the hospital.
- Establish a communication system to ensure that relevant information is forwarded to appropriate individuals and committees.
- Review serious adverse patient events and significant event reports and oversees that a root cause analysis is conducted, if indicated, and a corrective action plan is prepared.

- Review grievances and provide a response to the individual(s) within appropriate time frame.
- Evaluate the effectiveness of quality improvement and patient safety activities annually.
- Establish priorities based on important patient care processes and functions which are high-volume, high-risk, problem prone, high-cost, patient safety factors, incidence and prevalence, and patient experience. Reprioritization of quality improvement activities are considered as needs are identified.
- Approve the strategic goals for the quality improvement program annually.
- Review and make recommendations to the Board of Directors for renewal of clinical contracts annually.
- Oversee and review the activities of the Patient Safety Committee quarterly.
- Oversee and review the activities of the Medication Safety Committee quarterly.
- Assure that hospital leadership, medical staff, hospital employees, and those services provided by contract or arrangements receive training in quality improvement and lean methods. Quality Improvement methodology is included in the new employee orientation program and mandatory annual educational requirements.

The Quality Management Council meets on a quarterly basis.

C. QUALITY MANAGEMENT COUNCIL SUBCOMMITTEE

Memorial's Board of Directors has delegated responsibility to the Quality Management Council Subcommittee to review and resolve grievances. Furthermore, the subcommittee determines whether any action is necessary for Memorial to further its goals of reducing morbidity and mortality, eliminate preventable harm and minimize risk to patients.
The Quality Management Council Subcommittee is responsible for the review of adverse events and significant event reports. Upon discovery of an adverse event, a root cause analysis is conducted and a corrective action plan is prepared.

D. PATIENT SAFETY COMMITTEE

The Patient Safety Committee is a multidisciplinary group comprised of the vice-president risk management, vice-president patient care services, nursing/clinical directors, patient advocate, infection prevention, quality improvement coordinator, center for nursing excellence, perioperative services, and other directors/managers as necessary on an ad-hoc basis.

The Patient Safety Committee is responsible to identify and conduct analysis of patient safety Issues, including near misses, and develop approaches to improve patient safety, eliminate preventable harm and minimize risk to patients, conduct failure mode and effect analysis, monitor compliance with the National Patient Safety Goals.

The Patient Safety Committee reports its activities and recommendation to the Quality Management Council on a quarterly basis.

The Patient Safety Committee meets monthly.

E. ENVIRONMENT OF CARE COMMITTEE

The Environment of Care Committee is a multidisciplinary group comprised of the administrator, facility management director/safety officer, security manager, clinical engineering, environmental services, emergency preparedness, infection control , and quality improvement coordinator.

The committee is responsible to ensure the following management plans are developed and active monitoring is conducted to ensure the safety of the patient and provide a safe physical environment.

- Building Safety
- Building Security

- Hazardous Materials and Waste
- Fire Safety Control
- Medical Equipment Management
- Utility Systems Management
- Emergency Management
- Employee Safety (WPV)

The Environment of Care/Safety Committee reports its activities and recommendation to the Quality Management Council on a quarterly basis.

The Environment of Care /Safety Committee meets monthly.

F. MEDICATION SAFETY COMMITTEE

The Medication Safety Committee is a multidisciplinary group comprised of the director of pharmacy, supervisor+, clinical pharmacists, vice-president patient care services, vice-president medical affairs, vice-president risk management, nursing/clinical directors, nurse managers, staff nurses, nursing informatics, patient advocate, quality improvement coordinator, perioperative services and other directors/managers as necessary on an ad-hoc basis.

The Medication Safety Committee is responsible to identify and prioritize opportunities for improvement for safe medication practices and to reduce the potential for and actual incidence of medication events and improve patient safety.

The Medication Safety Committee reports its activities and recommendations to the Quality Management Council on a quarterly basis.

The Medication Safety Committee meets monthly.

G. NURSING QUALITY AND PRACTICE COUNCIL

The Quality & Nursing Practice Council's (QNPC) purpose is to provide oversight and monitor for quality patient outcomes, patient safety, and professional nursing practice within the department of nursing.

The council provides a structure for reporting of nursing quality and patient safety activities, and works with individual units/departments to ensure adherence to all quality and patient safety initiatives, along with core measures that are nurse sensitive.

The Quality and Nursing Practice Council oversees the nursing quality dashboard that displays unit-specific and aggregate clinical outcomes data as externally benchmarked with the National Database of Nursing Quality Indicators® (NDNQI). In addition each dashboard displays internally reported risk management events, i.e. falls, pressure injuries, etc. The QNPC works collaboratively with other professional governance councils and liaison committees to ensure hospital-wide nursing education for quality and patient safety initiatives occurs in practice. The QNPC is accountable to the Nurse Coordinating Council to ensure adherence to Magnet standards related to quality and safety.

NURSING CASE REVIEW

Nursing Case Review's purpose is to improve the clinical practice, professionalism and accountability of staff, internal quality control and/or the medical study of nursing in order to reduce morbidity and mortality, eliminate preventable harm, minimize risk to patients, and to improve patient care. Quarterly reports are provided to the Quality Management Council.

H. MEDICAL STAFF QUALITY IMPROVEMENT COMMITTEE

Medical Staff Quality Improvement Committee (MSQIC) is comprised of appointed medical staff members from Anesthesia, Emergency Room, Family Practice, General Surgery, Hospitalist,

Medical Director Cardiac Cath Lab, Medical Staff President, and Internal Medicine. Administrative representatives include vice-president medical affairs, vice-president risk management, director health information management, director medical affairs, and quality improvement coordinator.

Through peer review, the Medical Staff Executive Committee has delegated the following responsibilities to the MSQIC:

- Establish acceptable standards of care across clinical service lines.
- Review individual events relating to patient care, morbidity and mortality, concerns about possible departures from standard medical practice, patient complaints or other source and issues referred to the MSQIC.
- Ensure that physician related clinical contracted services meet quality standards and makes recommendations for renewal of the clinical contracted service.
- Receive and evaluate reports, conduct investigations and make recommendations to the Medical Staff Executive Committee.

The Chairperson of the MSQIC is a member of the Quality Management Council to ensure coordination and communication of assessing clinical quality and patient safety concerns and opportunities for improvement.

The Medical Staff Quality Improvement Committee meets on a quarterly basis

I. PATIENT EXPERIENCE

Patient Experience data is shared and reviewed in the Operating Review meeting biweekly and at monthly leadership meetings, via communication boards, and departmental level meetings. Priorities are identified and action plans developed to improve PX outcomes.

Memorial has a Patient and Family Advisory Council that acts as a resource to drive positive PX outcomes They enhance patient and family collaboration with Memorial administration, management, physicians, and staff in creating a Patient/Family Centered culture.

J. QUALITY IMPROVEMENT COORDINATOR RESPONSIBILITIES

The Quality Improvement Coordinator is responsible for the supervision, planning and implementation of a hospital-wide Quality Improvement and Patient Safety program that is integrated and designed to assess and improve the quality of patient care and patient safety.

The responsibilities of the Hospital Quality Improvement Coordinator are:

- Assumes all day-to-day responsibilities for maintaining an effective Quality Improvement Program.
- Meets with the executive leadership monthly to ensure the hospital-wide quality improvement activities are implemented and evaluated effectively.
- Maintains current knowledge of accreditation standards and state and federal regulations.
- Develops policy and procedures related to documentation of quality improvement activities,
- Provides education, support, consultation and guidance to administration and clinical staff in their monitoring, evaluation and improvement processes.
- Communicates relevant quality improvement information to the appropriate individuals, committees, or departments.
- Conducts education regarding the Quality Improvement Program during the New Provider and New Employee Orientation Programs.

K. CLINICAL DEPARTMENTS, DIVISIONS, SERVICE LINES AND ORGANIZATIONAL DEPARTMENT RESPONSIBILITIES

Clinical departments, divisions, service lines and organizational departments are responsible to assess and monitor the quality of care and services provided in their areas.

Their responsibilities are as follows:

- Identify opportunities for quality improvement and patient safety utilizing the MHE quality methodology.
- Review and report on their quality improvement and safety activities to their respective vice president on a quarterly basis.
- Document the findings, conclusions, recommendations and actions taken and submit to the Quality Improvement Coordinator on a quarterly basis.
- Foster an environment that encourages employee participation in unit/departmental quality improvement and patient safety activities, unit practice councils or quality representative.

L. CONTRACTED SERVICES

The clinical contracted services participate in the hospital's quality improvement program. Performance monitoring will be conducted on all clinical contracted services and will reflect how effective the clinical contract services are relative to the quality of service, high volume, high risk and problem prone or patient safety issues inherent in its processes. Quality improvement data related to the clinical contract service will be analyzed by the responsible administrator/director over that service and submit an evaluation of services performed and recommendations for renewal of the clinical contract to the Medical Staff Executive Committee and the Quality Management Council.

The Medical Staff Executive Committee is responsible to review the physician related clinical contract's evaluation on an annual basis to ensure that services meet quality standards and make recommendations to the board of directors for renewal. The Quality Management Council will review the clinical contracts quality indicators as part of the annual quality improvement program evaluation to ensure their services and performance meets the quality standards.

V. QUALITY IMPROVEMENT METHODOLOGY

Memorial Hospital East's approach to hospital-wide performance improvement is established by the mission, values, guiding principles and organizational strategic goals. This approach is based upon identification of important patient and service processes and outcomes that are prioritized and measured through the use of quality indicators and data collection. Analysis of the collected data is accomplished through statistically valid techniques to assess the performance of the quality of clinical patient care, the efficiency and effectiveness of delivery systems and the level of patient satisfaction provided during the performance of those services.

A. NEW SERVICES AND PROCESS DESIGN

When new services are designed, product lines extended, functions or processes are changed, mechanisms to evaluate are planned and implemented. Measures of performance and targets are established and monitored. Patients, care providers, staff and other key stakeholders are involved in the evaluation process.

B. QUALITY IMPROVEMENT MODEL

When an opportunity for improvement is identified, the FOCUS-PDCA methodology or DMAIC model is employed to make the improvements.

1. FOCUS-PDCA METHODOLOGY

Find a process to improve
Organize a team that knows the process
Clarify current knowledge of the process
Understand cause of process variation
Select the process improvement
Plan the improvement and continued data collection
Do the improvement, data collection, and analysis

Check and study the results
Act to hold the gain and to continue to improve the process

2. **DMAIC LEAN SIX SIGMA METHODOLOGY**
The Lean Six Sigma methodology may be implemented for process improvement projects that are identified as more appropriate to utilize the DMAIC model:
DEFINE Understand the problem, the opportunity and the approach
MEASURE Collect data on current performance/identify most important measures
ANALYZE Achieve an understanding of the sources of variation/process errors
IMPROVE Generate and test possible solutions/develop implementation plan
CONTROL Institutionalize the change/sustain the improvement.

VI. SCOPE OF THE QUALITY IMPROVEMENT PROGRAM ACTIVITIES

The scope of the Quality Improvement Program focuses on continually improving patient care and patient safety. Collaborative and specific indicators of key processes and outcomes of care are designed, measured, and assessed by all hospital departments and services including contract services and focus on measures related to improved health outcomes and the prevention and reduction of medical errors. These indicators are objective, measurable, based on current knowledge and medical evidence and are structured to produce statistically valid measures of care and outcomes. This methodology provides for evaluation of the effectiveness and the stability of the improvement over time. (Refer to Appendix A and B for specific activities and functions).

Participation in External Comparative Databases
Memorial Hospital East utilizes external data and information to compare its performance with that of other facilities and contributes information to external reference databases. Based on comparative data, indicators may require further analysis and action. (Appendix C).

VII. CONFIDENTIALITY

- All quality improvement information shall be developed, maintained and used solely for the improvement of patient care.
- All material is strictly confidential and is limited to those individuals or committees responsible for assessing quality improvement and patient safety or peer review functions.
- All documentation of quality improvement information will be coded in such a manner to prevent disclosure of patient, physician, or healthcare professional identities.

11/14/2019 Reviewed and approved by the Board Quality Improvement Committee

APPENDIX B
List of Quality and Patient Safety Indicators

Department Quality Improvement Activities	Frequency of data collection	Reporting
Accounting		BOD; Dept. Mgmt.
Financials- Outcomes Dashboard	M	
Administration- Patient Advocate		QMC
Grievances Closed within 14 days of receipt	Q	
Round on at least 10 patients per week and check completion of white board with f/u with staff (Lead Measure)	Biweekly	Daily Huddle
Cardiac Cath Lab		
STEMI Timeliness and Process Improvement	M	Chest Pain Comm.
Outpatient follow up calls (inclusive of interventional radiology patients)	Q	QMC
Center for Nursing Practice		QMC
Competency level and retention of first year nurses	Q	
Nurse Resource program	Q	
Central Processing		QMC
Surgical Tray Error Rate	M	
Positive Biological Indicator	M	
IUSS rate	M	
Communications		QMC
Minutes on phone call (lead measure)	Q	Huddle group
Community Relations		QMC
Open rate of newsletter (Lead Measure)	Biweekly	Daily Huddle
Dietary Food and Nutrition		QMC
Compliance with dietitian charting requirements	Q	
On-time meal delivery (trays delivered within 45 minutes of ordering)	M	
Environmental Services	Q	QMC; Infection Prevention
ATP testing		
Laboratory		QMC
STAT ED Lab turn-around-times (% within 30 minutes)-many	M	
Out-patient – Critical value results reported within 60 minutes	M	
Microbiology – Blood culture contamination rate	M	
Blood Bank – Adverse transfusion reaction	M	
Blood usage by product and blood type	M	
Blood product wastage	M	
Redraw rates	M	
Blood culture vol.	M	
Stat antibody screens TAT	M	
Cardiovascular Unit (Echo, Vascular, EEG)		Cardiovascular Section
Echocardiogram reporting with Ejection Fraction documented	M	
Echo exams read within 24 hours	M	
EEG exams read within 72 hours	M	
Facilities- see also EOC indicators	Biweekly	Daily Huddle
100% completion of all critical utility PM's on a monthly basis.(Lead measure)		
Weekly rounds to patient rooms, to ensure cosmetically & physically good condition.(Lead Measure)		
Human Resources		Dept. Mgrs.
Staff Turn-Over Rate- Outcomes Dashboard	M	

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APPENDIX A

Frequency and details of data collection

Details	Frequency	1Q	2Q	3Q	4Q	PRIORITY
CMS Quality Programs	Quarterly	X	X	X	X	HIGH
Patient Safety Measures	Quarterly	X	X	X	X	HIGH
Efficiency of Services	Quarterly	X	X	X	X	HIGH
Patient Satisfaction/HCAHPS	Quarterly	X	X	X	X	HIGH
Patient Grievances	Quarterly	X	X	X	X	HIGH
Critical Incident Review	Quarterly	X	X	X	X	HIGH
External Quality Data	Within the quarter received					HIGH
Medical Staff Functions and Measures	Quarterly	X	X	X	X	HIGH
Nurse Sensitive Measures	Bi-annual		X		X	HIGH
Hospital Department Level Measures	Quarterly	X	X	X	X	Medium
Contracted Services	Annual		X			HIGH
Restraint Use	Annual		X			HIGH
Organ and Tissue Procurement	Annual		X			HIGH

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APPENDIX A

Frequency and details of data collection

Details	Frequency	1Q	2Q	3Q	4Q	PRIORITY
CMS Quality Programs	Quarterly	X	X	X	X	HIGH
Patient Safety Measures	Quarterly	X	X	X	X	HIGH
Efficiency of Services	Quarterly	X	X	X	X	HIGH
Patient Satisfaction/HCAHPS	Quarterly	X	X	X	X	HIGH
Patient Grievances	Quarterly	X	X	X	X	HIGH
Critical Incident Review	Quarterly	X	X	X	X	HIGH
External Quality Data	Within the quarter received					HIGH
Medical Staff Functions and Measures	Quarterly	X	X	X	X	HIGH
Nurse Sensitive Measures	Bi-annual		X		X	HIGH
Hospital Department Level Measures	Quarterly	X	X	X	X	Medium
Contracted Services	Annual		X			HIGH
Restraint Use	Annual		X			HIGH
Organ and Tissue Procurement	Annual		X			HIGH

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Department Quality Improvement Activities	Frequency	Reporting
Nursing Service – Structure Indicators		QMC; QNPC
Birth Data	Q	
Lactation Consultant Hours	Q	
Nurse Turnover Rate	Q	
Nursing Care Hours – Unit Level	Q	
Nursing Care Hours – Perioperative	Q	
ED Patient Volume	Q	
RN Education	Q	
RN Certification	Q	
Outpatient Surgery/ Endoscopy		QMC
Outpatient follow up calls	Q	
Pastoral Care		QMC
Connect with the charge nurse/Clinical leader or attend rounds on all medical/surgical units and ED (Lead Measure)	Biweekly	Daily Huddle
Patient Access		QMC
Registration accuracy		
MPS completion for Medicare pts.		
Quality Improvement and Risk Management		QMC
Offer QI services to all departments every month (Lead Measure)	Biweekly	Daily Huddle
Radiology		QMC
Repeat images on x-ray equipment (d/t positioning, artifact, etc.)	M	
ED TAT ordered>taken	M	
CT Scan		QMC
Renal Failure patients completed	M	
Head CT results within 45 minutes	M	
ED ordered > started	M	
Nuclear Medicine		QMC
Patient preparation issues	M	
Ordered to taken ED (on call)	M	
Ultrasound		QMC
Ultrasound Exam Ordered to Taken ED on call: <2 hrs.	M	
Patient preparation issues	M	
Repeat patient (imaging quality)	M	
Mammography		QMC: Breast Health Comm.
Report TAT (Percent within 24 hours)	M	
Time from Screen to Diagnostic Mammogram (Days)	M	
Diagnostic Call Back Rate	M	
Diagnostic to Surgery / Excisional biopsy	M	
Time from Needle Biopsy and initial surgery (Days)	M	
MRI		QMC
Serious MRI safety issues	M	
Call backs/rescanned patients	M	
ED ordered>taken (on call)	M	
Respiratory Care		QMC
Critical Test Result Reporting	M	
Initial nebulizer assessments performed w/i 4 hours from order	M	
Complete CAB scores on ED peds pts.	M	
Decrease # of brachial sticks	M	

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Department Quality Improvement Activities	Frequency	Reporting
Rehabilitation Therapy (PT/OT/ST/Audiology)		QMC
IP PT, OT-Patient goals included in evaluation	M	
IP PT-Evaluation not completed w/i 24 hrs.	M	
OT,ST-Inpatient missed treatments	M	
OT-# of patients d/c prior to eval	M	
OP PT-% HFAP compliance recheck	M	
OP PT,OT,ST-Quality of care excellent rank	M	
OP PT,OT,ST-Quality of care % excellent	M	
OP PT,OT,ST-75th percentile	M	
Social Services – Discharge Planning		QMC
Readmission-related		
Supply Distribution		QMC
Safety issues	Daily	
Stockouts	Daily	
Mispicks	Daily	
Rush orders	Daily	
Transport Department		QMC
Transport times- receipt to arrival, dispatch to complete, receipt to complete	Q	
Environment of Care Committee		QMC
Medical Equipment Management: **(Clinical Engineering)** Medical equipment preventive maintenance completed as scheduled (PM Completion Rate)	Q	
Utilities Management– Generator testing, medical gas systems testing, battery powered lights testing completed as scheduled, Unplanned outages, ACH verification, Waterborne pathogens testing completed as scheduled	Q	
Hazardous Material and Waste Management: **(Environmental Services)** Laundry Reduction in PIMW, Hazardous spill incidents, Hazardous spill incidents	Q	
Environmental Safety Rounds- Identification of safety hazards and non-compliance	Q	
Life / Fire Safety Management– Fire drills completed as scheduled, kitchen hood testing completed as scheduled , maintenance of fire doors and smoke barriers, accidental fire alarm activations, actual fires reported, interim life safety measures implemented, fire watch rounds completed as scheduled	Q	
Safety & Security Management **(Security)** – Serious hazards identified, Code Pink drill completed as scheduled, infant abduction alarm activations, thefts, violent or weapons related incidents with police response	Q	
Emergency Management - Emergency readiness drills completed as scheduled	Q	
Occupational Health: Employee Accident Analysis	Q	
Emergency Department		MSQIC
Mortality in Emergency Department	M	
Pain Management – Long bone fracture (core measure)	Q	
AMI/chest pain- Median time to EKG	Q	
Severe Sepsis and Septic Shock	Q	
Stroke – Head CT performed and result communicated within 45 min of arrival	Q	
ED Throughput - Arrival to departure (median minutes)	Q	
ED Throughout - Arrival to admit (median minutes)	Q	
Emergency Department Approved for Pediatrics (EDAP age 0-17) Pediatric pain management; seizure management, code blue, mortality	Q	

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Critical Care		Crit. Care
ICU Mortality	Q	
Critical Assessment Team (CAT) Call Rate and Outcome	Q	
VAE Rate	Q	
ICU Utilization Measures	Q	
Pathology		QMC; MSQIC
Pathology – Pathology report turn-around-time (% within 2 days)	Q	
Pathology – Cytology report turn-around-time (% within 2 days)	Q	
Pathology – Bone Marrow report turn-around-time (%within 4 days)	Q	
FNA results w/in 2 d	Q	
Frozen section w/in 20"	Q	
Clinical Radiology		MSQIC
Radiology Discrepancy Review	Q	
Turn-around-time for radiology exams	Q	
Interventional Procedure Complications	Q	
OB-GYN Department		MS OB Dept.
C/Section, Primary, Repeat	BiM	
Early Elective Delivery Rate <39 weeks gestation (core measure)	BiM	
Emergency C/Section Decision to Incision (<=30 min)	BiM	
Obstetric Complications	BiM	
Perinatal Morbidity and Mortality Committee		PMM Comm
Maternal / Neonatal Transfers	S	
Neonatal/Fetal Death Review	S	
Maternal Death Review	S	
Ante/Post-Partum Women in ICU or Received Blood Transfusion	S	
Medical Staff Quality Improvement Committee and Peer Review		MSEC: MSQIC
Transfusion Utilization Review	Q	
Mortality / Quality of Care Review	Q	
CMS Clinical Core Measure Compliance	Q	
Transfusion Utilization Review / Blood Utilization Committee		MSQIC/
Appropriate indication for blood transfusion	M	
Adverse transfusion reaction	M	

Department Quality Improvement Activities	Frequency	Reporting
Surgical Service		MSQIC
Perioperative Mortality within 48 hours of Surgery	M	
Accidental Laceration or Injury	M	
Unplanned Return to OR	M	
Surgical Site Infection	M	
Anesthesia/Perioperative		MSQIC
Perioperative Mortality w/i 48 hrs.	M	
CNS/Peripheral Deficit w/i 48 hrs.	M	
Cardiac Arrest w/i 48 hrs.	M	
Acute MI w/i 48 hrs.	M	
Other injuries (dental/face/lip/skin burn)	M	
Medication Safety Committee / Pharmacy & Therapeutic Committee		QMC
Drug Usage Evaluations	Q	
Significant Adverse Drug Reaction	M	

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Medication Events	M	
Adverse Drug Events: Anticoagulation, Opioids	M	
Medication Over Ride	M	
E-Mar Process Issues: Bar code scanning	M	
Pharmacy Floor Inspections	M	
HCAHPS - Communication to Patient Regarding Medication	M	
Time Critical Medications Administration within 60 minutes	M	
High Alert Medication Events	M	
Health Information Management		MSEC
Timely Completion of H&P / H&P prior to surgery	M	
Timely Completion of Discharge Summary (within 30 days of discharge)	M	
Delinquent Record Completion	M	
Utilization Review/Care Management		UR Comm
Length of Stay	M	
Readmissions within 30 days	M	
Avoidable Days and Denied Days	M	
Insurance Denials	M	
Infection Control and Prevention		Infection Prev. Comm.
Hand Hygiene Compliance	Q	
Surgical Site Infection	Q	
Central Line Associated Blood Stream Infection – all units	Q	
Cather Associated Urinary Tract Infection – all units	Q	
Ventilator Associated Conditions (VAC/VAE/VAP)	Q	
Hospital Acquired Infections: C. Difficile, MRSA, Multi-Drug Resistant Organism	Q	
Isolation Compliance(>80%)	Q	
Hand hygiene compliance	Q	
EOC survey rounds- (100% completion)	Q	
EVS- ATP Performance (>85%)	Q	
Legionella Water Testing(Neg/Pos)	Q	
Heterotrophic Bacteria Excess	Q	
Dialysis Cultures (Neg/Pos)	Q	
Pharmacy Cultures (Neg/Pos)(compounding sterile preparations)	Q	
Instrument Error Rate	Q	
IUSS RATE	Q	
CSPD Biological (Neg/Pos)	Q	
Patient Safety Committee		QMC
AHRQ PSI 90	Q	
Hospital Acquired Conditions (HACs)	Q	
Patient falls	Q	
Hospital acquired pressure injuries	Q	
Restraint use	Q	
Organ/tissue Donation		QMC
Request for organ donation - documentation completion rate	A	
Organ and Tissue donations obtained	A	
Stroke Accreditation - AHA GWTG Measures	Frequency	Stroke Committee
Lab studies performed within 45 minutes	M	
Neuro-Imaging door to CT within 25 min	M	
Thrombolytic therapy within 3 hrs	M	
Discharged on antithrombotic therapy	M	

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Anticoagulation therapy for Atrial Fib	M	
Venous Thromboembolism (VT) prophylaxis	M	
Discharged on Statin therapy	M	
Stroke education	M	
Dysphagia screening	M	
Assessed for Rehabilitation	M	
NIHSS score documented	M	
Performance Improvement Projects- Clinical Excellence Scorecard- mortality, patient safety, patient satisfaction, effectiveness	Q	QMC

Legend: M= Monthly, Q = Quarterly, S = Semiannual, A = Annual yearlong project
Legend: QMC = Quality Management Council, NQC = Nursing Quality Council, MSQIC = Medical Staff Quality Improvement Committee, MSEC= Medical Staff Executive Committee

Nurse Sensitive Indicators-2020

- All nursing units participate in NDNQI clinical and staffing outcomes indicators as appropriate to their nursing unit. When opportunities for improvement are evident a clinical outcomes or staffing indicator is selected for focused quality improvement activities through the determination of two nurse sensitive indicators (NSI) for the year.
- In addition, other clinical outcomes may be identified that are benchmarked at the highest level (internal, State, National, etc)

Unit	Indicator	Compare Information
4th-Med-Surg	• Falls/Falls with Injury • HAPI	NDNQI NDNQI
5th Cardiac Tele	• Falls/Falls with Injury • HAPI	NDNQI NDNQI
ICU	• Ventilator Associated Events • HAPI	NDNQI NDNQI
ED	• Turn-Around-Time • Falls/Falls with Injury	Internal NDNQI
OR	• Closing Debriefing • Skin & Wound Assessment	Internal Internal
OPS/PACU/ATC	• Family/SO Education • Pain Management	PRC Score Internal
FCBC *Well Newborns* *Level II Nursery-NICU*	• Falls-Falls w/Inj/Epidural Patient • Safe Sleep-well babies • Breast Milk Storage	NDNQI Internal
CCL/CV	• Medication Documentation • Pt. Education-Post Procedure	Internal Internal

APPENDIX C
Participation in External Comparative Databases

Memorial Hospital East utilizes external data and information to compare its performance with that of other facilities and contributes information to external reference databases. Based on comparative data, indicators may require further analysis and action. Participating databases and registries include, but are not limited to:

- CMS Scope of Work and Illinois Quality Improvement Organization (QIO) Comparison with national and statewide baseline clinical performance measures,
- National Database of Nursing Quality Indicators (NDNQI) to evaluate nursing care related to patient safety and quality improvement efforts by providing research-based data and the relationship of this care to patient outcomes,
- National Cardiovascular Data Registry (NCDR) to support self-assessment and quality improvement at the provider/hospital level for Chest Pain Accreditation,
- Professional Research Consultants Satisfaction Survey to evaluate patient satisfaction and HCAHPS (Hospital Consumer Assessment of Healthcare Providers Systems),
- National Cancer Database and Illinois State Cancer Registry to evaluate the incidence of cancer and survival outcome,
- AHA Get With The Guidelines (GWTG) Stroke Registry
- Midas/ Conduent Health Analytics Solutions uses patient-centric data to manage, measure and monitor quality to patient safety to improve financial and clinical outcomes.
- Vizient Clinical Database- healthcare performance improvement company

APPENDIX D
Organizational Strategic Quality Improvement Goals

- Achieve 75th percentile rank for "overall quality of care" on patient satisfaction surveys.
- Achieve 75th percentile rank in all domains of HCAHPS surveys.
- Achieve meeting the US average scores in public reporting initiatives: Core measures, Hospital acquired conditions (HAC), Hospital acquired infections (HAI), Readmissions and Mortality. Track clinical processes and results, compare those elements against national, state and internal benchmarks, and respond with quality improvement initiatives.
- Achieve the established target performance scores for the Clinical Excellence Scorecard measures as established by Barnes Jewish Christian Clinical Excellence Scorecard and Measures of Success programs.
- Maintain a constant state of readiness and compliance with accreditation and regulatory agencies. Leadership assignment of key staff to be responsible for HFAP accreditation and IDPH rules and regulations.

APPENDIX E

Quality Improvement Program
Structure
2020

- Board of Directors
  - Medical Staff Executive Committee
    - Medical Staff Quality Improvement Committee and Peer Review
    - Credentials Committee
  - Quality Improvement Board Committee
    - Quality Management Council
      - CMC Subcommittee
        - NQF Serious Reportable Events
        - SPP NP Events
        - Grievances
        - Nursing Quality Peer Review
      - Patient Safety Committee
        - Occurrence Event Review
        - Medication Safety
        - Hospital Acquired Conditions (HAC)
        - AHRQ Patient Safety Indicators (PSI)
        - NQF 30 Safe Practices
      - Public Reporting Initiatives
        - CMS Hospital Compare Timely & Effective Care
        - CMS Hospital Readmissions Reduction Program
        - CMS Complications and 30 day Mortality
        - CMS Healthcare Associated Infections
        - HCAHPS / Patient Experience
        - DPH Hospital Report Card Act
      - Benchmark and Comparative Measures
        - NDNQI Nurse Sensitive Measures
        - Stata piMD Physician Performance Review
        - ACC-NCDR Cardiac Cath PCI Registry - Chest Pain Accreditation
        - Get With the Guidelines – Stroke Accreditation
        - ACS Improving Surgical Care and Recovery
      - Quality Improvement and Lean Six Sigma Initiatives
        - Hospital Wide QI Team Process Improvement & Lean Six Sigma
        - Operating System Daily Huddle Problem Identification
        - Department Specific Management Measures
        - Contract Services QI Activities
        - Quality and Nursing Practice Council
      - Environment of Care / Culture of Safety
        - Environment Safety, Workplace Violence, Occ Health
        - Building Security & Fire Safety
        - Hazardous Materials and Waste
        - Medical Equipment Management
        - Utility System Management
        - Emergency Management

ATTACHMENT 6

#7