THE OHIO STATE UNIVERSITY

OFFICIAL PROCEEDINGS OF THE

SIXTH MEETING OF THE

WEXNER MEDICAL CENTER BOARD

Columbus, Ohio, August 29, 2014

The Wexner Medical Center Board met on Friday, August 29 at the Longaberger Alumni House, Columbus, Ohio, pursuant to adjournment.

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Minutes of the last meeting were approved.

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Mr. Wexner called the meeting of the Wexner Medical Center Board to order on Friday, August 29, 2014 at 9:04 am.

Present: Leslie A. Wexner, Chairman, Cheryl L. Krueger, Abigail S. Wexner, Corbet A. Price, David B. Fischer, Stephen D. Steinour, John F. Wolfe, Jeffrey Wadsworth, Michael V. Drake, Steven G. Gabbe, Geoffrey S. Chatas, Edmund F. Funai, E. Christopher Ellison, and Michael A. Caligiuri.

Mr. Wexner:

Good Morning. I would like to convene the meeting and remind everybody to turn off their electronic devices. Ms. Link, would you note the attendance please?

Ms. Link:

A quorum is present, Mr. Chairman.

Mr. Wexner:

The minutes of the June meeting of the Wexner Medical Center Board were distributed to all members of the Board, and if there are no additions or corrections, the minutes are approved as distributed.

Dr. Drake, I want to welcome you.

President Drake:

Thank you.

Mr. Wexner:

It is good to have you here.

President Drake:

Thank you, I appreciate that. It is good to be here.

Mr. Wexner:

We've got a tight agenda today. The target is to end at 10:00 am and then we will go into an executive session. I will begin with Dr. Gabbe.

Dr. Gabbe:

Thank you. We have several resolutions that we must pass as part of the accreditation requirements. They are included in your books.

The first is the Plan for Patient Care Services for University Hospitals which includes the Ross Heart Hospital, Harding Hospital, University Hospital East, and University Hospital. This plan has been approved by our Quality and Professional Affairs Committee of the Wexner Medical Center Board on July 16, 2014. It has also been approved by the University Hospital Medical Staff Administration Committee.

PLAN FOR PATIENT CARE SERVICES

Resolution No. 2015-74

UNIVERSITY HOSPITALS

Synopsis: Approval of the annual review of the plan of care and scope of services for The Ohio State University Hospital, Richard M. Ross Heart Hospital, Harding Hospital, and University Hospital East, is proposed.

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

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

WHEREAS the plan of care and scope of services for The Ohio State University Hospital, Richard M. Ross Heart Hospital, Harding Hospital, and University Hospital East were approved by the Quality and Professional Affairs Committee of the Wexner Medical Center Board on July 16, 2014 and are being recommended to the Wexner Medical Center Board for approval:

NOW THEREFORE

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

(See Appendix I for background information, page 19)

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Dr. Gabbe:

We have the Plan for Patient Care Services as well for the Arthur G. James Cancer Hospital. These plans are generally approved annually. This was also approved by the Quality and Professional Affairs Committee of the Wexner Medical Center Board on July 16, 2014, and by the James Medical Staff Administration Committee.

PLAN FOR PATIENT CARE SERVICES

Resolution No. 2015-75

ARTHUR G. JAMES CANCER HOSPITAL

Synopsis: Approval of the annual review of the plan of care and scope of services for the Arthur G. James Cancer Hospital, is proposed.

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

WHEREAS the plan for inpatient and outpatient care describes the integration of clinical departments and personnel who provide care and services to patients at the Arthur G. James Cancer Hospital; and

WHEREAS the plan of care and scope of services for the Arthur G. James Cancer Hospital was approved by the Quality and Professional Affairs Committee of the Wexner Medical Center Board on July 16, 2014 and are being recommended to the Wexner Medical Center Board for approval:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board approves the plan of care and scope of services for the Arthur G. James Cancer Hospital as outlined in the attached Plan for Patient Care Services.

(See Appendix II for background information, page 29)

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Dr. Gabbe:

We have a resolution to support the verification of our burn center. This verification process occurs every three years. We are one of only three adult burn centers in the state. Nationwide Children's is verified for pediatric burn care. The burn center will have a site visit on September 9th and 10th. It will be its third verification site visit to be approved by the American Burn Association and the American College of Surgeons Committee on Trauma. This has been supported by the University Hospitals Medical Staff Administration Committee.

BURN CENTER VERIFICATION

Resolution No. 2015-76

Synopsis: Support for Burn Center verification, is proposed.

WHEREAS the Ohio State University Wexner Medical Center's mission includes teaching, research and patient care; and

WHEREAS, the Ohio State University Wexner Medical Center is cognizant of the resources needed to support a verified Burn Center and the contribution of this program to its tripartite mission:

NOW THEREFORE

BE IT RESOLVED, That the Ohio State University Wexner Medical Center Board supports the application for Burn Center verification by the American Burn Association and the American College of Surgeons, Committee on Trauma.

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Dr. Gabbe:

We have two Clinical Quality Management, Patient Safety and Service Plans. Again, these are generally reviewed annually. The first is for University Hospital, Ross Heart Hospital, Harding Hospital, and University Hospital East. We also have the Clinical Quality Management, Patient Safety and Service Plan for the Arthur G. James Cancer Hospital. Both of these plans were also approved by the Quality and Professional Affairs Committee of the Wexner Medical Center Board on July 16, 2014 of this year. They have also been approved by each of the hospitals' Medical Staff Administration Committees.

CLINICAL QUALITY MANAGEMENT, PATIENT SAFETY AND SERVICE PLAN

Resolution No. 2015-77

UNIVERSITY HOSPITALS

Synopsis: Approval of the annual review of the Clinical Quality Management, Patient Safety and Service Plan for The Ohio State University Hospital, Richard M. Ross Heart Hospital, Harding Hospital, and University Hospital East, is proposed.

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

WHEREAS the Clinical Quality Management, Patient Safety and Service Plan outlines assessment and improvement of processes in order to deliver safe, effective, optimal patient care and services in an

environment of minimal risk for inpatients and outpatients of The Ohio State University Hospital, Richard M. Ross Heart Hospital, Harding Hospital, and University Hospital East; and

WHEREAS the Clinical Quality Management, Patient Safety and Service Plan for The Ohio State University Hospital, Richard M. Ross Heart Hospital, Harding Hospital, and University Hospital East were approved by the Quality and Professional Affairs Committee of the Wexner Medical Center Board on July 16, 2014 and is being recommended to the Wexner Medical Center Board for approval:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board approves the Clinical Quality Management, Patient Safety and Service Plan for The Ohio State University Hospital, Richard M. Ross Heart Hospital, Harding Hospital, and University Hospital East.

(See Appendix III for background information, page 41)

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CLINICAL QUALITY MANAGEMENT, PATIENT SAFETY AND SERVICE PLAN

Resolution No. 2015-78

ARTHUR G. JAMES CANCER HOSPITAL

Synopsis: Approval of the annual review of the Clinical Quality Management, Patient Safety and Service Plan for the Arthur G. James Cancer Hospital, is proposed.

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

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

WHEREAS the Clinical Quality Management, Patient Safety and Service Plan for the Arthur G. James Cancer Hospital was approved by the Quality and Professional Affairs Committee of the Wexner Medical Center Board on July 16, 2014 and is being recommended to the Wexner Medical Center Board for approval:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby recommends the attached Clinical Quality Management, Patient Safety and Service Plan for the Arthur G. James Cancer Hospital be recommended to the Board of Trustees for approval.

(See Appendix IV for background information, page 74)

Dr. Gabbe:

I'd be happy to answer any questions. If not, I'd move that these resolutions be approved.

Mr. Wexner:

Good. So a motion has been made is there a second?

Upon motion of Dr. Gabbe, seconded by President Drake, the Wexner Medical Center Board members adopted the foregoing motion by unanimous roll call vote, cast by board members Mr. Chatas, Dr. Gabbe, President Drake, Dr. Wadsworth, Mr. Price, Mrs. Wexner, and Ms. Krueger.

Mr. Wexner:

Thank you, Geoff.

Mr. Chatas:

Thank you. Yesterday, the Board of Trustees reviewed the fiscal year 2015 budget for the university which includes the Wexner Medical Center and all its components: the health system, the College of Medicine, and the physicians practice group.

Today, we are asking this Board to review and recommend approval of the Health System budget. Mr. Geier will review that with us now.

Mr. Geier:

Thank you. Let's do quick recap of last year. We covered these numbers with the Board. This is for the full fiscal year that ended June 30, 2014. We are on budget on most of our metrics and on budget on margin. We are on budget with EBIDA at 14%, as well as on budget with our days cash on hand and debt service coverage. We are underway with the university audit on the fiscal year 2014.

A quick look at how the year has started out. In the month of July, the first month of our fiscal year, our activity levels are on budget. I would expect, taking a look at the August activity levels of admissions and surgeries and outpatient visits, that those yellow lines will likely be green in terms of volume. We are quite busy, quite full in terms of admissions and surgical activity.

As you drop down on the income statement, one of the things we have been watching closely is our revenue and expense per adjusted admission. This is a good volume of activity adjusted indicator. At least for this month, the expense for adjusted admission was pretty flat and actually lower than it was in the same month a year ago on higher volume. That all translated into a good operating month in terms of operating performance. All of the hospitals and operating units were on budget or above budget. At least for the first month, EBIDA was about 17%; our days cash is up to 75, which will move around obviously through the year; debt service coverage at 7. The first month was off to a good start for fiscal year 2015.

Turning to the budget, these are kind of the major assumptions for this year's fiscal budget around revenue and volumes. We have factored in Medicaid expansion that is providing some growth. We don't have any price increases built into our budget for the third straight year.

In terms of admissions and outpatient visits, and we have talked about this, it is going to be an interesting year with the opening of the new hospital. It creates some real challenges in terms of opening, it would almost be a story of two years; or two different years when the hospital opens in terms of what happens before and what happens after. When we get through the opening, we expect the admissions to grow about 2% overall. A lot of that is due to the new hospital. As I said, we are full now.

We will be opening some new beds and about 5.6% growth in outpatient visits. That is a little lower than what we've had. In past years, we've been growing about 7% to 8%. I will just remind the committee that we had been opening new ambulatory space around Columbus at a pretty progressive clip. We are now filling those up which makes it a normalized rate of growth.

Our surgical volume is at 1.5%. We've recruited a lot of new surgeons and will be opening up more surgical space in the new hospital. Outpatient surgeries are up about a half percent. We don't see any

change in our case index. If it does, from severity, that obviously is a positive. We have not factored anything in relative to changing our length of stay.

Our beds, with the opening of the new tower, will increase from about 1,172 to 1,367. We will begin backfilling, over the course of the year and into next year, the beds in University Hospital and what would be considered the old James Cancer Hospital building.

On the expense side, we have raises of 2% for those employees earning up to $250,000. We have about 3% increase in our pharmacy expense, adjusting for volumes. We reported the James Cancer Hospital is opening up a new retail pharmacy. We have an increase in inventory of about $25 million to open that pharmacy. We think this is great for patient care and also from a financial standpoint. That pharmacy is now open and will be serving our customers when the new building opens up.

We take on the debt for interest expenses and I will show you the balance sheet in terms of what happens with the balance sheet of the hospital system. All of the debt for the new facility comes on this year. Our interest expense is up about 182%, you'll see that in the operating margin. Depreciation, which is a non-cash item, is still up about $25 million as we start to depreciate the new building, and that is up about 33%. Those are probably the two largest increases in expenses on the income statement.

We have about $68 million in annual capital expenditures. We continue at our historical level of cash transfers to the College of Medicine that go to support the academic and teaching endeavors of about $100 million in this budget.

This is just a breakdown of the units. When we put all this together, the top box is really direct cost before we allocate out: physician practice costs; shared service, which are typical shared services; accounting; facilities; finance; and then depreciation and interest. This shows you those varying units; hospital operations and the ambulatory operations which are primary to the surgical center, CarePoints, and our employed physician groups. At the bottom, once we fully allocate out, which we do typically by beds, you can see the units on a fully expense basis. We go from $218 million to about $183 million again, primarily with the increases in expenses.

I would like to point out a couple of things on the balance sheet. You get a sense of our cash growth, which are our reserves and how we did, and the budget for this year. If you look at the liabilities, you can get a sense of the debt. This is the full amount of the debt. It never reached $1 billion because we began borrowing it early when we could pay it off early. This is the peak year when all the debt comes on the balance sheet of the hospital system and we begin paying that down over the next 20 years.

In terms of a summary, this shows where some of the opportunities are and the risks in this budget. We've got it underway with a lot of targeted savings in our non-labor and can do a lot better with that. We are seeing benefits in payer mix with the Medicaid expansion, but we're also seeing some increases inpatient receivables as the high deductible plans come. We are watching that as a nationwide trend. I talked about the case mix index. If we do better with coding our severity, it leads to better reimbursements. We've got efforts underway on collections on the receivables of high deductible plans. Again, that is something that we're going to have to continue to watch closely and we are doing that with PricewaterhouseCoopers.

If our research grants in the college exceed plan, it will take pressure off cash transfers to the college because the research grants and philanthropy can help fund the academic endeavors. Some of the risks are cost overruns with the new hospital. I think we feel pretty comfortable, I know Jay is going to report on this, the cost of the build is in pretty good shape. Obviously, once you get into a new building, people will start requesting various changes. We are watching that closely in terms of any cost exceeding after we move in. We have tried to make some reserves for that.

Admission numbers are heavily dependent on the opening of the hospital on time. Dr. Caliguiri is here and can comment on some of the plans relative to the new hospital. We are full and our emergency department is full. Every day the physicians do a great job of getting our patients in to the hospital but we do have an issue with capacity right now. Another risk is if we lose any high volume surgeons, like we

experienced last year. We don't see any on the horizon. We count on philanthropy and probably need to count on philanthropy more and more to help fund some of our cash needs. That concludes my presentation on the fiscal year 2015 health system budget.

Mr. Wexner:

Questions?

Mr. Steinour:

Pete, with the new building, there is $68 million CAPEX, is that a run-rate CAPEX and what would it be used for?

Mr. Geier:

It's a run-rate. It is the annual capital budget and is generally used for everything from fixing up the carpet, paint, patch and repair, and new facilities. It's probably too low in terms of what we would need if you look at our depreciation number. Our plan is to start moving that back up because that's really going back into what I would consider the older facilities and not necessarily the newer facilities.

It is annual capital budget for, as I said, room fix-up, Sports Medicine Institute, but it's an annual cash item.

President Drake:

I have a question about the influence of Medicaid expansion on the case mix index. You mentioned those as being flat earlier and then show this sort of pull and push here on the second line. Just a word about that in a little more detail?

Mr. Geier:

We have seen the benefit from Medicaid expansion and much of that benefit has accrued financially to University Hospital East. We have not yet seen a change at all in our case mix index, relative to the Medicaid expansion. It's early. The only change we've seen is that we are seeing an increase in our patient receivables relative to people who either now have Medicaid but still have a high deductible or they are going into the high deductible plans on the exchanges. We have not seen a case mix yet. That's one of the things we are keeping an eye on.

Mr. Wexner:

I wanted to follow up on Steve's question about the depreciation or the CAPEX, what should it be?

Mr. Geier:

Our depreciation number is approximately $80 to $90 million. I think a good rule of thumb is to be 120% to 130% of that number. We are low now. We plowed a lot of money with the expansion back into University Hospital and Doan Hall but that was primarily in the HVAC, not into the rooms. Rooms are still semi-private. It should be closer to $100 million from a CAPEX standpoint annually.

Mr. Wexner:

For this Board and to get a better understanding on the details of the hospital, I never heard about the pharmacy business. You say it's a good business and it has a $25 million inventory. How good a business is it to invest $25 million?

Dr. Caligiuri:

It should be a very good business and we have a business plan for it. There is a margin on there of about $1 million or so a year that we should be making. It's chemotherapy; it's our ability to purchase chemotherapy which is incredibly expensive. We have to stock up on expensive chemotherapy to get the pharmacy going and that's where the original expense comes from.

Dr. Loborec:

The pharmacy that is going into the new James Cancer Hospital is known as a "Specialty Pharmacy" and is separate from the traditional pharmacy that you may be thinking of. The pharmacy will stock high cost medications such as the oral chemotherapy medications that he mentioned. To give you a specific example, a new medication called Sofosbuvir, which is used to treat Hepatitis C. A typical six month course of this new medication will cost $168,000 for patients to receive this treatment. There is an overall large cash advance from doing this. In terms of the University HealthSystem Consortium of academic medical centers, we really are behind the curve. We are one of the few institutions that do not already have a specialty pharmacy within our hospitals and we lose a lot of revenue because of it. Everyone is getting those medications from elsewhere.

Mr. Geier:

That increases the inventory for this year. You get a one-time increase when you open it, that's what's running through the PNL statement.

Mr. Price:

Are you getting any drugs on consignment or anything like this or are you just buying them out right?

Mr. Geier:

I believe buying out right but I'm not completely certain.

Mr. Wexner:

I don't know anything about this and I am not a pharmacist, but from a business point of view, a $25 million investment that makes 4% isn't a great investment. It would be very difficult to say this is really a business. It might be a good social need and maybe we should do it.

Dr. Loborec:

Some other things to add is that a specialty pharmacy does not carry traditional medication, only these very special medications and in order to get them, each medication that you stock requires a specific contract with each of these suppliers. It takes a significant amount of time to set up the contracts and infrastructure. Within the first year that we have this facility, we are only focusing on a very low number of medications. After a number of years, when we have built ourselves up to the standard of other specialty pharmacies, the revenue will be much higher. It does increase incrementally over the next few years.

Mr. Wexner:

Again, my intention isn't to be tough about it but when a business is described as a good business that potentially makes 4% on a $25 million investment; I just shake my head. Then you say it is going to get much better, I don't know how you define much better; 6%, 10%.

Dr. Loborec:

I don't have the numbers in front of me but I am happy to discuss the data with you at a later time.

Dr. Caligiuri:

We should get the business plan in front of the Board. Is Jeff Walker here? He might be able to add to that.

Mr. Walker:

I am not going to be able to add too much more to what has been talked about regarding a specialty retail pharmacy and the business plan. The other practicality here is that this will give us the access to certain chemotherapeutic agents that we need for our patients. Though it will be profitable, and again we should bring the business plan back, it's also helping secure business going forward for our patients.

Mr. Wexner:

I will look to see the plan. Any other questions?

Mr. Price:

I just have an observation here. In terms of operational growth or unit for ambulatory care, have you looked at those numbers? If not, could you look at them going forward to report in so we can get a sense of what is going on so that we don't come in and say that revenues are up because you added a new unit. We need to compare the current units.

Mr. Geier:

We can do that. We don't have any plan openings this year. That's a good number to look at going forward.

Mr. Price:

Can we add to the financial report?

Mr. Steinour:

Could we also ask for a return of a CAPEX plan looking at it on a more long-term basis and have an appreciation for this run-rate increase please?

Mr. Geier:

Yes, we can do that.

Mr. Wolfe:

When we had a private meeting on finances, you showed expectations for the next five years. I think that would be helpful to see what the trend lines are both in income and bottom line. Also, with your payer contracts coming up in 2016, what assumptions are you going to make as far as reimbursement? Are they going to be Medicaid/Medicare reimbursement rates or are they going to be a premium over that?

Mr. Geier:

Yes, we can bring all that back.

Mr. Price:

Given the headwinds that we are going against right now with days cash on hand, I'd like for the Board to fully understand that where we are is anemic. We should be well above 120+ days. As things get tighter, we will have to depend upon that. I know that there is a concept that the university will step in and start feeding us cash as we need it but I think as a unit we should be on a standalone basis to be able to ensure that we maximize the days cash on hand going forward.

Mr. Wexner:

We talked about that and I think it is good to have that common understanding. This year we increased days cash by four days and that was how many millions of dollars?

Mr. Geier:

About $33 million.

Mr. Wexner:

If you want to get from 75 days cash on hand to 125 days cash on hand, it will take a lot of years to reach $50 million.

Mr. Geier:

You can't see it here on the balance sheet but we had $306 million. It's about $40 million to take it up to four and a half days in one year. To go from 346 to 373 is three days in the budget. That just gives you a sense of the order of magnitude of dollars every year to get to 100 days.

Mr. Price:

Our cost structure plays a major role in that going forward. One competitive institution in the community has 220 days cash on hand.

Mr. Geier:

We don't have the slide here but did show it in our budget meetings on the total cash position. The other thing that plays in this is how well we do with research grant growth and philanthropy because that takes the pressure off these cash numbers in terms of supporting the college.

Dr. Wadsworth:

There are two things going on. We need to see a business plan that is self-contained within the system and understand the risks associated with depending upon philanthropy. We are all saying the same thing.

WEXNER MEDICAL CENTER FISCAL YEAR 2015 BUDGET

Resolution No. 2015-79

Synopsis: Approval of the Wexner Medical Center Budget Plan for the fiscal year ending June 30, 2015, is proposed.

WHEREAS the State of Ohio Biennial Budget for State Fiscal Years 2014 and 2015, including funding levels for State institutions of higher education, has been signed into law; and

WHEREAS the proposed 2015 Wexner Medical Center operating budget generates margins and cash flows sufficient to meet or exceed the Health System's three strategic financial targets; and

WHEREAS the President now recommends approval of the Wexner Medical Center Budget Plan for the fiscal year 2015 ending June 30, 2015:

NOW THEREFORE

BE IT RESOLVED, The Board of Trustees hereby approves that the Wexner Medical Center's Budget Plan for the fiscal year ending June 30, 2015, as described in pages 23-26 of the accompanying Fiscal Year 2015 Budget Plan Book, be approved, with authorization for the president to make expenditures within the projected income.

(See Appendix V for background information, page 110)

Mr. Wexner:

I think this will be the work of the Board for the next 12 months; to get the understanding and set the strategy to make our dreams come true. Any other comments?

I appreciate the inquiry. It reminds me of things we should look into.

May I have a motion to recommend the fiscal year 2015 health system budget as part of the university's fiscal year 2015 budget to the University Board of Trustees for approval?

Upon motion of President Drake, seconded by Mrs. Wexner, the Wexner Medical Center Board members adopted the foregoing motion by unanimous voice vote.

Mr. Wexner:

Initiatives and scorecard, Dr. Gabbe?

Dr. Gabbe:

Thank you. Before we show the scorecard and review it, we wanted to make sure the Wexner Medical Center Board was familiar with a remarkable advance in neuroscience that occurred about two months ago. The Ohio State University and the Wexner Medical Center in collaboration with Battelle, for the first time ever, enabled a paralyzed man to move his hand. We have the team of leaders who were instrumental in that group, Dr. Ali Rezai who heads our Neurosciences Programs, Dr. Chad Bounton from Battelle, and Dr. Jerry Mysiw, who chairs our rehabilitation and physical services department at the medical center. We wanted to show you this video at this time. They will be available to answer any questions after this. Thank you.

VIDEO

Dr. Gabbe:

This is pretty remarkable. Congratulations to the team. I understand Ian is making further progress and there will be five total patients in this trial. I want to also congratulate Dr. Rezai and his team with Dr. Randy Nelson who chairs our neuroscience department. They received one of the six university Discovery Theme grants for their studies of chronic brain injuries. Congratulations Ali for that as well.

Dr. Rezai:

We have the best people across the world collaborating with the various departments in our colleges here at the university, with our colleagues at Battelle, and others and leverage the work we are doing with the Air Force Research lab. We recently received a $160 million award from the State of Ohio to develop neurotechnologies. It is going to be a fantastic opportunity to make Ohio State University Wexner Medical Center the hub for the future for those with severe brain injuries: stroke, traumatic brain injury, Alzheimer's, and Autism. We are very excited about this opportunity.

Dr. Gabbe:

Thank you Ali very much.

Mr. Steinour:

Would we have time for a few more words about what that future could look like for Dr. Rezai?

Dr. Rezai:

Basically, the ability to leverage brain activity. It can be linked to patients with spinal cord and traumatic brain injuries and they can use their minds to interact with their environment. The other thing we are developing are microchips that are used to stop migraine headaches. We are looking at home health monitoring for those with Alzheimer's and Autism to enable those patients to interact and their families can know what the status of their future is.

We are bringing some of the best recruits in the world. For example, Professor Jan Schwab is the world's expert from Germany for those with spinal cord injury. All this is enabling us by collaboration with engineers, scientists, and clinicians to really seize the future for those with a whole host of brain injuries; whether it's a trauma injury, a spinal cord injury, a stroke, or if it's damage to the brain from Alzheimer's or Parkinson's or many other conditions. I am very excited about the future possibilities. This transformative grant from the State of Ohio is a partnership between the State of Ohio and private and public institutions that brings forth $160 million over the next four years to develop translational commercialization research that will come back to the university with the spin out companies that are being supported. So there is a new model for revenue for the university as well. I would be happy to discuss that further but we are very excited about this opportunity at this point.

Dr. Gabbe:

Thank you. Now we can take a look at the Medical Center Initiative Scorecard. I won't review the information that was provided in the budget update. If you look under A for strategic growth, I'll comment on number two.

The Medical Center Expansion project is one percent below target at the end of fiscal year 2014 and that really relates to the services that have been billed by Turner. The project, as you will soon hear from Mr. Kasey, is on budget and on time. If you look at number seven, the long range financial plan is our development dollars. You'll see that while we increased our fundraising from fiscal year 2013 to fiscal year 2014 by $600,000, we fell short of our target of $131.9 million by $4.2 million. I think it's of note that unlike last year when we reached that $127 million mark, we had no eight figure gifts this year. Despite that, we did well overall.

Under the section marked academic and research excellence, you'll see that we exceeded our target for total research dollars by $30 million and we increased our NIH funding from $119 million to $135.5 million over the last year. We did fall short of our NIH target by $5.4 million. You'll see that we rose in the ranks of *U.S. News and World Report's* Best Medical Schools from 38th to 34th. We were ranked 12th among all public university medical schools in research category and 20th among all public universities in primary

care. Just for note of comparison, U.S. News ranks 140 medical schools and 21 osteopathic schools. That is the total pool.

If you look at the entering medical student credentials, we had an entering class this year with a GPA of 3.7 and MCATs of 11.2, just below our targets for the year. These are very strong credentials across the country and I note that our class is 20% underrepresented in medicine. It is a very diverse class.

Finally, patient care, quality, and satisfaction. This year we fell off in the number of specialties that we had ranked in the 50. Although with five specialties ranked in that group, we're among the top 1% of all hospitals in the country. We had eight specialties that were identified as high performing and we were rated the top hospital in Central Ohio. You see that our readmission rate did decline although we fell short of our 11.2% goal for all cause readmissions. The decline is related in part to our home care program where we are identifying those patients at greatest risk for readmission and providing services for them in the home setting. Our inpatient mortality was better than our goal for the year at 0.63% observed to expected, and in fact, puts us among the top five hospitals for observed to expected mortality in the University Health Systems Consortium (UHC). We fell short of our goals in both inpatient patient satisfaction and outpatient patient satisfaction. We were ranked at about the 75th percentile in those areas. We are doing the right things but we are not doing them consistently enough. In the outpatient area, our challenge has been to get patients the test results they want in the way that is best for them to receive them and that is something we're working on in this year. I would be happy to answer any questions you might have about those metrics.

Mr. Wexner:

Questions? Did we make any progress in the philanthropy that comes from grateful patients?

Dr. Gabbe:

That program has been launched relatively recently. We're making progress but we still have more that is to be made. We've been training physicians and we have over 100 physicians who have been trained in the purpose and how to best interact with those patients but we have much more work to do.

President Drake:

I have been looking at these a lot. I particularly would like to comment on the observed to expected mortality. This is a spectacularly good number. This is actually people's lives saved. This is just something to pause for a moment and think about; 0.63% is an incredible number there.

Dr. Gabbe:

That means a lot to us and it represents hundreds of patients going home to their families who would not otherwise be expected to. As I say, at the end of the year, we ranked 4th among the UHC Academic Medical Centers.

Mr. Wexner:

Thank you. Next is Jay Kasey.

Mr. Kasey:

Thank you, Mr. Chairman. I am here to give you an update on the Medical Center Expansion Project. I'll remind you that just about 30 days from today, our contractor is scheduled to give us substantial completion of the construction of the building. At that time, according to our schedule, the building will be turned over to us. They will still be doing some punch list items but we will be able to move into the building to do IT installation, building commissioning, HVAC balancing, and other activity.

In the interest of time, I won't go through all the picture slides but they are there for appreciation. I will mention that at the beginning of August, the emergency department was turned over. This is the first patient care area which was turned over on schedule to the Medical Center for direct patient care. This allows the Medical Center to go back into the previous existing emergency department and start renovation of that space. That renovation is to be completed in February which will allow the eventual combined capacity of that emergency department to be a little over 100 treatment spaces. This will be very good for our patient care, their waits, and our outreach to the community.

I want to move to some of the more informative slides. Major medical equipment installed, as of the time this slide was put together, is on track and is on schedule. This represents a tremendous amount of work. These major pieces of equipment all have to be delivered, acceptance tested, inspected, installed, calibrated, and that takes a lot of time. The six linear accelerators have been delivered. This was done in a lean technique that was unanticipated when the schedule was put together which allowed us to do these concurrently instead of a serial nature. Each of these takes about six weeks to install. We were able to pick up a lot of time there. On the right hand side, you'll see that the brachial therapy and linear accelerators that are in the existing basement of the James Cancer Hospital will be the last major pieces of equipment installed. As the new equipment comes online, we can take these down and move over to the new building. We're on schedule there and at this time have not had any bad surprises.

We have new partners in our new tower. I want to bring these to your attention. Huntington is right on track with us. They will be prepared for our opening events. The opening events are in the first week of November. We want all our partners to represent themselves and our Medical Center well at that time.

Then, "go-live" is the middle of December when patients will arrive in the building. We are concerned that the two food providers, the Express Oasis and Au Bon Pain, won't have their store fronts completed by the time of the opening events. We are working very hard with them at this time. They believe they will make it. We're just trying to be cautious but we have every confidence that their back office, back room, their food prep areas, and their patient and visitor areas will be prepared by our "go-live" for patients.

This is the all-important schedule that you have seen before. It is very important to us that floors be delivered to us in a cascade and not in a waterfall. We'd like these to come in a step-by-step basis so that our people can come in and work on them appropriately and not be overburdened by too much coming at one time. Again, my concern at the time this slide was put together was that we were tracking a few days behind on the ground level turnover. The ground level was actually turned over to us on August 22nd. It was just a couple days behind but it was recoverable for our team. The level 10 Critical Care floor is going to be turned over to us on September 19th. This is well within the final delivery date of September 26th for all floors and we can recover on that one. Level 21, which is the top floor and was added later, is scheduled to be completed and built out as we showed a need later. It will be provided to us on November 16th. Again, this will be acceptable to us. We still think we can throw people in there and get that cleaned up and ready to go by the time we move patients on December 15th. At this time we think the schedule is going to work for us. The Medical Center has got a tremendous number of quality IT staff in installing equipment, furniture, and moveable equipment.

I will just move quickly through and reassure you that our budget commitments for each element of the expansion project are under control. We have contract commitments that are a little over a billion dollars.

Our contingency numbers, this is one you've watched for some time, are still tracking with about $8 million in contingencies. We think there are still potential uses to those contingencies although they're narrowing. I also would add that our general contractor, Turner-Linley's, has about $6-8 million in their contingency funds. Those funds will come back to us but since they are a contractor at risk, they have control over them until a certain point in the turnover of the building. I say with some confidence that we'll be safe on our budget and it will be known to us probably in the next 60 days at the final tie-out.

Finally, we have tracked for some time our EDGE, or our minority-owned contractors, who are doing work in the building. This is tracking at a remarkable 29% of commitments and 28% of paid contracts. It's been a great contribution to Central Ohio and to the state. State contractors have had 87% of the construction

contracts for the building. We are pleased with that commitment to the state. I will take any questions you might have.

Mr. Wexner:

Sweating less, at one time, and hopefully on or under budget.

Mr. Kasey:

I don't want to use that term anymore. It makes me to nervous now.

Mr. Wexner:

We will know November 1st?

Mr. Kasey:

We will know very soon.

Mr. Wexner:

Any questions or comments or curiosities? I think Dr. Gabbe or Mr. Chatas is going to talk about the Upper Arlington program.

Dr. Gabbe:

Geoff and I will quickly go through the Upper Arlington project. There were questions raised at our last Wexner Medical Center Board meeting about this project. Why is the ambulatory presence so important and I think some of that information has been provided to you. It relates to providing a better patient experience, aligning with the payer's expectations, and helping improve our operating performance. The key attributes of the Arlington proposal will be a 100,000 square foot building in the Kingsdale Shopping Center; 80,000 square feet of it will be built out initially. It will be done in collaboration with Upper Arlington. There will be conference rooms and classrooms within the ambulatory facility that are linked in and schools can use as they need. The specialties there should be very appealing for Upper Arlington, particularly for our health plan members. I might note that 4,000 Ohio State employees and their families live in Upper Arlington which has a population of 34,000. Over 13,000 citizens of Upper Arlington are Ohio State alums. It is a place where there are many health plan members and many supporters of Ohio State. The services will be primary care, women's health, heart and vascular, a variety of internal medicine specialties, a general surgery clinic, a laboratory, and imaging services. This was a question at our last meeting, will include x-ray, bone densitometry, mammography, ultrasound, and heart imaging as well.

The projected cost of this facility matches the cost of our other CarePoints and it's about $6.5 million. The payback period is projected to be 3.7 years. We've done a sensitivity analysis, including what happens if the investment must increase 5%, or the expenses increased 5% or the volumes fall off 5%, they could increase the payback period to 4.8 years.

We also wanted to respond to a question about how much of this business would be new. We projected that 76% of the volume would be new business and 24% would come from other ambulatory sites. In fact, when we looked at the activity at Martha Morehouse, which is the closest ambulatory site that we now operate, very little of that was from Upper Arlington residents. We think that the majority of it will be new business, especially in primary care. This investment is comparable to our other ambulatory facilities. The last page of your handout shows you the investment that we made in other sites. Our next ambulatory priority would be considering the consolidation of several sites that we now have in Dublin to increase our presence and reduce our costs. We are pleased that we were chosen by Upper Arlington for this

opportunity and we look forward to bringing back to the Board a resolution concerning the lease in the future at our next meeting. Geoff, comments? Thank you.

Mr. Wexner:

I don't understand that chart or map that is on page 4. It says 35% of health plans live in these zip codes. Is that all the colored zip codes?

Dr. Gabbe:

Yes that's all their zip codes.

Mr. Wexner:

Ok. Steve, I think you gave a percentage of the total that is serviced by Upper Arlington.

Dr. Gabbe:

Right, there are 4,000 employees and their families in Upper Arlington and our total healthcare membership is about 60,000. Maybe I didn't make that clear.

Mr. Wexner:

This is 64%?

Dr. Gabbe:

OSU health plan has about 60,000 members and 4,000 are in Upper Arlington itself.

Mr. Wexner:

Any questions? Thank you I appreciate that.

Mr. Price:

In terms of the Upper Arlington center, is it dependent upon the health plan for its success?

Dr. Gabbe:

No, it's not.

Mr. Price:

Second question. What competitors do we have in that area now?

Dr. Gabbe:

Ohio Health has some ambulatory sites but not within that central location. This is the last best site for an ambulatory service in that area.

Mr. Price:

Will it have any impact on our existing centers that we have?

Dr. Gabbe:

No, we analyzed how much of the business that could go there would be taken from other ambulatory sites, very little.

Mr. Geier:

We have a small primary care site on Bethel Road that we would likely close when that lease is up and move that into this site.

Dr. Gabbe:

That will help with costs. Thank you.

Mr. Wexner:

I know we just approved it, when does that open? I assume about a year.

Mr. Geier:

A little over a year. The resolution that was passed by the Board last time was to proceed and then bring back the final terms and conditions of the lease. We plan to bring that back at the next Medical Center Board Meeting for final approval.

Dr. Gabbe:

I think it would be 2016, Pete.

Mr. Geier:

Yes.

Mr. Wexner:

Any other questions or comments? We covered everything and we're right on time. I would like to recess into executive session to discuss personnel matters.

Upon motion of Mr. Wexner, seconded by President Drake, the Wexner Medical Center Board members adopted the foregoing motion by unanimous roll call vote, cast by board members Mr. Wexner, Ms. Krueger, Mrs. Wexner, Mr. Price, Mr. Fischer, Mr. Steinour, Mr. Wolfe, Dr. Wadsworth, President Drake, Dr. Gabbe, and Mr. Chatas.

Mr. Wexner:

Thank you, we are adjourned.

Attest:

Leslie H. Wexner	Heather A. Link
Chairman	Associate Secretary

(APPENDIX I)

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Revised: Dec 2012; Jan 2014
MSAC Approved: March 12, 2014
QPAC Approved: July 16, 2014

TITLE: THE OHIO STATE UNIVERSITY HOSPITAL, RICHARD M. ROSS HEART HOSPITAL, HARDING HOSPITAL, AND UNIVERSITY HOSPITAL EAST PLAN FOR PATIENT CARE SERVICES

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

OSU WEXNER MEDICAL CENTER MISSION, VISION AND VALUES

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

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

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

The Hospitals embrace the mission, vision and values of The Ohio State Wexner Medical Center; in addition – our vision statement, developed by our staff members, physicians and administration team members, complements and reflects our unique role in The Ohio State's Wexner Medical Center.

PHILOSOPHY OF PATIENT CARE SERVICES

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

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

i) Respect for each patient's rights and decisions as an essential component in the planning and provision of care; and,
j) Staff member behaviors reflect a philosophical foundation based on the values of Ohio State's Wexner Medical Center.

THE HOSPITAL LEADERSHIP

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

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

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

Other leadership responsibilities include:

a) Communication of the organization's mission, goals, objectives and strategic plans across the organization;
b) Ensuring appropriate and competent direction, management and leadership of all services and/or departments;
c) Collaborating with community leaders and organizations to ensure services are designed to be appropriate for the scope and level of care required by the patients and communities served;
d) Supporting the patient's continuum of care by integrating systems and services to improve efficiencies and care from the patient's viewpoint;
e) Ensuring staffing resources are available to appropriately and effectively meet the needs of the patients served and to provide a comparable level of care to patients in all areas where patient care is provided;
f) Ensuring the provision of a uniform standard of patient care throughout the organization;
g) Providing appropriate job enrichment, employee development and continuing education opportunities which serve to promote retention of staff and to foster excellence in care delivery and support services;
h) Establishing standards of care that all patients can expect and which can be monitored through the hospital's performance assessment and improvement plan;
i) Approving the organizational plan to prioritize areas for improvement, developing mechanisms to provide appropriate follow up actions and/or reprioritizing in response to untoward and unexpected events;
j) Implementing an effective and continuous program to improve patient safety;

k) Appointing appropriate committees, task forces, and other forums to ensure interdepartmental collaboration on issues of mutual concerns and requiring interdisciplinary input; and,
l) Supporting patient rights and ethical considerations.

ROLE OF THE CHIEF NURSING OFFICER

The Chief Nursing Officer of each hospital is a member of their Executive Leadership Team and is under the direction of the CEO / Executive Director of their respective hospital and the Chief Nurse Executive of the Health System. The Chief Nursing Officer has the requisite authority and responsibility for directing the activities related to the provision of nursing care in those departments defined as providing nursing care to patients.

The Chief Nursing Officer ensures the following functions are addressed:

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

DEFINITION OF PATIENT SERVICES, PATIENT CARE AND PATIENT SUPPORT

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

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

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

Competency for patient caregivers is determined in orientation and at least annually through performance evaluations and other department specific assessment processes. Physicians direct all medical aspects

of patient care as delineated through the clinical privileging process and in accordance with the Medical Staff By-Laws. Registered nurses support the medical aspect of care by directing, coordinating, and providing nursing care consistent with statutory requirements and according to the organization's approved Nursing Standards of Practice and hospital-wide Policies and Procedures. Allied health care professionals provide patient care and services in keeping with their licensure requirements and in collaboration with physicians and registered nurses. Unlicensed staff may provide aspects of patient care or services at the direction of and under the supervision of licensed professionals.

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

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

SCOPE OF SERVICES / STAFFING PLANS

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

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

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

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

The Administrator, in conjunction with the budget and performance measurement process, reviews all patient care areas staffing and monitors ongoing regulatory requirements. Each department staffing plan is formally reviewed during the budget cycle and takes into consideration workload measures, utilization review, employee turnover, performance assessment, improvement activities, and changes in customer

needs/expectations. A variety of workload measurement tools may be utilized to help assess the effectiveness of staffing plans.

STANDARDS OF CARE

Personalized health care at Ohio State is "the integrated practice of medicine and patient support based upon an individual's unique biology, behavior, and environment". It is envisioned as health care that will utilize gene-based information to understand each person's individual requirements for the maintenance of their health, prevention of disease, and therapy tailored to their genetic uniqueness. Ideally, it also includes incorporating knowledge of their environment, health-related behaviors, culture and values. Thus, personalized health care promises to be predictive and preventive.

Patients of the Hospitals can expect that:

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

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

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

STANDARDS of COMPETENT PERFORMANCE/STAFF EDUCATION
All employees receive an orientation consistent with the scope of responsibilities defined by their job description and the patient population to whom they are assigned to provide care. Ongoing education (such as in-services) is provided within each department. In addition, the Educational Development and Resource Department provides annual mandatory education and provides appropriate staff education associated with performance improvement initiatives and regulatory requirements. Performance appraisals are conducted at least annually between employees and managers to review areas of strength and to identify skills and expectations that require further development.

CARE DELIVERY MODEL –
The care delivery model is guided by the following goals:

- The patient and family will experience the benefits of **personalized** care that integrates skills of all care team members. The benefits include enhanced quality of care, improved service, appropriate length of hospitalization and minimized cost.
- Hospital employees will demonstrate behaviors consistent with the philosophy of **Personalized Health Care**. The philosophical foundation reflects a culture of collaboration, enthusiasm and mutual respect.
- Effective communication will impact patient care by ensuring timeliness of services, utilizing staff resources appropriately, and maximizing the patient's involvement in his/her own personalized plan of care.
- Configuring departmental and physician services to accommodate the care needs of the patient in a timely manner will maximize quality of patient care and patient satisfaction.
- The professional nursing practice model is a framework which reflects our underlying philosophy and vision of providing personalized nursing care. Aspects of the professional model support:
  (1) matching nurses with specific skills to patients with specific needs to ensure "safe passage" to achieve the optimal outcome of their hospital stay
  (2) the ability of the nurse to establish and maintain a therapeutic relationship with their patients
  (3) the presence of an interdisciplinary team approach to patient care delivery. The knowledge and expertise of all caregivers is utilized to provide personalized care for the patient.
  (4) Physicians, nurses, pharmacists, respiratory therapists, case managers, dieticians and many other disciplines collaborate and provide input to patient care.
- The patient and family will be involved in establishing the plan of care to ensure services that accommodate their needs, goals and requests.
- Streamlining the documentation process will enhance patient care.

PATIENT RIGHTS AND ORGANIZATIONAL ETHICS

Patient Rights

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

Organizational Ethics

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

- Services and capabilities offered meet identified patient and community needs and are fairly and accurately represented to the public.
- Adherence to a uniform standard of care throughout the organization, providing services only to those patients for whom we can safely care for within this organization. The hospitals do not discriminate based upon race, creed, sex, national origin, disability, religion, sexual orientation, or source of payment.
- Patients will be billed only for care and services provided.

Biomedical Ethics

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

- improve patient care and ensure patient safety;
- clarify any uncertainties regarding medical decisions;
- explore the values and principles underlying disagreements;
- facilitate communication between the attending physician, the patient, members of the treatment team and the patient's family (as appropriate); and,
- mediate and resolve disagreements.

INTEGRATION OF PATIENT CARE AND SUPPORT SERVICES

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

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

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

CONSULTATIONS AND REFERRALS FOR PATIENT SERVICES

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

INFORMATION MANAGEMENT PLAN

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

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

PATIENT CARE ORGANIZATIONAL IMPROVEMENT ACTIVITIES

All departments are responsible for following the Hospitals' plan for improving organizational performance.

PLAN REVIEW

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

Appendix A: Scope of Services: Patient Support Services

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

DEPARTMENT	SERVICE
CASE MANAGEMENT	As part of the health care team, provides world class personalized care coordination and resource management with patients and families.
CHAPLAINCY AND CLINICAL PASTORAL EDUCATION	Assists patients, their families and hospital personnel in meeting spiritual needs through professional pastoral and spiritual care and education.
CLINICAL ENGINEERING	Routine equipment evaluation, maintenance, and repair of electronic equipment, evaluation of patient owned equipment.
COMMUNICATIONS AND MARKETING	Responsible for developing strategies and programs to promote the organization's overall image and specific products and services to targeted internal and external audiences. Handles all media relations, advertising, internal communications, special events and publications.
DIAGNOSTIC TESTING AREAS	Provides tests based on verbal, electronic or written consult. Preliminary report via phone or electronic patient record. Permanent reports in patient record.
DIAGNOSTIC TRANSPORTATION	Provision of transportation services for patients requiring diagnostic, operative or other ancillary services.
EARLY RESPONSE TEAM (ERT)	Provides timely diagnostic and therapeutic intervention before there is a cardiac or respiratory arrest or an unplanned transfer to the Intensive Care Unit. Consists of a Critical Care RN and Respiratory Therapist who are trained to help patient care staff when there are signs that a patient's health is declining.
EDUCATIONAL DEVELOPMENT & RESOURCES	Provides and promotes ongoing development and training experiences to all member of the OSU Wexner Medical Center community; provides staff enrichment programs, organizational development, leadership development, orientation and training, skills training, continuing education, competency assessment and development, literacy programs and student affiliations.
ENVIRONMENTAL SERVICES	Provides quality monitoring for routine housekeeping in patient rooms. Routine housekeeping of nursing unit environment. Additional services upon request: extermination, wall cleaning, etc.
EPIDEMIOLOGY	Enhance the quality of patient care and the work environment by minimizing the risk of acquiring infection within the hospital setting.
FACILITIES OPERATIONS	Provide oversight, maintenance and repair of the building's life safety, fire safety, and utility systems. Provide preventative, repair and routine maintenance in all areas of all buildings serving patients, guests, and staff. This would include items such as electrical, heating and ventilation, plumbing, and other such items. Also providing maintenance and repair to basic building components such as walls, floors, roofs, and building envelope. Additional services available upon request.
FISCAL SERVICES	Works with departments/units to prepare capital and operational budgets.
HUMAN RESOURCES	Serves as a liaison for managers regarding all Human Resources information and services; assists departments with restructuring efforts; provides proactive strategies for managing planned change within the Health System; assists with Employee/Labor Relations issues; assists with performance management process; develops compensation strategies; develops hiring strategies and coordinates process for placements; provides strategies to facilitate sensitivity to issues of cultural diversity; provides HR information to employees, and establishes equity for payroll.

DEPARTMENT	SERVICE
INFORMATION SYSTEMS	Work as a team assisting departments to explore, deploy and integrate reliable, state of the art Information Systems technology solutions to manage change.
MATERIALS MANAGEMENT	Routinely supplies stock in patient care areas, distributes linen. Sterile Central Supply, Storeroom - upon request, distributes supplies/equipment not stocked on units.
MEDICAL INFORMATION MANAGEMENT	Maintains patient records serving the needs of the patient, provider, institution, and various third parties to health care.
NUTRITION SERVICES	Provides nutrition care and food service for Medical Center patients, staff and visitors. Clinical nutrition assessment and consultation are available in both inpatient and outpatient settings. The Department provides food service to inpatients and selected outpatient settings in addition to operating a full-service cafeteria and acts as a liaison for vending and sub-contracted food services providers.
PATIENT ACCESS SERVICES	Coordinates registration/ admissions with nursing management.
PATIENT EXPERIENCE	Develops programs for support of patient relations and customer service, and includes front-line services such as information desk.
PATIENT FINANCIAL SERVICES	Provides financial assistance upon request from patient/family.
PHARMACY	Provides comprehensive pharmaceutical care through operational and clinical services. Responsible for medication distribution via central and satellite pharmacies, as well as 797 compliant IV compounding room and automated dispensing cabinets. Some of the many clinical services include pharmacokinetic monitoring, renal and hepatic dose adjustments, and patient educational Specialist pharmacists also round with patient care teams to optimize medication regimens and serve as the team's primary drug information resource.
PULMONARY DIAGNOSTICS LAB	Provides service to patients requiring an evaluation of the respiratory system. Performs Pulmonary Function Testing to assess the functional status of the respiratory system. Bronchoscopy and other diagnostic/interventional pulmonology procedures are performed to diagnose and/or treat abnormalities that exist in the airways, lung parenchyma or pleural space.
QUALITY AND OPERATIONS IMPROVEMENT	Provides an integrated quality management program and facilitates continuous quality improvement efforts throughout the medical center
RESPIRATORY THERAPY	Provide all types of respiratory therapeutic interventions and diagnostic testing, by physician order, mainly to critically ill adults and neonates, requiring some type of ventilator support, bronchodilator therapy, or pulmonary hygiene, due to chronic lung disease, multiple trauma, pneumonia, surgical intervention, or prematurity.
REHABILITATION SERVICES	Physical therapists, occupational therapists, speech and language pathologist, and recreational therapists evaluate and develop a plan of care and provide treatment based on the physician's referral. The professional works with each patient/family/caregiver, along with the interdisciplinary medical team, to identify and provide the appropriate therapy/treatment and education needed for the established discharge plan and facilitates safe and timely movement through the continuum of care.
RISK MANAGEMENT	Protect resources of the hospital by performing the duties of loss prevention and claims management. Programs include: Risk Identification, Risk

DEPARTMENT	SERVICE
	Analysis, Risk Control, Risk Financing, Claims Management and Medical-Legal Consultation
SAFETY	Handles issues associated with licensing and regulations, such as EPA and fire regulations
SECURITY	Provides a safe and secure environment for patients, visitors, and staff members by responding to all emergencies such as workplace violence, fires, bomb threats, visitor/staff/patient falls, Code blues (cardiac arrests) in public places, internal and external disasters, armed aggressors, or any other incident that needs an emergency response.
SOCIAL WORK SERVICES	Social work services are provided to patients/families to meet their medically related social and emotional needs as they impact on their medical condition, treatment, recovery and safe transition from one care environment to another. Social workers provide psychosocial assessment and intervention, crisis intervention, financial counseling, discharge planning, health education, provision of material resources and linkage with community agencies. Consults can be requested by members of the treatment team, patients or family members.
VOLUNTEER SERVICES	Volunteer Services credentials and places volunteers to fill departmental requests. Volunteers do wayfinding, host visitors in waiting areas, serve as patient / family advisors, and assist staff. Volunteer Services manages the patient mail & flower room, cultural support volunteer program, and the pet visitation program. Volunteer Services serves as a liaison for the Service Board auxiliary which annually grants money to department-initiated projects than enhance the patient and family experience.

(APPENDIX II)

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Revised: January 2014
MSAC Approved: April 4, 2014
QPAC Approved: July 16, 2014

THE ARTHUR G. JAMES HOSPITAL PLAN FOR PROVIDING PATIENT CARE SERVICES

Prepared by: **ADMINISTRATION**

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

THE HOSPITAL MISSION, VISION, AND VALUES

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

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

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

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

Philosophy of Patient Care Services

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

- A mission statement that outlines the synergistic relationship between patient care, research and teaching;
- Long-range strategic planning with hospital leadership to determine the services to be provided;
- Establishing annual goals and objectives that are consistent with the hospital mission, and which are based on a collaborative assessment of patient/family and the community's needs;
- Planning and design conducted by hospital leadership, which involves the potential communities to be served;
- Provision of services that are appropriate to the scope and level required by the patients to be served based on assessment of need;
- Ongoing evaluation of services provided through formalized processes; such as performance assessment and improvement activities, budgeting and staffing plans;

- Integration of services through the following mechanisms: continuous quality improvement teams; clinical interdisciplinary quality programs; performance assessment and improvement activities; communications through management operations meetings, Division of Nursing governance structure, Medical Staff Administrative Committee, administrative staff meetings, participation in OSU WMC and OSU governance structures, special forums, and leadership and employee education/development;
- Maintaining competent patient care leadership and staff by providing education designed to meet identified needs;
- Respect for each patient's rights and decisions as an essential component in the planning and provision of care; and
- Staff member behaviors reflect a philosophical foundation based on the values of The James Cancer Hospital and Richard J. Solove Research Institute.

Hospital Leadership

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

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

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

Other leadership responsibilities include:

•Communication of the organization's mission, goals, objectives and strategic plans across the organization;

•Ensuring appropriate and competent direction, management and leadership of all services and/or departments;

•Collaborating with community leaders and organizations to ensure services are designed to be appropriate for the scope and level of care required by the patients and communities served;

•Supporting the patient's continuum of care by integrating systems and services to improve efficiencies and care from the patient's viewpoint;

•Ensuring staffing resources are available to appropriately and effectively meet the needs of the patients served and to provide a comparable level of care to patients in all areas where patient care is provided;

•Ensuring the provision of a uniform standard of patient care throughout the organization;

•Providing appropriate job enrichment, employee development and continuing education opportunities which serve to promote retention of staff and to foster excellence in care delivery and support services;

•Establishing standards of care that all patients can expect and which can be monitored through the hospital's performance assessment and improvement plan;

•Approving the organizational plan to prioritize areas for improvement, developing mechanisms to provide appropriate follow up actions and/or reprioritizing in response to untoward and unexpected events;

•Implementing an effective and continuous program to improve patient safety;

•Appointing appropriate committees, task forces, and other forums to ensure interdepartmental collaboration on issues of mutual concerns and requiring interdisciplinary input; and,

•Supporting patient rights and ethical considerations.

Role of the Executive Director, Patient Services

The Executive Director, Patient Services is a member of the Executive Leadership Team and is under the direction of the Senior Executive Director, Administration of the hospital. The Executive Director, Patient Services has the requisite authority and responsibility for directing the activities related to the provision of care services in those departments defined as providing care to patients.

The Executive Director, Patient Services ensures the following functions are addressed:

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

Definition of Patient Services, Patient Care and Patient Support

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

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

Patient Care encompasses the recognition of disease and health, patient teaching, patient advocacy, spirituality and research. The full scope of patient care is provided by professionals who are charged with the additional functions of patient assessment and planning patient care based on findings for the assessment. Patient care and services are planned, coordinated, provided, delegated and supervised by professional health care providers who recognize the unique physical, emotional and spiritual (body, mind and spirit) needs of each person. Under the auspices of the hospital, medical staff, registered nurses and allied health care professionals function collaboratively as part of an interdisciplinary, personalized patient-focused care team to achieve positive patient outcomes.

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

Nursing Care (nursing practice) is defined as competently providing all aspects of the nursing process in accordance with Chapter 4723 of the Ohio Revised Code (ORC), which is the law regulating the Practice of Nursing in Ohio. The law gives the Ohio Board of Nursing the authority to establish and enforce the requirements for licensure of nurses in Ohio. This law, also, defines the practice of both registered nurses and licensed practical nurses. All activities listed in the definitions, including the supervision of nursing care, constitute the practice of nursing and therefore require the nurse to have a curren6t valid license to practice nursing in Ohio.

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

Scope of Services/Staffing Plans

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

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

Staffing plans for patient care service departments are developed based on the level and scope of care provided, the frequency of the care to be provided, and a determination of the level of staff that can most appropriately (competently and confidently) provide the type of care needed. Nursing units are staffed to accommodate a projected average daily patient census. Unit management (including nurse manager and/or charge nurse) reviews patient demands to plan for ade2uate staffing. Staffing can be increased or decreased to meet patient needs. When the number of patients is high or the need is great, float staff assist in providing care. When staff availability is projected to be low due to leaves of absence, the unit manager and director may request temporary agency nurses. The James Cancer Hospital follows the Staffing Guidelines set by the American Nurses Association. In addition, we utilize staffing recommendations from various specialty nursing organizations, including ANCC, AACN, AORN, OCN, and others.

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

Standards of Care

Personalized health care at The James Cancer Hospital is the integrated practice of medicine and patient support based upon the individual's unique biology, behavior, and environment. It is envisioned as health care that will utilize gene-based information to understand each person's individual requirements for the maintenance of their health, prevention of disease, and therapy tailored to their genetic uniqueness. Thus personalized health care promises to be predictive and preventive.

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

- Hospital staff will provide the correct procedures, treatments, interventions and care. Their efficacy and appropriateness will be demonstrated based on patient assessment and reassessments, state-of-the-art practice and achievement of desired outcomes
- Hospital staff will design, implement and evaluate care delivery systems and services which are consistent with patient centered care focus which will be delivered with compassion, respect and dignity for each individual without bias in a manner that best meets the individual needs of the patients and families.
- Staff will provide a uniform standard of care and services throughout the organization

- Care will be coordinated through interdisciplinary collaboration to ensure continuity and seamless delivery of care to the greatest extent possible
- In a manner that maximizes the efficient use of financial and human resources, streamlines processes, decentralized services, enhances communication, supports technological advancements and maintains patient safety

Patient Assessment:

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

Coordination of Care:

Patients are identified who require discharge planning to facilitate continuity of medical care and/or other care to meet identified needs. Discharge planning is timely, is addressed during initial assessment as well as during discharge planning process (rounds, etc.) and can be initiated by any member of the multidisciplinary team. Patient Care Resource Managers, Advanced Practice Nurses, and Social Workers coordinate and maintain close contact with the health care team members to finalize a discharge plan best suited for each individual patient.

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

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

Patient Care encompasses the recognition of disease and health, patient teaching, patient advocacy, spirituality and research. The full scope of patient care is provided by professionals who are charged with the additional functions of patient assessment and planning patient care based on findings for the assessment. Patient care and services are planned, coordinated, provided, delegated and supervised by professional health care providers who recognize the unique physical, emotional and spiritual (body, mind and spirit) needs of each person. Under the auspices of the hospital, medical staff, registered nurses and allied health care professionals function collaboratively as part of an interdisciplinary, personalized patient-focused care team to achieve positive patient outcomes.

Standards of Competent Performance/Staff Education

All employees receive a formalized orientation consistent with the scope of responsibilities as defined by their job description and the patient population to whom they are assigned to provide care. Competency for patient caregivers is determined in orientation and at least annually through performance evaluations and other department specific assessment processes. Physicians direct all medical aspects of patient care as delineated through the clinical privileging process and in accordance with the Medical Staff By-Laws. Registered nurses support the medical aspect of care by directing, coordinating, and providing

nursing care consistent with statutory requirements and according to the organization's approved Nursing Standards of Practice and hospital-wide Policies and Procedures. Allied health care professionals provide patient care and services in keeping with their licensure requirements and in collaboration with physicians and registered nurses. Unlicensed staff may provide aspects of patient care or services at the direction of and under the supervision of licensed professionals.

Medical Staff members are assigned to a clinical department or division. Each clinical department has an appointed chief responsible for a variety of administrative duties including development and implementation of policies that support the provision of departmental services and maintaining the proper number of qualified and competent person needed to provide care within the service needs of the department.

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

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

Care Delivery Model

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

- The patient and family will experience the benefits of personalized care that integrates skills of all care team members. The benefits include enhanced quality of care, improved service, appropriate length of hospitalization and minimized cost.
- Hospital employees will demonstrate behaviors consist with the philosophy of personalized health care. The philosophical foundation reflects a culture of collaboration, enthusiasm and mutual respect.
- Effective communication will impact patient care by ensuring timeliness of services, utilizing staff resources appropriately, and maximizing the patient's involvement in his /her own plan of care.
- Configuring departmental and physician services to accommodate the care needs of the patient in a timely manner will maximize quality of patient care and patient satisfaction.
- Relationship based care, the professional nursing practice model is a framework which reflects our underlying philosophy and vision of providing personalized nursing care. Aspects of the professional model support:
    - Matching nurses with specific skills to patients with specific needs to ensure "safe passage" to achieve the optimal outcome of their hospital stay
    - The ability of the nurse to establish and maintain a therapeutic relationship with their patients
    - The presence of interdisciplinary team approach to patient care delivery. The knowledge and expertise of all caregivers is utilized to provide personalized care for the patient.
    - Physicians, nurses, pharmacists, respiratory therapist, patient care resource managers and many other disciplines collaborate and provide input to patient care.

- The patient and family will be involved in establishing the plan of care to ensure services that accommodate their needs, goals and requests.
- Streamlining the documentation process will enhance patient care.

Patient Rights and Organizational Ethics

Patient Rights

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

Organizational Ethics

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

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

Biomedical Ethics

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

- Improve patient care and ensure patient safety;
- Clarify any uncertainties regarding medical decisions;
- Explore the values and principles underlying disagreements;
- Facilitate communication between the attending physician, the patient, members of the treatment team and the patient's family (as appropriate); and,
- Mediate and resolve disagreements.

Integration of Patient Care and Support Services

The importance of a collaborative interdisciplinary team approach, which takes into account the unique knowledge, judgment, and skills of a variety of disciplines in achieving desired patient outcomes, serves as a foundation for integration of patient care. Cross functional performance improvement initiates further support effective integration of Hospital and health system policies, procedures and protocols evidence functional relationships between departments. See appendix A for a listing of support services.

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

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

Consultations and Referrals For Patient Services

The James Cancer Hospital provides services as identified in the Plan for Providing Patient Care to meet the needs of our community. Patients who have assessed needs that require services not offered at The James Cancer Hospital are transferred to the member hospital of The Ohio State Wexner Medical Center in a timely manner after stabilization, or another quality facility. Safe transportation is provided by air or ground ambulance with staff and equipment appropriate to the required level of care. Physician consultation occurs prior to transfer to ensure continuity of care. Referrals for outpatient care occur based on patient need.

Information Management Plan

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

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

Patient Organization Improvement Activities

All departments are responsible for following and participating in the hospital's plan for improving organizational performance.

Plan Review

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

Appendix A: Scope of Services: Patient Support Services

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

DEPARTMENT	SERVICE
Chaplaincy and Clinical Pastoral Education	Assists patients, their families and hospital personnel in meeting spiritual needs through professional pastoral and spiritual care and education.
Clinical Engineering	Routine equipment evaluation, maintenance, and repair of electronic equipment, evaluation of patient owned equipment. Refer to James Hospital Policy 04-08; Equipment Safety for Patient Care Areas.
Communications and Marketing	Responsible for developing strategies and programs to promote the organization's overall image and specific products and services to targeted internal and external audiences. Manages all media relations, advertising, internal communications, special events, and publications for the Hospital.
Diagnostic Testing Areas	Provides tests based on verbal, electronic or written consult requests.
Early Response Team (ERT)	Provides timely diagnostic and therapeutic intervention before there is a cardiac or respiratory arrest or an unplanned transfer to the Intensive Care Unit. The team is comprised of response RN and Respiratory Therapist trained to assist patient care staff when there are signs that a patient's health is declining
Environmental Services	Provides housekeeping of patient rooms and nursing unit environments.
Epidemiology	Enhance the quality of patient care and the work environment by minimizing the risk of acquiring infection within the hospital and ambulatory setting.
Facilities Operations	Provide oversight, maintenance and repair of the building's life safety, fire safety, and utility systems. Provide preventative, repair and routine maintenance in all areas of all buildings serving patients, guests, and staff.
Financial Services	Assists managers in preparation and management of capital and operational budgets; provides comprehensive patient billing services and works with patients and payers to facilitate meeting all payer requirements for payment.
Patient Experience	Develops programs for support of patient relations and customer service and information desk. Volunteers do way-finding, host visitors in waiting areas, serve as patient/family advisors and assist staff. Volunteer Services serves as a liaison for the Service Board auxiliary which annually grants money to department-initiated projects that enhance the patient and family experience
Human Resources	Serves as a liaison for managers regarding all Human Resources information and services; assists departments with restructuring efforts; provides proactive strategies for managing planned change within the Health System; assists with Employee/Labor Relations issues; assists with performance management process; develops compensation strategies; develops hiring strategies and coordinates process for placements; provides strategies to facilitate sensitivity to issues of cultural diversity; provides Human Resources information to employees, and established equity for payroll
Information Systems	Assists departments to explore, deploy and integrate reliable, state of the art information systems technology solutions to manage change.
Materials Management	Supplies stock in patient care areas
Medical Information Management	Maintains patient records serving the needs of the patient, provider, institution and various third parties to health care in the inpatient and ambulatory setting

Oncology Laboratories	Provides clinical laboratory support services for medical, surgical, bone marrow transplantation and radiation oncology units
Nutrition Services	Provides nutrition care and food service to James hospital and ambulatory site patients, staff and visitors. Clinical nutrition assessment and consultation are available in both inpatient and outpatient settings. The department provides food service to inpatients and selected ambulatory settings.
Patient Access Services	Coordinates registration/admissions with nursing management
Patient Care Resource Management and Social Services	Provides personalized care coordination and resource management with patients and families. Provides discharge planning, coordination of external agency contacts for patient care needs and crisis intervention and support for patients and their families. Provides services upon phone/consult request of physician, nurse or the patient or family
Patient Financial Services	Provides financial assistance upon request from the patient/family
Pulmonary Diagnostics Lab	Provides service to patients requiring an evaluation of the respiratory system including pulmonary function testing, bronchoscopy and other diagnostic/interventional pulmonary procedures.
Quality and Patient Safety	Provides integrated quality management and facilitates continuous quality improvement efforts throughout the Hospital.
Rehabilitation Services	Physical therapists, occupational therapists, speech and language pathologist and recreational therapists, evaluate, formulate a plan of care, and provide treatment based on physician referral and along with the interdisciplinary medical team for appropriate treatment and education needed for the established discharge plan.
Respiratory Therapy	Provides respiratory therapeutic interventions and diagnostic testing, by physician order including ventilator support, bronchodilator therapy, and pulmonary hygiene.
Security	Provides a safe and secure environment for patients, visitors, and staff members by responding to emergencies such as workplace violence, fires, bomb threats, internal and external disasters, armed aggressors, or any other incident that needs and emergency response.
Staff Development and Education	Provides and promotes ongoing employee development and training related to oncology care, provides clinical orientation, and continuing education of staff

(APPENDIX III)

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

LEADERSHIP COUNCIL
FOR CLINICAL QUALITY, SAFETY AND SERVICE

The Ohio State University Wexner Medical Center

Clinical Quality Management, Patient Safety, & Service Plan

FY 2013 -2014

Clinical Quality Management, Patient Safety, & Service Plan

ATTACHMENTS

Clinical Quality Management, Patient Safety, & Service Plan

Definition

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

Program Scope

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

Program Purpose

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

Objectives

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

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

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

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

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

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

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

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

9) Assure processes involve an interdisciplinary teamwork approach.

Structure for Quality Oversight

The Leadership Council for Clinical Quality, Safety & Service serves as the single, multidisciplinary quality and safety oversight committee for the OSUWMC. The Leadership Council (Attachment I and II) determines annual goals for the health system.

Roles and responsibilities

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

Medical Center Board

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

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

Chief Executive Officer (CEO)

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

Chief Quality Officer (CQO)

The CQO reports to the Medical Center CEO and provides oversight and leadership for the OSUWMC in the conceptualization, development, implementation and measurement of OSUWMC approach to quality, patient safety and adverse event reduction.

Chief Medical Officer (CMO)

The CMO for the Medical Center is responsible for ensuring the implementation of the overall Clinical Quality Management and Patient Safety Plan at OSUWMC. The CMO is responsible for implementing

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

Medical Director/Director of Medical Affairs

Each business unit Medical Director is responsible to the appropriate Board for the implementation and oversight of the Clinical Quality Management and Patient Safety Plan. Each Medical Director is also responsible for reviewing the recommendations from the Clinical Quality Management and Patient Safety Plan.

Associate Medical Directors

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

Health System Chief Executive Officer (CEO)

The OSUWMC CEO is responsible to the Board for implementation of the Clinical Quality Management and Patient Safety Plan.

Business Unit Associate Executive Directors

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

Clinical Department Chief and Division Directors:

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

Medical Staff

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

A house staff quality forum with representatives from each ACGME accredited program has dedicated one medical resident who will be the quality liaison to the overall Quality Program . This committee will report to the Health System Clinical Quality & Patient Safety committee.

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

Nursing Quality

The Chief Nursing Executive (CNE) provides leadership and oversight for the Nursing Quality Plan and the integration of this plan into the overall Clinical Quality Management & Patient Safety Plan. Nursing leadership and staff are active participants in the Leadership Council for Clinical Quality, Safety and Service and all other associated Committees outlined in this plan. Nursing staff are responsible for ensuring the delivery of world class personalized nursing care to patients and families. Nursing-related quality activities are integrated and aligned with the goals and tactics established by the LCCQSS.

Hospital Department Directors

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

Health System Staff

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

- Suggesting improvements and reporting medical/health care errors
- Monitoring activities and processes, such as patient complaints and patient satisfaction participating in focus groups
- Attending staff meetings
- Participating in efforts to improve quality and safety

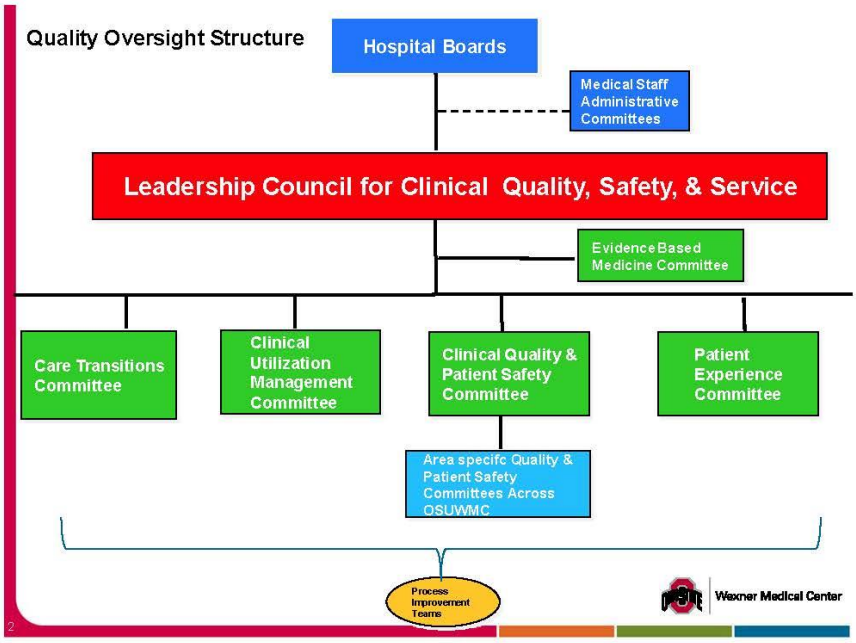
Quality and Operations Improvement Department:

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

Patient Experience Department

The primary responsibility of the Patient Experience Department is to coordinate and facilitate a service oriented approach to providing healthcare throughout the Health System. This is accomplished through both strategic and program development as well as through managing operational functions within the Health System. The primary responsibility for the implementation and evaluation of service-related activities resides in each department/program; however, the Patient Experience staff also serves as an

internal consultant for the development and evaluation of service quality activities. The Patient Experience Department maintains human and technical resources for interpreter services, information desks, patient relations, team facilitation, and use of performance improvement tools, data collection, statistical analysis, and reporting. The Department also oversees the Patient/Family Advisor Program which is a group of current/former patients, or their primary caregivers, who have had experiences at any OSU Health System facility. These individuals are volunteers who serve on committees and workgroups, as Advisory Council members, complete public speaking engagements and review materials



COMMITTEES:

Medical Staff Administrative Committees (MSACs)

Composition: Refer to Medical Staff Bylaws and Rules and Regulations

Function: Refer to Medical Staff Bylaws and Rules and Regulations

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

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

Leadership Council for Clinical Quality, Safety and Service (LCCQSS):

Composition: Refer to Medical Staff Bylaws and Rules and Regulations

Function: Refer to Medical Staff Bylaws and Rules and Regulations

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

Evidence-Based Practice Committee (EBPC)

Composition:

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

Function:

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

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

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

Clinical Quality and Patient Safety Committee (CQPSC)

Composition:

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

Function:

1. Create a safe environment, which promotes organizational learning related to patient safety and minimizes individual blame or retribution for involvement in a medical/health care error

2. Assure optimal compliance with patient safety-related accreditation standards.

3. Proactively identifies risks to patient safety and initiates actions to reduce risk with a focus on process and system improvement.

4. Oversees completion of proactive risk assessment as required by TJC.

5. Oversees education & risk reduction strategies as they relate to Sentinel Event Alerts from TJC.

6. Provides oversight for clinical quality management committees.

7. Evaluates and, when indicated, provides recommendations to improve clinical care and outcomes.

8. Ensures actions are taken to improve performance whenever an undesirable pattern or trend is identified.

9. Receive reports from committees that have a potential impact on the quality & safety in delivering patient care such as, but not limited to, Environment of Care committee, Health Safety Committee, Clinical IHIS Steering Committee, Value Based Clinical Transformation Committee, and Infection Prevention Committee

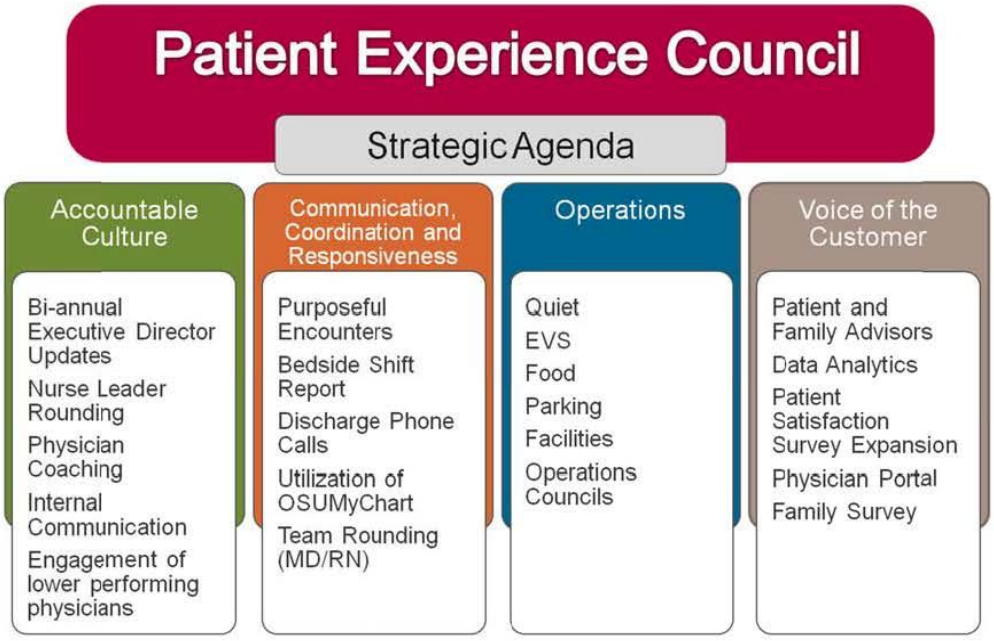
Patient Experience Council

Composition:

The Patient Experience Council consists of multidisciplinary representatives from across all settings. The Council is co-chaired by the Chief Nurse Executive for the Health System and a physician leader. The committee reports to the Leadership Council and reports out to additional committees as applicable. One of the goals of the Patient Experience Council is to ensure the organization maintains a patient- and family-centered approach.

Function:

1. Create a culture and environment that delivers an exceptional patient experience consistent with the OSU Medical Center's mission, vision and values focusing largely on service quality.
2. Measure and review voice of the customer information in the form of Patient and Family Experience Advisor program and related councils, patient satisfaction, comments, letters and related measures.
3. Monitor publicly reported and other metrics used by various payers to ensure optimal reimbursement.
4. Recommends system goals and expectations for a consistent patient experience.
5. Collaborates with other departments to reward and recognize faculty and staff for service excellence performance.
6. Provides guidance and oversight on patient experience improvement efforts ensuring effective deployment and accountability throughout the system.
7. Serves as a communication hub reporting out objectives and performance to the system.
8. Serves as a coordinating body for subcommittees working on specific aspects of the patient experience.


Patient Experience Council
Strategic Agenda
Accountable Culture
Bi-annual Executive Director Updates
Nurse Leader Rounding
Physician Coaching
Internal Communication
Engagement of lower performing physicians
Communication, Coordination and Responsiveness
Purposeful Encounters
Bedside Shift Report
Discharge Phone Calls
Utilization of OSUMyChart
Team Rounding (MD/RN)
Operations
Quiet
EVS
Food
Parking
Facilities
Operations Councils
Voice of the Customer
Patient and Family Advisors
Data Analytics
Patient Satisfaction Survey Expansion
Physician Portal
Family Survey

Care Transitions Committee (CTC)

Composition:

The CTC committee of multidisciplinary representatives from Hospital Administration, Medical Staff, Case Management, Financial Services, Information Technology, and Nursing. The assistant chief operating officer for the Health System chairs the committee. CTC reports to LCCQSS, Health System Committee, and shares pertinent information with the Medical Staff Administrative Committees.

Function:

1. Promote the efficient and effective patient care transitions processes while assuring the highest quality of care.
2. Serves to facilitate optimal capacity management related to patient care settings across the care continuum
3. Direct the development of action plans to address identified areas of improvement.
4. Resolve or escalate barriers related to effective and efficient care transition processes in the health care delivery system, which impede efficient and effective care transition processes.

Key areas of focus:

- Capacity Management/Transitions
- Readmission management
- Targeted early discharge processes
- LOS management
- Transfer Center Processes

Clinical Utilization Management Committee

Composition:

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

Function:

1. Promote the efficient utilization of resources for patients while assuring the highest quality of care.
2. Direct the development of action plans to address identified areas of improvement.
3. Resolve or escalate barriers related to clinical practice patterns in the health care delivery system, which impede the efficient, appropriate utilization of resources.
4. Review patients for appropriate level of care (e.g., inpatient, observation, outpatient, extended care facility, etc.) and for the efficiency and effectiveness of professional services rendered (physician, nursing, lab, therapists)

5. Ensure compliance with regulatory requirements related to utilization management (Ie: RAC Audits, denial management, etc).
6. Administration of the Utilization Management Plan

Key areas of focus:

- Availability and appropriateness of clinical resources and services
    - OP/IP beds appropriateness
    - Post-acute partnerships
    - Availability of necessary services
    - Timeliness of necessary services
    - Appropriate use of necessary services
- LOS management
- Medical necessity and appropriateness of level of care and related denial management.
- Readmission management

Technology Assessment Committee (TAC)

Composition:

The TAC is composed of multi-disciplinary representatives from the medical staff, hospital administration, Biomedical Clinical Engineering and Strategic Sourcing. TAC is chaired by the Director of Peri-operative Services and reports to the Clinical Resource Utilization Committee.

Function:

Evaluate and make decisions regarding the appropriate use and acquisition of new and existing technologies across The Ohio State University Health System.

Key areas of focus:

- Clinical benefits
- Financial impact
- Alignment with strategic plan

Practitioner Evaluation Committee (PEC)

Composition:

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

Function:

1. Provide leadership for the clinical quality improvement processes within The OSU Health System.
2. Provide clinical expertise to the practitioner peer review process within The OSU Health System by thorough and timely review of clinical care and/or patient safety issues referred to the Practitioner Evaluation Committee.

3. Advise the CMO & Director of Medical Affairs at the James regarding action plans to improve the quality and safety of clinical care at the Health system.
4. Develop follow up plans to ensure action is successful in improving quality and safety.

Health System Information Systems Steering Team (HSISST)

Composition:
The HSISST is a multi-disciplinary group chaired by the Chief Medical Information Officer of The Ohio Sate University Health System.

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

Sentinel Event Team

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

The Sentinel Event Determination Group (SEDG)
The SEDG is a sub-group of the Sentinel Event Team and determines whether an event will be considered a sentinel event or near miss, assigns the Root Cause Analysis (RCA) Executive Sponsor, RCA Workgroup Leader, RCA Workgroup Facilitator, and recommends the Workgroup membership to the Executive Sponsor. The Sentinel Event Team facilitator will attend to support the members.
The SEDG membership includes the CMO or designee, Director of Risk Management, and Quality Director of respective business unit for where the event occurred (or their designee).

Sentinel Event Team Function:
Approves & makes recommendations on sentinel event determinations and teams, and action plans as received from the Sentinel Event Determination Group, 2) evaluates findings, recommendations, and approves action plans of all root cause analyses. The documentation created as a result of a sentinel event or near miss is not externally reported or released.

Clinical Quality & Patient Safety Sub-Committees

Composition:
For the purposes of this plan, Quality & Patient Safety Sub-Committees will refer to any standing committee or sub-committee functioning under the Quality Oversight Structure. Membership on these committees will

represent the major clinical and support services throughout the hospitals and/or clinical departments. These committees report, as needed, to the appropriate oversight committee(s) defined in this Plan.

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

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

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

Approach to Quality, Safety & Service Management

The OSU Health System approach to clinical quality management, patient safety, and service is leadership-driven and involves significant staff and physician participation. Clinical quality management and patient safety activities within the Health System are multi-disciplinary and based on the Health System's mission, vision, values, and strategic plan. It embodies a culture of continuously measuring, assessing, and initiating changes including education in order to improve outcomes. The Health System employs the following principles of continuous quality improvement in its approach to quality management and patient safety:

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

Safe
Timely
Effective
Efficient
Equitable
Patient-centered

These principles are:

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

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

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

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

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

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

Continuous: Measurement and improvement are ongoing.

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

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

Model

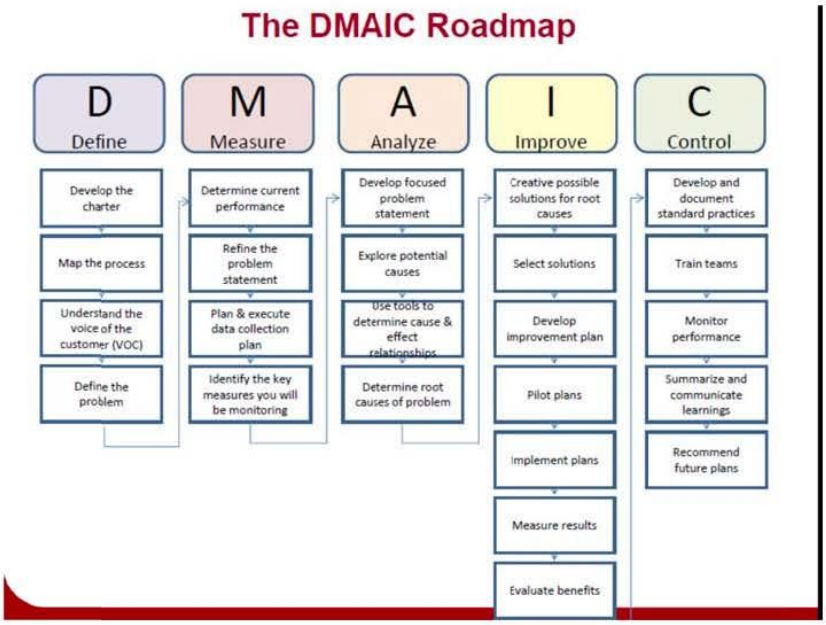
Systematic Approach/Model to Process Improvement

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

***The Process Improvement Toolkit**

Methodology
PDCA
Rapid Cycle Improvement
DMAIC
Lean Principles

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



Consistent Level of Care

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

- Policies and procedures and services provided are not payer driven.
- Application of a single standard for physician credentialing.
- Health system monitoring tools to measure like processes in areas of the Health System.
- Standardize and unify health system policies and procedures that promote high quality, safe care.

Performance Transparency

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

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

Confidentiality

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

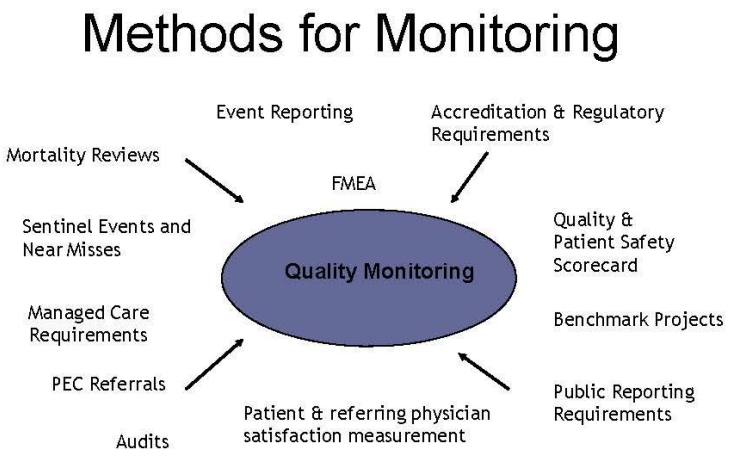
Conflict of Interest

Any person, who is professionally involved in the care of a patient being reviewed, should not participate in peer review deliberations and voting. A person is professionally involved if they are responsible for patient care decision making either as a primary or consulting professional and/or have a financial interest (as determined by legal counsel) in the case under review. Persons who are professionally involved in the care under review are to refrain from participation except as requested by the appropriate administrative or medical leader. During peer review evaluations, deliberations, or voting, the chairperson will take steps to avoid the presence of any person, including committee members, professionally involved in the care under review. The chairperson of a committee should resolve all questions concerning whether a person is professionally involved. In cases where a committee member is professionally involved, the respective chairperson may appoint a replacement member to the committee. Participants and committee members are encouraged to recognize and disclose, as appropriate, a personal interest or relationship they may have concerning any action under peer review.

Determining Priorities

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

Data Measurement and Assessment



Determination of data needs

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

External reporting requirements

There are a number of external reporting requirements related to quality, safety, and service. These include regulatory, governmental, payer, and specialty certification organizations. Attachment V displays some examples of external organizations where quality, safety, and service data are reported.

Collection of data

Data, including patient demographic and diagnosis, are systematically collected throughout the Health System through various mechanisms including:

- Administrative and clinical databases
- Retrospective and concurrent medical record review
- Reporting systems (e.g., patient satisfaction)
- Surveys (i.e. patients, families, and staff).

Assessment of data

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

Surveillance system

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

Quality & Safety Scorecard

The Quality and Safety Scorecard is a set of health system-wide indicators related to those events considered potentially preventable. The Quality & Safety Scorecard covers the areas such as never events, sentinel events, hospital-acquired conditions, falls, medication events, and several other categories. The information is shared in various Quality forums with staff, clinicians, administration, and the Boards. The indicators to be included in the scorecard are reviewed each year to represent the priorities of the quality and patient safety program (Attachment VI).

Quality Notice Information

The Quality Notice is distributed monthly to all clinical staff and key administrative leaders showing year-to-date performance for mortality index and 30 day readmission rate. The results are displayed for the health system and by hospital compared to targets established by the LCCQSS. Additionally, attending physicians are provided a link from the Quality Notice to an online report of their individual CORE measure results.

Patient Satisfaction Dashboard

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

Quality, Patient Safety, and Service Educational Information

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

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

Benchmark data

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

Internal Benchmarking

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

External Benchmarking

The OSU Health System participates in various database systems and focused benchmarking projects to compare performance with that of peer institutions. The University HealthSystem Consortium, The US News Report, and the Ohio Department of Health are examples of several external organizations that provide benchmarking opportunities.

Design and evaluation of new processes

- New processes are designed and evaluated according to the Health System's mission, vision, values, priorities, and are consistent with sound business practices.
- The design or re-design of a process may be initiated by:
- Surveillance data indicating undesirable variance
- Patients, staff, or payers perceive the need to change a process

- Information from within the organization and from other organizations about potential risks to patient safety, including the occurrence of sentinel events
- Review and assessment of data and/or review of available literature confirm the need

Performance Based Physician Quality & Credentialing

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

Profiling Process:

- Data gathering from multiple sources
- Report generation and indicator analysis
- Profile review meetings with department chairs
- Discussion at Credentialing Committee
- Final Recommendation & Approval:
    - Medical Staff Administrative Committees
    - Medical Director
    - Hospital Board

Service-Specific Indicators

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

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

Purpose of Medical Staff Evaluation

- To appoint quality medical staff
- To monitor and evaluate medical staff performance

- To integrate medical staff performance data into the reappointment process and create the foundation for high quality care
- To provide periodic feedback and inform clinical department chairs of the comparative performance of individual medical staff
- To identify opportunities for improving quality of care

Annual Evaluation

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

Attachment I: LCCQSS Priorities 2013-2014

Key Result Area: Quality

- Reduce Quality & Safety Scorecard Events by 15%
  - Focus on Falls, DPUs, & Hospital Acquired Infections
- Improve in UHC Quality & Accountability ranking for health system risk-adjusted inpatient mortality to index of 0.67
- Achieve top decile in all Value Based Purchasing Clinical Indicators
- Hand Hygiene Compliance $\geq$ 90%

Key Result Area: Productivity and Efficiency

- Achieve the UHC Top Quartile for 30 day readmission rates in Heart Failure and Knee/Hip Replacements
- Achieve the UHC Median for 30 day readmission rates in AMI, Pneumonia, and COPD

Key Result Area: Service and Reputation

- Achieve and sustain top decile status by FY2015 for patient satisfaction HCAHPS Score 78%

Key Result Area: Work Place of Choice

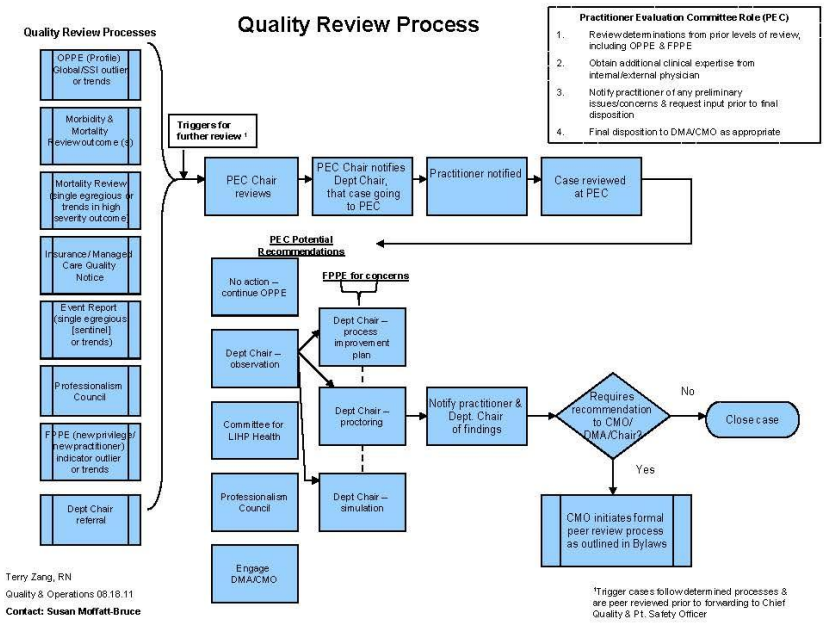
- Achieve 25% reduction in Employee Injuries

Attachment II: Priority Criteria

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

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

Attachment III: Physician Performance Based Profile



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

Status	Indicator	My Score	Peers Score	Target	SPC Alert	Current Period	6 Month Values		
							My Score	Peer Score	Start Month
A - Volume and Acuity									
	CMI	n/a	2.03	n/a		Q2 2013	No Data	1.97	Feb 2013
	IP Discharges	n/a	14.6	n/a		Q2 2013	No Data	14.0	Feb 2013
★ ▼	IP LOS Index (Obs_Exp Total Days)	0.83	1.06	1.06		Q1 2013	No Data	1.06	Feb 2013
▼	IP Procedures	4	42.7	n/a		Q2 2013	4	34.5	Mar 2013
▼	Observation Cases	0	1.85	n/a		Q2 2013	0	2.83	Feb 2013
▲	Outpatient Visits	189	107	n/a		Q2 2013	398	102	Feb 2013
B - Patient Care									
★ —	Autopsy Discrepancy	0	0.00	0		Q2 2013	0	1.00	Feb 2013
	Cath PCI Peri-procedure AMI	No Data	1.1%	n/a		Q2 2013	No Data	1.2%	Mar 2013
	Cath PCI Retro-peritoneal Bleed	No Data	0.3%	n/a		Q2 2013	No Data	0.2%	Mar 2013
	CM - AMI_2 Aspirin Prescribed at Discharge	n/a	91.2%	100.0%		Q4 2012	No Data	No Data	No Data
	CM - AMI_3 ACEI or ARB for LVSD	n/a	24.6%	100.0%		Q4 2012	No Data	No Data	No Data
	CM - AMI_5 Beta Blocker at Discharge	n/a	87.7%	100.0%		Q4 2012	No Data	No Data	No Data
	CM - AMI_9 Inpatient Mortality	n/a	0.0%	0.0%		Q4 2012	No Data	No Data	No Data
	CM - HF_2 Evaluation of LVS Function	n/a	95.7%	100.0%		Q4 2012	No Data	No Data	No Data
	CM - HF_3 ACEI or ARB for LVSD	n/a	46.8%	100.0%		Q4 2012	No Data	No Data	No Data
	ICD Registry CVA	No Data	0.0%	n/a		Q1 2013	No Data	0.0%	Mar 2013
★ ▼	IP Mort Index (Obs_Exp)	0.00	0.50	0.79		Q1 2013	No Data	0.47	Feb 2013
—	Mortalities Reviewed	1	0.44	n/a		Q2 2013	1	1.57	Mar 2013
★ —	Mortalities Sent for Peer Review	0	0.14	0		Q2 2013	0	1.07	Feb 2013
★ —	Mortality Peer Review #1 Score 4 or 5	0	0.00	0		Q2 2013	0	No Data	No Data
★ —	Quality Management Events - Standard of Care Not Met	0	0.04	0		Q2 2013	0	1.14	Mar 2013
—	Related ReAdmit 30 days	0.00%	3.34%	n/a		Q1 2013	No Data	3.19%	Feb 2013
	SSI CABG Procedures	No Data	0.0%	3.0%		Q2 2013	No Data	0.0%	May 2013
	SSI Pacemaker and AICD	No Data	0.0%	n/a		Q2 2013	No Data	0.0%	Apr 2013
C - Medical and Clinical Knowledge									
★ —	Formal Peer Reviews	0	0.00	0		Q2 2013	0	0.00	Feb 2013
E - Interpersonal and Communication									
★ —	Patient Complaints	0	0.02	0		Q2 2013	0	1.00	Mar 2013

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

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

	Reviewed By	Outcome	Notes
Jan 29, 2013	<name>	Maintain privileges without modification	The Provider's performance meets expectations.

SPC Alert Legend

Most recent period is below Lower Control Limit

Most recent period is above Upper Control Limit

Process shift: Most recent 8 periods are all above the Center Line

Process shift: Most recent 8 periods are all below the Center Line

Most recent 6 periods are all increasing

Most recent 6 periods are all decreasing

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

Attachment IV: Patient Safety Program

Vision

To be the safest health system in the world.

Goals

- Improve patient safety with full integration of key safety initiatives as evidenced by the Quality and Patient Safety Scorecard.
- Improve the culture of patient safety as evidenced by culture of safety survey results

Our Culture of Patient Safety

- "Just Culture"
- Balance system/process issues with accountability for expected behaviors
- Responsible, Accountable and Fair
- Ownership and integrity
- Create a work environment that is open, honest and transparent

Patient Safety Program Components

The patient safety program is a comprehensive plan comprised of initiatives in the following domains:

- Culture of safety
- Performance monitoring and improvement
- Regulatory and accreditation
- Event reporting
- Sentinel events
- Education
- Innovation
- Recognition

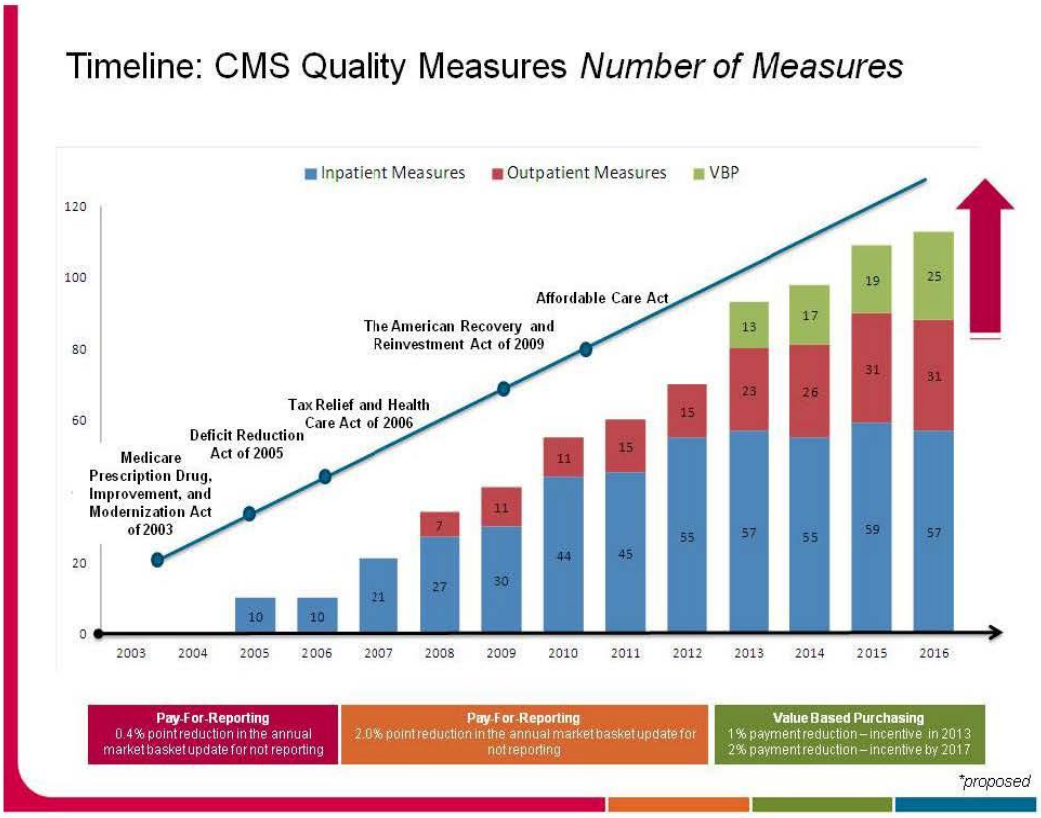
A Patient of Safety Culture Survey will be administered at a frequency determined by CQO and other Senior Leaders.

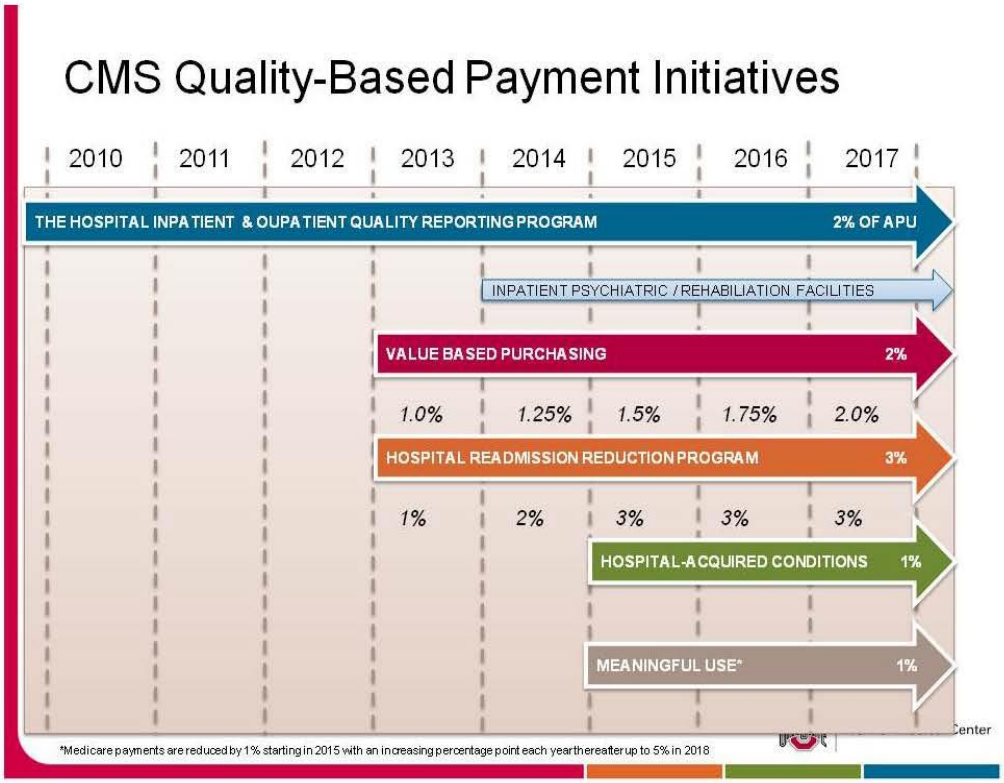
Attachment V: External Reporting

Quality Data & External Reporting?

Regulatory/Public Data	Payers	Registries/ Benchmarking
CMS	Anthem	STS
ODH	United Healthcare	ACC
TJC	Aetna	GWTG
Leapfrog	Optum Health	Vermont Oxford
Franklin Co		NSQIP
NHSN/CDC		UHC
Oryx		BOLD
CARF		eRehab
		Coverdell
		SVS
		INTERMACS
		ELSO

Red = Public Data


Timeline: CMS Quality Measures *Number of Measures*
Inpatient Measures
Outpatient Measures
VBP
120
100
80
60
20
0
Medicare Prescription Drug, Improvement, and Modernization Act of 2003
Deficit Reduction Act of 2005
Tax Relief and Health Care Act of 2006
The American Recovery and Reinvestment Act of 2009
Affordable Care Act
10
10
21
27
7
30
11
44
11
45
15
55
15
57
23
13
55
26
17
59
31
19
57
31
25
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
Pay-For-Reporting
0.4% point reduction in the annual market basket update for not reporting
Pay-For-Reporting
2.0% point reduction in the annual market basket update for not reporting
Value Based Purchasing
1% payment reduction – incentive in 2013
2% payment reduction – incentive by 2017
*proposed


CMS Quality-Based Payment Initiatives
2010
2011
2012
2013
2014
2015
2016
2017
THE HOSPITAL INPATIENT & OUPATIENT QUALITY REPORTING PROGRAM
2% OF APU
INPATIENT PSYCHIATRIC / REHABILIATION FACILITIES
VALUE BASED PURCHASING
2%
1.0%
1.25%
1.5%
1.75%
2.0%
HOSPITAL READMISSION REDUCTION PROGRAM
3%
1%
2%
3%
3%
3%
HOSPITAL-ACQUIRED CONDITIONS
1%
MEANINGFUL USE*
1%
*Medicare payments are reduced by 1% starting in 2015 with an increasing percentage point each year thereafter up to 5% in 2018

Attachment VI: Quality and Safety Scorecard

Current Scorecard Categories

Type of Event
Retained Foreign Bodies
Wrong Site Events
Medication Events with Harm (Severity E-I)
Falls with Harm (Injury Level 2-4)
Hospital Acquired Pressure Ulcer
Central Line Blood Stream Infections
Ventilator Associated Pneumonia
Hospital Acquired Surgical Site Infections
Hospital Acquired Clostridium Difficile Infection
Catheter Associated Urinary Tract Infections
Total Potentially Avoidable Events

(APPENDIX IV)

The Ohio State University
Comprehensive Cancer Center
James Cancer Hospital and Solove Research Institute
(OSUCCC-James)

LEADERSHIP COUNCIL
for CLINICAL QUALITY, SAFETY AND SERVICE

OSUCCC –James Quality & Patient Safety Committee

Clinical Quality Management, Patient Safety, & Service Plan

2013-2014

Clinical Quality Management, Patient Safety and Service Plan

Clinical Quality Management, Patient Safety and Service Plan

Definition

The Clinical Quality Management, Patient Safety and Service Plan of The Ohio State University Comprehensive Cancer Center and James Cancer Hospital/Solove Research Institute (referred to as the "OSUCCC-James Plan") is the organization-wide approach to the systematic assessment and improvement of process design and performance. It integrates all activities defined in the Clinical Quality Management, Patient Safety & Service Plan to deliver safe, effective, optimal patient care and services in an environment of minimal risk.

Program Scope

The OSUCCC-James Plan encompasses all of the James clinical services, including inpatient and outpatient areas. Through partnership activities with the Comprehensive Cancer Center (CCC), the plan also includes quality and patient safety goal(s) for process improvements related to functions that affect both the CCC and the James.

As a PPS exempt hospital that is the clinical care delivery arm of an NCI-designated Comprehensive Cancer Center, the James has a unique opportunity to offer value-added services and research expertise to its oncology patients, families and the community. As the OSUCCC-James continues to expand clinical and clinical research activities, it is anticipated that quality management, quality improvement and patient safety strategies will be instrumental in those improvement efforts.

OSUCCC-James Mission:
To eradicate cancer from individuals' lives by creating knowledge and integrating groundbreaking research with excellence in education and patient centered-care

OSUCCC-James Vision:
Creating a cancer-free world. One Person, one discovery at a time.

Program Purpose

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

Objectives

The primary objectives of the OSUCCC-James plan are to:

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

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

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

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

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

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

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

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

9) Assure processes involve an interdisciplinary teamwork approach

Structure for Quality Oversight

The Leadership Council for Clinical Quality, Safety & Service serves as the single, multidisciplinary quality and safety oversight committee for the OSU Health System. The Leadership Council (Attachment I) determines annual goals for the health system.

Roles and responsibilities

Clinical quality management, patient safety and service excellence are responsibilities of all staff members, volunteers, visitors, patients and their families.

Medical Center and James Operations Boards

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

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

Chief Medical Officer (CMO)

The CMO for the Medical Center is responsible for providing leadership and oversight of the implementation of the Clinical Quality Management, Patient Safety and Service Plan.

Chief Quality Officer (CQO)

The CQO reports to the Medical Center CEO and provides oversight and leadership for the OSU Health System in the conceptualization, development, implementation and measurement of OSUHS's approach to quality, patient safety and adverse event reduction.

OSUCCC-James Physician-in-Chief

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

Medical Director/Director of Medical Affairs

Each business unit's Medical Director is responsible to the appropriate Board for the implementation and oversight of the Clinical Quality Management, Patient Safety and Service Plan. Each Medical Director is also responsible for reviewing the recommendations from the Clinical Quality Management, Patient Safety and Service Plan.

Associate Medical Directors

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

Health System Chief Executive Officer (CEO)

The Health System CEO is responsible to the Board for implementation of the Clinical Quality Management, Patient Safety and Service Plan.

Business Unit Associate Executive Directors

The OSU Health System staff, under the direction of the Health System CEO and Hospital Administration, implements the program throughout the organization. Hospital Administration provides authority and supports corrective actions within its realm for clinical quality management, patient safety and service activities.

Clinical Department Chief and Division Directors

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

Medical Staff

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

Nursing Quality

The Chief Nursing Executive (CNE) provides leadership and oversight for the Nursing Quality Plan and the integration of this plan into the overall Clinical Quality Management & Patient Safety Nursing leadership and staff are active participants in the Leadership Council for Clinical Quality, Safety and Service and all other associated Committees outlined in this plan. Nursing staff are responsible for ensuring the delivery of world class personalized nursing care to patients and families. Nursing-related quality activities are integrated and aligned with Relationship Based Care, as well as the goals and tactics established by the LCCQSS.

Hospital Department Directors

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

Health System Staff

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

Suggesting improvements and reporting medical/health care errors

Monitoring activities and processes, such as patient complaints and patient satisfaction

Participating in focus groups

Attending staff meetings

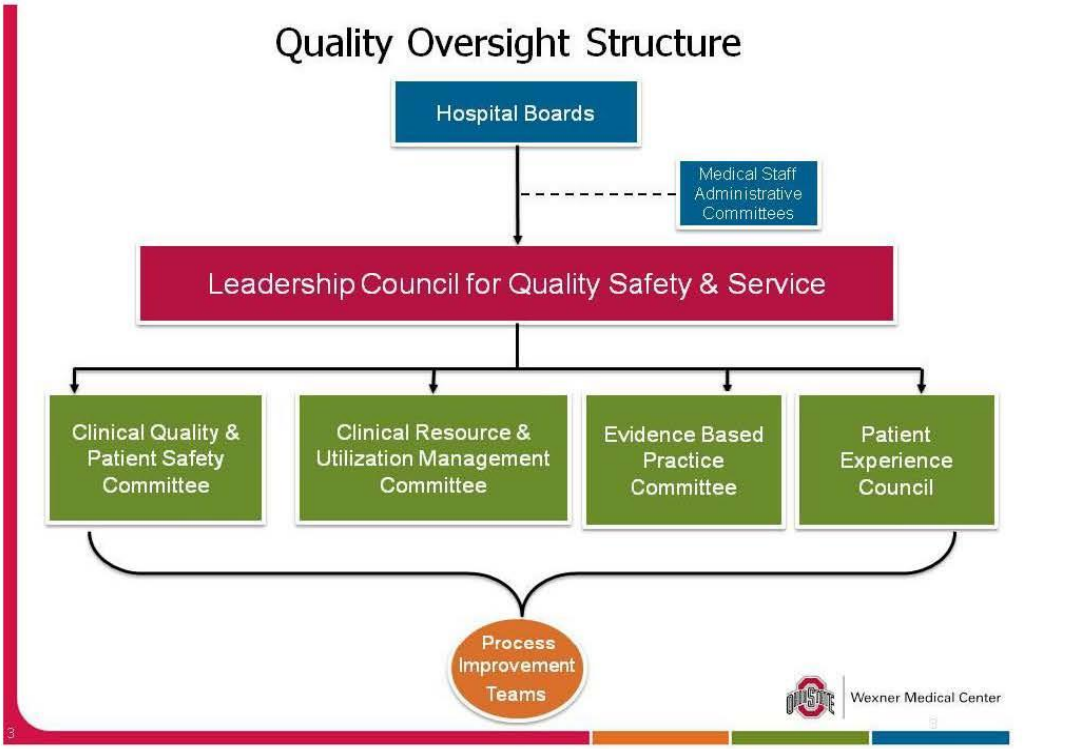
Participating in efforts to improve quality, safety, and service

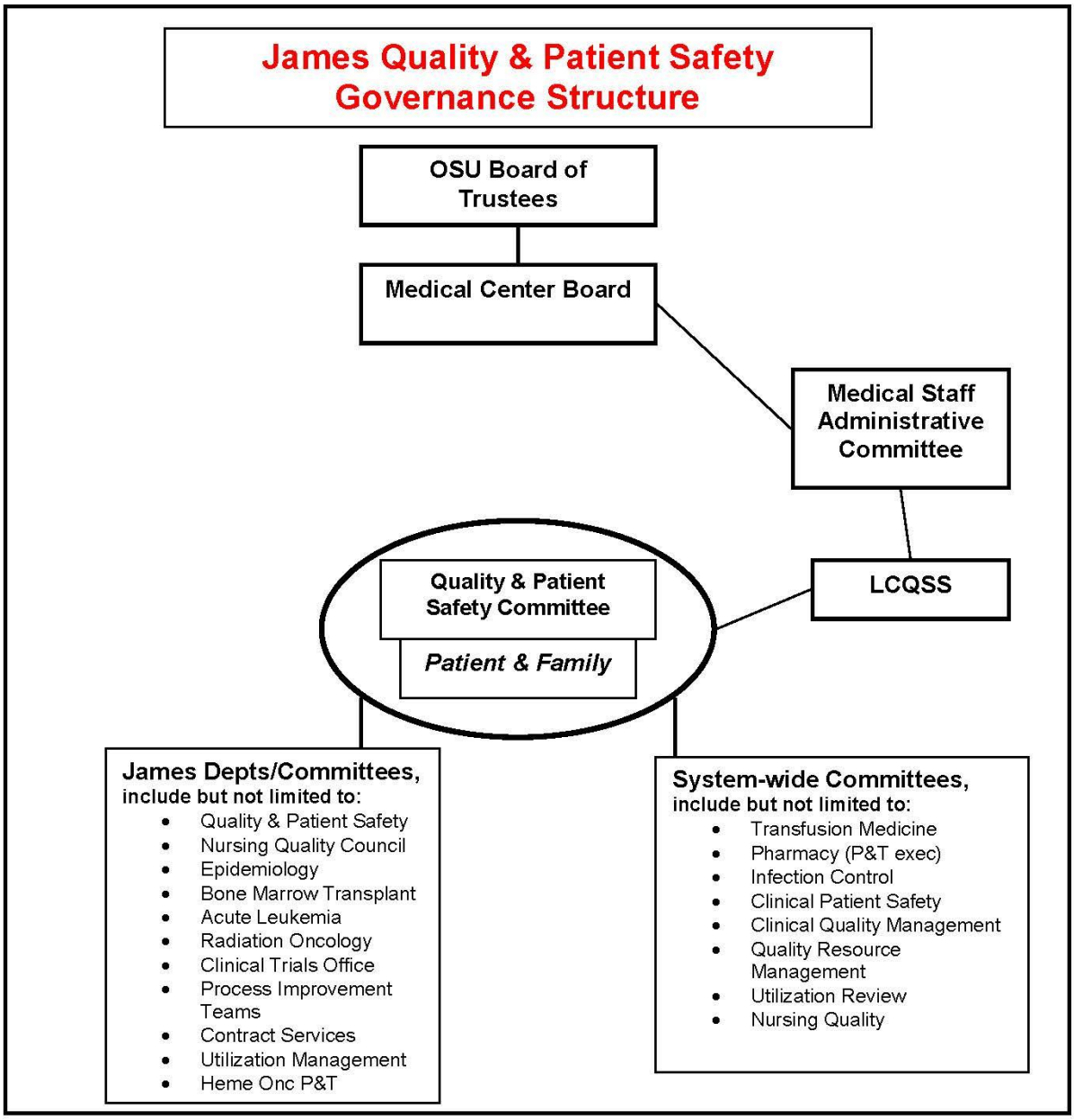
Health System Quality and Operations Improvement Department

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

Patient Experience Department

The primary responsibility of the Patient Experience Department is to coordinate and facilitate a service oriented approach to providing healthcare throughout the Health System. This is accomplished through both strategic and program development as well as through managing operational functions within the Health System. The primary responsibility for the implementation and evaluation of service-related activities resides in each department/program; however, the Patient Experience staff also serves as an internal consultant for the development and evaluation of service quality activities. The Patient Experience Department maintains human and technical resources for interpreter services, information desks, patient relations, team facilitation, and use of performance improvement tools, data collection, statistical analysis, and reporting.




James Quality & Patient Safety Governance Structure
OSU Board of Trustees
Medical Center Board
Medical Staff Administrative Committee
LCQSS
Quality & Patient Safety Committee
Patient & Family
James Depts/Committees, include but not limited to:
Quality & Patient Safety
Nursing Quality Council
Epidemiology
Bone Marrow Transplant
Acute Leukemia
Radiation Oncology
Clinical Trials Office
Process Improvement Teams
Contract Services
Utilization Management
Heme Onc P&T
System-wide Committees, include but not limited to:
Transfusion Medicine
Pharmacy (P&T exec)
Infection Control
Clinical Patient Safety
Clinical Quality Management
Quality Resource Management
Utilization Review
Nursing Quality

COMMITTEES:

Medical Staff Administrative Committees (MSACs)

Composition: Refer to Medical Staff Bylaws and Rules and Regulations

Function: Refer to Medical Staff Bylaws and Rules and Regulations

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

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

Leadership Council for Clinical Quality, Safety and Service (LCCQSS)

Composition: Refer to Medical Staff Bylaws and Rules and Regulations

Function: Refer to Medical Staff Bylaws and Rules and Regulations

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

Clinical Quality and Patient Safety Committee (CQPSC)

Composition:

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

Function:

1) Create a safe environment, which promotes organizational learning related to patient safety and minimizes individual blame or retribution for involvement in a medical/health care error

2) Assure optimal compliance with patient safety-related accreditation standards.

3) Proactively identifies risks to patient safety and initiates actions to reduce risk with a focus on process and system improvement.

4) Oversees completion of proactive risk assessment as required by The Joint Commission (TJC).

5) Oversees education & risk reduction strategies as they relate to Sentinel Event Alerts from TJC.

6) Provides oversight for clinical quality management committees.

7) Evaluates and, when indicated, provides recommendations to improve clinical care and outcomes.

8) Ensures actions are taken to improve performance whenever an undesirable pattern or trend is identified.

9) Receive reports from committees that have a potential impact on the quality & safety in delivering patient care such as, but not limited to, Environment of Care committee, Health Safety Committee, Clinical IHIS Steering Committee, Value Based Clinical Transformation Committee, and Infection Prevention Committee.

Patient Experience Council

Composition:

The Patient Experience Council consists of multidisciplinary representatives from across all settings. The Council is co-chaired by the Chief Nurse Executive for the Health System and a physician leader. The committee reports to the Leadership Council and reports out to additional committees as applicable. One of the goals of the Patient Experience Council is to ensure the organization maintains a patient- and family-centered approach.

Function:

1) Create a culture and environment that delivers an exceptional patient experience consistent with the OSU Medical Center's mission, vision and values focusing largely on service quality.

2) Measure and review voice of the customer information in the form of Patient and Family Experience Advisor program and related councils, patient satisfaction, comments, letters and related measures.

3) Monitor publicly reported and other metrics used by various payers to ensure optimal reimbursement.

4) Recommends system goals and expectations for a consistent patient experience.

5) Collaborates with other departments to reward and recognize faculty and staff for service excellence performance.

6) Provides guidance and oversight on patient experience improvement efforts ensuring effective deployment and accountability throughout the system.

7) Serves as a communication hub reporting out objectives and performance to the system.

8) Serves as a coordinating body for subcommittees working on specific aspects of the patient experience.

Evidence-Based Practice Committee (EBPC)

Composition:

The EBPC consists of multidisciplinary representatives from Hospital Administration, Medical Staff, Information Technology, Pharmacy, and Nursing. An active member of the medical staff chairs the committee. The EBPC reports to LCCQSS and the OSU Hospitals Boards, and shares pertinent information with the Medical Staff Administrative Committees.

Function:

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

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

Clinical Resource Utilization Committee (CRUC)

Composition:

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

Function:

1) Promote the efficient utilization of resources for patients while assuring the highest quality of care.

2) Direct the development of action plans to address identified areas of improvement.

3) Resolve or escalate barriers related to clinical practice patterns in the health care delivery system, which impede the efficient, appropriate utilization of resources.

4) Review patients for appropriate level of care (e.g., inpatient, observation, outpatient, extended care facility, etc.) and for the efficiency and effectiveness of professional services rendered (physician, nursing, lab, therapists).

5) Administration of the Utilization Management Plan.

Key areas of focus:

- LOS management
- Readmission management
- Medical necessity and appropriateness of level of care and related denial management.
- Availability and appropriateness of clinical resources and services
  - Availability of necessary services
  - Timeliness of necessary services
  - Appropriate use of necessary services

Technology Assessment Committee (TAC)

Composition:

The TAC is composed of multi-disciplinary representatives from the medical staff, hospital administration, Biomedical Clinical Engineering and Strategic Sourcing. TAC is chaired by the Director of Peri-operative Services and reports to the Clinical Resource Utilization Committee.

Function:

Evaluate and make decisions regarding the appropriate use and acquisition of new and existing technologies across The Ohio State University Health System.

Key areas of focus:

- Clinical benefits
- Financial impact
- Alignment with strategic plan

Practitioner Evaluation Committee (PEC)

Composition:
The Practitioner Evaluation Committee (PEC) is the PEER review committee that provides medical leadership in overseeing the PEER review process. The PEC is composed of the Chair

of the Clinical Quality and Patient Safety Committee physicians, and advanced practice licensed health care providers from various business units & clinical areas as appointed by the CMO & Director of Medical Affairs at the James.

Function:

1) Provide leadership for the clinical quality improvement processes within The OSU Health System.

2) Provide clinical expertise to the practitioner peer review process within The OSU Health System by thorough and timely review of clinical care and/or patient safety issues referred to the Practitioner Evaluation Committee.

3) Advise the CMO & Director of Medical Affairs at the James regarding action plans to improve the quality and safety of clinical care at the Health system.

4) Develop follow up plans to ensure action is successful in improving quality and safety

Hospital Information Technology Steering Team (HISST)

Composition:

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

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

Sentinel Event Team

Composition:

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

The Sentinel Event Determination Group (SEDG)

The SEDG is a sub-group of the Sentinel Event Team and determines whether an event will be considered a sentinel event or near miss, assigns the Root Cause Analysis (RCA) Executive

Sponsor, RCA Workgroup Leader, RCA Workgroup Facilitator, and recommends the Workgroup membership to the Executive Sponsor. The Sentinel Event Team facilitator attends to support the members. The SEDG membership includes the CMO or designee, Director of Risk Management, and Quality Director of respective business unit for where the event occurred (or their designee).

Sentinel Event Team Function:

Approves & makes recommendations on sentinel event determinations and teams, and action plans as received from the Sentinel Event Determination Group, evaluates findings, recommendations, and approves action plans of all root cause analyses. The documentation created as a result of a sentinel event or near miss is not externally reported or released.

Health System Clinical Quality & Patient Safety Sub-Committees Committees

Composition:

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

Function:

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

Process Improvement Teams

Composition:

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

Function:

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

James Nursing Directors

Each department director is responsible for ensuring the standards of care and service are maintained or exceeded within their department/division. In addition, department directors will collaborate on recommendations from the Nursing Quality Plan, or participate in action plans for improving nursing staff performance on key measures.

James nurse manager, nursing staff, and nursing quality improvement and patient safety department, and NQPS Council

Nurse Managers

Nurse Managers are responsible for assuring the delivery of safe, timely, efficient, high quality of care within their respective unit/department. Nurse Managers work with their staff, interdisciplinary directors and the CNO and other senior leaders in order to facilitate positive change and quality improvement at the unit/department level with interdisciplinary teams and ancillary departments.

James Hospital Staff

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

Suggesting improvements and reporting medical/health care errors

Monitoring activities and processes, such as patient complaints and patient satisfactionParticipating in focus groups

Attending staff meetings

Participating in efforts to improve quality, safety, and service excellence

OSUCCC- The James Quality and Patient Safety Quality & Patient Safety Committee (with support from the James Quality & Patient Safety Department)

In partnership with the Health System Quality and Operations Improvement department, OSUCCC James Quality and Patient Safety Committee has the primary responsibility to coordinate and facilitate quality and patient safety activities throughout the James. The primary responsibility for the implementation and evaluation of quality and patient safety activities resides in each department/program; however, the Quality and Patient Safety department staff also serves as internal consultants for process improvement teams and patient safety activities. The Quality and Patient Safety Department maintains human and technical resources for team facilitation, use of performance improvement tools, data collection, statistical analysis, and reporting in support of quality and patient safety.

OSUCCC – James Utilization Management Committee (UMC)

The OSUCCC – James UMC has responsibility for establishment and implementation of the James Utilization Management Plan. The UMC implements procedures for reviewing the efficient utilization of care and services, including but not limited to admissions, continued stays, readmissions, over and under-utilization of services, the efficient scheduling of services, appropriate stewardship of hospital resources, access and throughput and timeliness of discharge planning. The UMC collects and analyzes data to fulfill its responsibilities. Any quality or utilization opportunities identified by the UMC through utilization review activities will be acted upon by the committee or referred to the appropriate entity for resolution. The UMC provides education on care and utilization issues to all health care professionals and medical staff at the James.

Approach to Quality, Safety & Service Management

The OSU Health System approach to clinical quality management, patient safety and service is leadership-driven and involves significant staff and physician participation. Clinical quality management, patient safety and service activities within the Health System are multi-disciplinary and based on the Health System's mission, vision, values, and strategic plan. It embodies a culture of continuously measuring, assessing, and initiating changes including education in order to improve outcomes. The Health System employs the following principles of continuous quality improvement in its approach to quality management, patient safety and service.

Principles

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

Safe
Timely
Effective
Efficient
Equitable
Patient-centered

These principles include:

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

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

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

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

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

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

Continuous: Measurement and improvement are ongoing.

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

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

Model

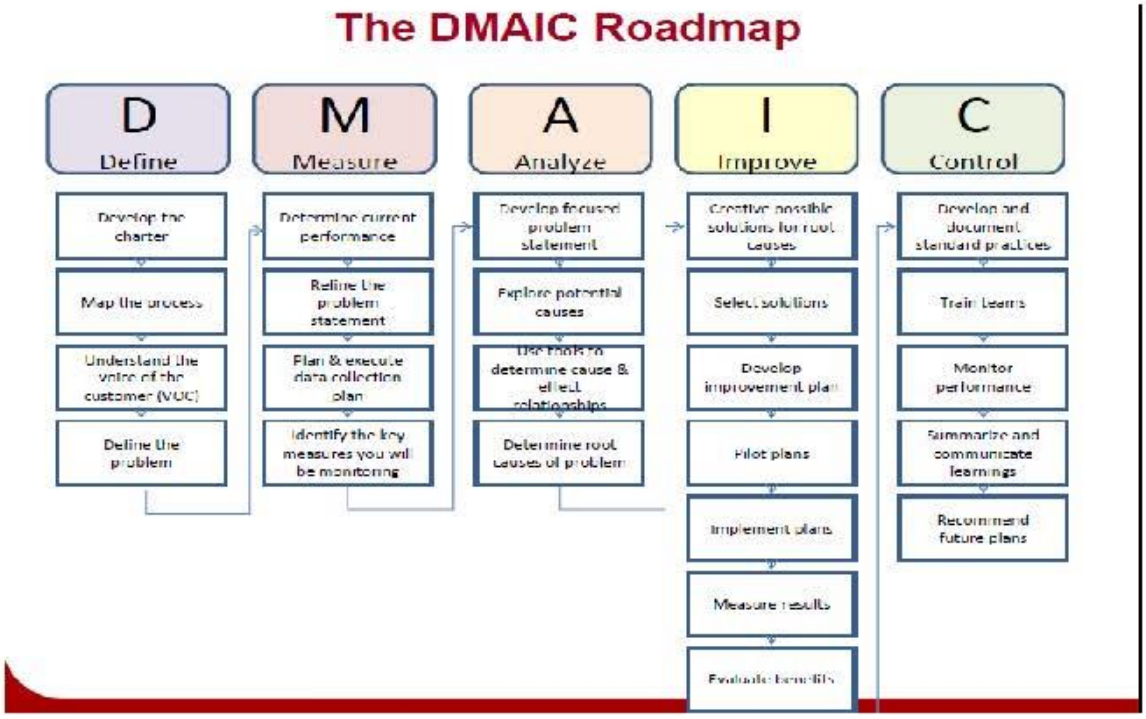
Systematic Approach/Model to Process Improvement

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

The Process Improvement Toolkit*

Methodology
PDCA
Rapid Cycle Improvement
DMAIC
Lean Principles

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



Consistent Level of Care

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

- Policies and procedures and services provided are not payer driven.
- Application of a single standard for physician credentialing.
- Health system monitoring tools to measure like processes in areas of the Health System.
- Standardize and unify health system policies and procedures that promote high quality, safe care.

Performance Transparency

The Health System Medical and Administrative leadership, working with the Boards, have a strong commitment to transparency of performance as it relates to clinical, safety and service performance. Clinical outcome, service and safety data are shared on the external OSUWMC website for community viewing. The purpose of sharing this information is to be open and

honest about OSUWMC performance and to provide patients and families with information they can use to help make informed decisions about care and services.

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

Confidentiality

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

Conflict of Interest

Any person, who is professionally involved in the care of a patient being reviewed, should not participate in peer review deliberations and voting. A person is professionally involved if they are responsible for patient care decision making either as a primary or consulting professional and/or have a financial interest (as determined by legal counsel) in the case under review. Persons who are professionally involved in the care under review refrain from participation except as requested by the appropriate administrative or medical leader. During peer review evaluations, deliberations, or voting, the chairperson takes steps to avoid the presence of any person, including committee members, professionally involved in the care under review. The chairperson of a committee should resolve all questions concerning whether a person is professionally involved. In cases where a committee member is professionally involved, the respective chairperson may appoint a replacement member to the committee. Participants and committee members are encouraged to recognize and disclose, as appropriate, a personal interest or relationship they may have concerning any action under peer review.

Determining Priorities

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

Data Measurement and Assessment

Determination of data needs

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

External reporting requirements

There are a number of external reporting requirements related to quality, safety, and service. These include regulatory, governmental, payer, and specialty certification organizations. Attachment VI displays some examples of external organizations where quality, safety, and service data are reported.

Collection of data

Data, including patient demographic and diagnosis, are systematically collected throughout the Health System through various mechanisms including:

- Administrative and clinical databases
- Retrospective and concurrent medical record review
- Reporting systems (e.g., patient satisfaction)
- Surveys (i.e., patients, families, and staff)

Assessment of data

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

Surveillance system

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

Vital Signs of Quality

Vital Signs of Quality (VSQ) are a health system-wide set of indicators related primarily to the following Key Result Areas (KRAs): Quality, Productivity, Efficiency and Service & Reputation. The VSQ are available to all faculty and staff via an on-line scorecard and are reviewed routinely by multiple committees including the hospital's Boards and various clinical quality management committees to identify areas for potential improvement. The indicators to be included in the VSQ are reviewed each year to represent the priorities of the quality and patient safety program.

Health System Quality & Safety Scorecard

The Quality and Safety Scorecard is a set of health system-wide indicators related to those events considered potentially preventable. The Quality & Safety Scorecard covers the areas such as never events, sentinel events, infections, falls, decubitus ulcers, medication events, and several other categories. The information is shared in various Quality forums with staff, clinicians, administration, and the Boards. The indicators to be included in the scorecard are reviewed each year to represent the priorities of the quality and patient safety program.

Quality Notice Information

The Quality Notice is distributed monthly to all clinical staff and key administrative leaders showing year-to-date performance for mortality index and 30 day readmission rate. The results are displayed for the health system and by hospital compared to targets established by the LCCQSS. Additionally, attending physicians are provided a link from the Quality Notice to an online report of their individual Mortality Index, Length of Stay Index, Readmission Rate, and Patient Satisfaction results.

Patient Satisfaction Dashboard

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

Quality, Patient Safety, and Service Educational Information

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

- On line videos
- Quality & Patient Safety Simulcasts
- News Letters
- Classroom forums
- Simulation Training
- Computerized Based Learning Modules (e-learning)

- Partnerships with IHI Open School
- Curriculum Development within College of Medicine
- Websites (internal OneSource and external OSUMC)

Benchmark data

Both internal and external benchmarking provides value when evaluating performance.

Internal Benchmarking

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

External Benchmarking
The OSU Health System participates in various database systems and focused benchmarking projects to compare performance with that of peer institutions. The University HealthSystem Consortium, The US News Report, and the Ohio Department of Health are examples of several external organizations that provide benchmarking opportunities. OSUCCC also benchmarks against cancer consortiums such as C4QI and ADCC.

Design and evaluation of new processes

New processes are designed and evaluated according to the Health System's mission, vision, values, priorities, and are consistent with sound business practices.

The design or re-design of a process may be initiated by:

- Surveillance data indicating undesirable variance
- Patients, staff, or payers perceived need to change a process
- Information from within the organization and from other organizations about potential risks to patient safety, including the occurrence of sentinel events
- Review and assessment of data and/or review of available literature confirm the need

Performance Based Physician Quality & Credentialing

Performance based credentialing ensures processes that assist with promoting the delivery of quality and safe care by physicians and advanced practice licensed health care providers. Both Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) occur. Focused Professional Practice Evaluation (FPPE) is utilized on three

occasions: initial appointment, when a Privileged Practitioner requests a new privilege, and for cause when questions arise regarding the practitioner's ability to provide safe, high quality patient care. Ongoing Professional Practice Evaluation (OPPE) is performed on an ongoing basis (every 6 months).

Profiling Process:

- Data gathering from multiple sources
- Report generation and indicator analysis
- Profile review meetings with department chairs
- Discussion at Credentialing Committee
- Final Recommendation & Approval:
    - Medical Staff Administrative Committees
    - Medical Director
    - Hospital Board

Service-Specific Indicators

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

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

The purpose of the medical Staff Evaluation is several-fold:

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

Annual Evaluation

The Health System Quality Management, Patient Safety and Service Plan is approved by the Leadership Council, the Medical Staff Administrative Committees, and the hospitals Boards on an annual basis. The OSUCCC-James Quality Management, Patient Safety and Service Plan is approved by the OSUCCC-James Quality and Patient Safety Committee and the James Board. The annual evaluation includes a review of the program activities and an evaluation of the effectiveness of the structure.

Attachment I

LCCQSS Priorities 2013-2014

Key Result Area: Quality

- Reduce Overall Quality & Safety Scorecard Events by 15%
- Improve UHC risk adjusted inpatient mortality index to 0.67
- Hand Hygiene Compliance >= 90%
- Achieve top decile in all Value Based Purchasing Clinical Indicators

Key Result Area: Productivity and Efficiency

- Achieve the UHC Top Quartile for 30 day readmission rates in Heart Failure and Knee/Hip Replacements
- Achieve the UHC Median for 30 day readmission rates in AMI, Pneumonia, and COPD

Key Result Area: Service and Reputation

- Achieve top decile status for patient satisfaction HCAHPS Score

Key Result Area: Workplace of Choice

- Achieve 25% reduction in Employee Injuries

Attachment II

OSUCCC Priorities 2013-2014

- Reduce Total Quality & Safety scorecard events (15%)
- Improve Discharge Process to Reduce Unplanned Readmissions
- Reduce Time to Clinical Trial Implementation (≤4 months)
- Improve Medication Reconciliation Process
- Advanced Care Planning – Ambulatory
- Improve Pain Management Process

Attachment III

Priority Criteria

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

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

Attachment IV

Physician Performance Based Profile – SAMPLE

MIDAS+ Generated Profile:**Profile: QM Profile**
Department
Provider:
Provider Service:
Provider Specialty:
Facility:

Indicator	Oct-Dec 2010	Jan-Mar 2011	Total	Service
Total IP Discharges				
CMI				
Total Inpatient Procedures				
Total Outpatient Admissions				
Total Short Stay Admissions				
Total Quality Management Events				
Total Events Where Standard of Care Not Met				
FPPE Focus Reviews				
Autopsy Discrepancy				
Number mortalities reviewed				
Number of mortality cases sent for peer review				
Number of mortality cases with peer review score of 4 or 5				
Total Patient Complaints				
# of Surgical Team Safety Checklist Variances				

OHIO STATE UNIVERSITY Medical Center

Performance-Based Credentialing Profile
Supplement to MIDAS generated profile report

includes profile indicators not present in the MIDAS data system

Based Upon Patients Discharged Oct 2010 - Mar 2011

Confidential

Department: **Division:**

Specialty: **Peer Group:**

Facility: All

Provider:

GLOBAL INDICATORS	Type	Physician	Peer Group	Flag
IP Volume (as Attending)	(Total)			
Consult Volume	(Total)			
Mortality Obs Count	(Total)			
Mortality Obs Rate	(Rate)			[illegible] Peer_Grp
Mortality Index (Obs / Exp)	(Ratio)		n/a	[illegible]
31 Day Related Readmit Count	(Total)			
31 Day Related Readmit Rate	(Rate)			
IP LOS Obs Avg (Length Of Stay)	(Avg.)			
LOS Index (Obs / Exp)	(Ratio)		n/a	
Patient Satisfaction Survey Count	(Total)			
Patient Satisfaction Avg Score	(Avg)			

TOP 10 DRG: LOS & MORTALITY

SERVICE SPECIFIC INDICATORS

FINAL DISPOSITION OF ONGOING PROFESSIONAL PRACTICE EVALUATION

Maintain privileges without modification

Modify privileges (see comments below)

Privilege revocation recommended (see comment below)

Reviewer Comments/Action:

ONGOING EVALUATION REVIEWED BY:

(Clinical Department Chair) (Date)

Attachment V

Patient Safety Program

Vision
To be the safest health system in the world.

Goals
- Improve patient safety with full integration of key safety initiatives as evidenced by the Quality and Patient Safety Scorecard.
- Improve the culture of patient safety as evidenced by culture of safety survey results

Our Culture of Patient Safety
- "Just Culture"
- Balance system/process issues with accountability for expected behaviors
- Responsible, Accountable and Fair
- Ownership and integrity
- Create a work environment that is open, honest and transparent

Patient Safety Program Components
The patient safety program is a comprehensive plan comprised of initiatives in the following domains:
- Culture of safety
- Performance monitoring and improvement
- Regulatory and accreditation
- Event reporting
- Sentinel events
- Education
- Innovation
- Recognition

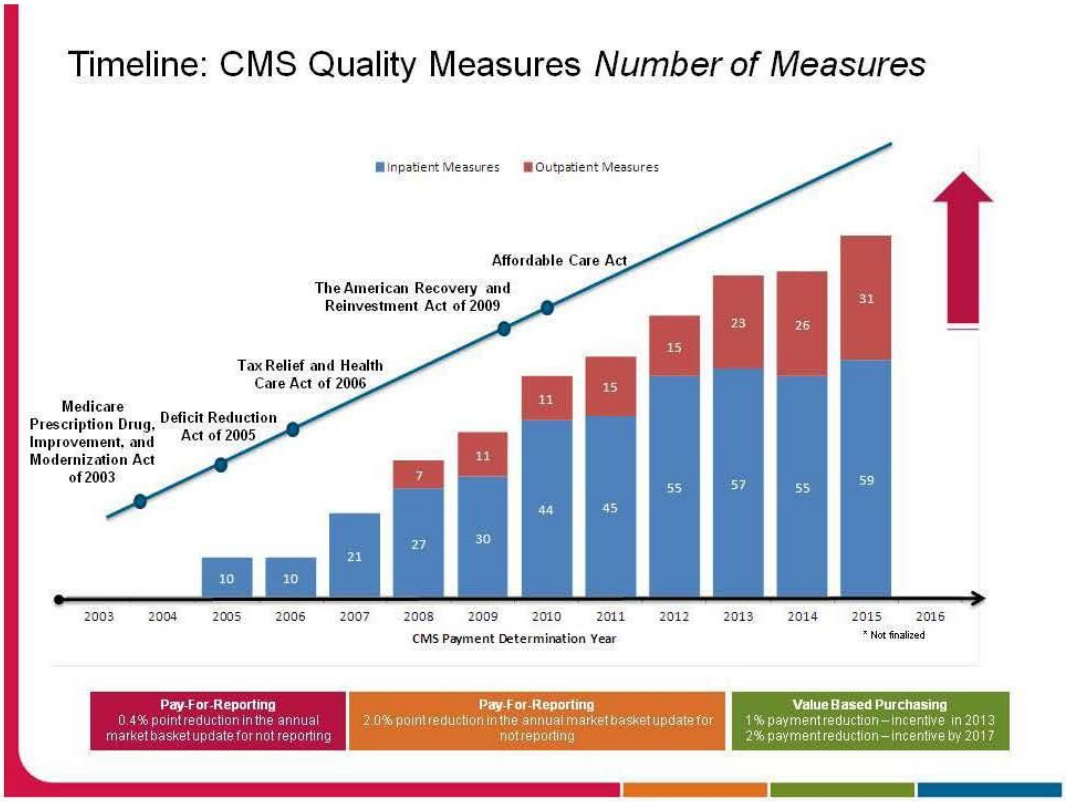
A Patient of Safety Culture Survey will be administered at a frequency determined by CQO and other Senior Leaders.

Attachment VI

Quality Data & External Reporting

Regulatory/ Public Data	Payers	Registries/ Benchmarking
CMS	Anthem	STS
ODH	Aetna	ACC
JCAHO	MMO	GWTG
Leapfrog	United Healthcare	Vermont Oxford
Franklin Co.	Cigna	NSQIP
NHSN		UHC
Oryx		BOLD
CARF		eRehab

Red = Public Data


Timeline: CMS Quality Measures *Number of Measures*
Inpatient Measures
Outpatient Measures
Medicare Prescription Drug, Improvement, and Modernization Act of 2003
Deficit Reduction Act of 2005
Tax Relief and Health Care Act of 2006
The American Recovery and Reinvestment Act of 2009
Affordable Care Act
10
10
21
27
7
30
11
44
11
45
15
55
15
57
23
55
26
59
31
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
CMS Payment Determination Year
* Not finalized
Pay-For-Reporting
0.4% point reduction in the annual market basket update for not reporting
Pay-For-Reporting
2.0% point reduction in the annual market basket update for not reporting
Value Based Purchasing
1% payment reduction – incentive in 2013
2% payment reduction – incentive by 2017

Attachment VII:

Quality and Safety Scorecard

Type of Event
Retained Foreign Bodies
Wrong Site Events
Medication Events with Harm (Severity E-I)
Falls with Harm (Injury Level 2-4)
Hospital Acquired Pressure Ulcer
Central Line Blood Stream Infections
Ventilator Associated Pneumonia
Hospital Acquired Surgical Site Infections
Hospital Acquired Clostridium Difficile Infection
Total Potentially Avoidable Events

(APPENDIX V)

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

The Ohio State University Wexner Health System

FY 2015 Budget Overview

August 2014



The Ohio State University Wexner Health System
Operating and Financial Highlights
FOR THE YTD ENDING: JUNE 30, 2014

		ACTUAL	BUDGET	BUDGET % VAR	PRIOR YEAR	PY % VAR	ANNUAL BUDGET
Inpatient Admissions	⇔	57,024	57,747	-1.3%	56,592	0.8%	57,747
Patients in Beds including Obs Area	⇔	73,522	73,940	-0.6%	72,808	1.0%	73,940
Patient Discharges	⇔	56,913	57,480	-1.0%	56,462	0.8%	57,480
Total Surgeries	⇔	38,381	39,760	-3.5%	38,627	-0.6%	39,760
Outpatient Visits	↑	1,593,519	1,460,775	9.1%	1,485,147	7.3%	1,460,775
ED Visits	⇔	117,977	120,713	-2.3%	118,280	-0.3%	120,713
Adjusted Admissions	↑	104,719	104,289	0.4%	101,932	2.7%	104,289
Oper. Rev. / Adjust. Admit	↑	$ 20,294	$ 20,266	0.1%	$ 19,906	1.9%	$ 20,266
Expense / Adj. Admit	↑	$ 18,207	$ 18,270	0.3%	$ 17,904	1.7%	$ 18,270
(in millions)							
Operating Revenues	↑	$ 2,125.2	$ 2,113.5	0.6%	$ 2,029.1	4.7%	$ 2,113.5
Total Expenses	⇔	$ 1,906.6	$ 1,905.4	-0.1%	$ 1,825.0	4.5%	$ 1,905.4
Gain from Operations	↑	$ 218.6	$ 208.1	5.0%	$ 204.1	7.1%	$ 208.1
Excess Rev.Over Exp.	↑	$ 222.6	$ 209.3	6.4%	$ 205.2	8.5%	$ 209.3
				Y/E Target			
Operating EBIDA Margin	↑	14.4%	14.1%	14.1%	14.5%		
Days Cash on Hand	↑	69.0	67.1	67.1	64.1		
Debt Service Coverage	↑	6.1	5.8	5.8	6.7		

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THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

The Ohio State University Wexner Health System
Operating and Financial Highlights

FOR THE YTD ENDING: JULY 31, 2014

	ACTUAL	BUDGET	BUDGET % VAR	PRIOR YEAR	PY % VAR	ANNUAL BUDGET
Inpatient Admissions	4,931	4,932	0.0%	5,107	-3.4%	58,621
Patients in Beds including Obs Area	6,404	6,422	-0.3%	6,464	-0.9%	75,686
Patient Discharges	4,922	4,894	0.6%	5,075	-3.0%	56,022
Total Surgeries	3,296	3,196	3.1%	3,303	-0.2%	38,813
Outpatient Visits	137,144	137,511	-0.3%	131,949	3.9%	1,655,294
ED Visits	10,379	10,423	-0.4%	10,440	-0.6%	124,002
Adjusted Admissions	9,204	9,041	1.8%	9,003	2.2%	108,577
Oper. Rev. / Adjust. Admit	$ 19,937	$ 20,285	-1.7%	$ 19,674	1.3%	$ 20,485
Expense / Adj. Admit	$ 17,296	$ 17,992	3.9%	$ 17,427	0.8%	$ 18,793
(in millions)						
Operating Revenues	$ 183.5	$ 183.4	0.1%	$ 177.1	3.6%	$ 2,224.2
Total Expenses	$ 159.2	$ 162.7	2.1%	$ 156.9	1.5%	$ 2,040.5
Gain from Operations	$ 24.3	$ 20.7	17.2%	$ 20.2	20.2%	$ 183.7
Excess Rev.Over Exp.	$ 24.5	$ 20.8	17.6%	$ 20.3	20.4%	$ 185.1
			Y/E Target			
Operating EBIDA Margin	17.1%	15.4%	14.1%	15.6%		
Days Cash on Hand	75.3	74.8	72.0	68.1		
Debt Service Coverage	7.1	6.4	4.3	8.3		

3

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

Primary Assumptions - FY15 Budget

Factor	Assumptions & Explanation
Payor mix and price implications	Medicaid expansion providing some growth; no price increases
Admissions/outpatient visits	2.0% inpatient growth and 5.6% growth in outpatient visits
Surgeries	+1.5% inpatient; .5% outpatient
Case mix index	Constant year over year
Length of stay	No change
Total beds	Increase from 1,172 to 1,367 beds. 348 beds will open in the tower (72 ICU & 276 Med Surg). The existing James (160 beds) will be closed during backfill renovation and are planned to be available in FY2016

Primary Assumptions - FY15 Budget (continued)

Factor	Assumptions & Explanation
Salary/wages	2% raises for employees earning less than $250K
Pharma/drugs	Adjusting for volumes and new retail pharmacy – drug costs up 3.1%
Interest	Increase $17.2M or 182%
Depreciation	Increase $25.9M or 33%
Annual Capital Expenditures	$68M
Medical Center Investments (cash transfers to the College of Medicine)	$100M

The OSU Wexner Health System 2015 Budget

(in thousands)

OSU Health System Gain/Loss from Operations	Budget 2014	Actual 2014	Budget 2015
Gain/Loss from Operations before Allocations, Depreciation & Interest			
UH	$182,305	$192,038	$177,810
Ross	$53,699	$55,355	$56,781
James	$269,817	$270,198	$288,788
East	$36,047	$42,163	$42,607
Harding	$4,817	$4,989	$3,249
Ambulatory	$16,027	$16,423	$15,141
Physician Practices	($31,481)	($38,354)	($32,338)
Shared	($184,910)	($189,194)	($188,206)
Allocations, Deprec & Int	($138,203)	(135,026)	($180,131)
Gain/Loss from Operations	$208,117	$218,591	$183,700

OSU Health System Gain/Loss from Operations	Budget 2014	Actual 2014	Budget 2015
UH	$35,800	$48,341	$27,558
Ross	$5,828	$7,670	$13,104
James	$189,086	$189,816	$162,187
East	($4,361)	$2,064	$1,945
Harding	($1,423)	($1,601)	($3,331)
Ambulatory	$7,125	$7,428	$7,678
Physician Practices	($24,001)	($30,370)	($25,439)
Shared	$64	($4,757)	$0
Gain/Loss from Operations	$208,117	$218,591	$183,700

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THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

The OSU Wexner Health System 2015 Balance Sheet

(in thousands)

Balance Sheet	Actual 2013	Actual 2014	Budget 2015
Assets			
Cash	$ 306,410	$ 346,638	$ 373,626
Accounts Receivable & Other Current Assets	273,344	296,818	316,273
Property, Plant, Equipment - net of Depreciation	1,082,739	1,287,229	1,500,472
Other	89,591	185,411	74,608
Total Assets	$ 1,752,084	$ 2,116,096	$ 2,264,979
Liabilities & Fund Balance			
Current Liabilities	$ 225,967	$ 249,640	$ 263,558
Debt	643,936	854,764	845,041
Fund Balance	882,181	1,011,692	1,156,380
Total Liabilities and Fund Balance	$ 1,752,084	$ 2,116,096	$ 2,264,979

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THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

Opportunities and Risks- FY15 Operating Plan

- Opportunities
  - Exceed savings targets and supply chain rapid re-pricing
  - Payor mix shift from bad debt/no pay to Medicaid due to Medicaid expansion in Ohio
  - Case mix index improves above planned levels
  - Improved collections associated with high deductible health plans
  - Research grants exceed planned levels
  - Reduce out of network medical costs for OSU Health Plan
- Risks
  - Cost overruns with the new hospital
  - Admissions in new hospital and University Hospital backfill
  - Higher than budgeted losses on high deductible plans
  - Loss of high volume surgeons
  - Philanthropy falls below planned levels

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THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Fiscal Year 2015 Operating Budget

The Ohio State University
Office of Business and Finance
Financial Planning and Analysis

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Executive Summary

The Ohio State University continues to move forward to achieve its vision to be the world's preeminent public comprehensive university, solving problems of world-wide significance and, to fulfill our mission to advance the well-being of the people of Ohio and the global community through the creation and dissemination of knowledge. In order to meet this vision and mission the university has continued to work towards augmentation of traditional revenue streams and streamlining expenses while seeking to expand the revenue base in new and unique ways in order to invest in areas core to the university vision and mission.

Vision

The Ohio State University will be the world's preeminent public comprehensive university, solving problems of world-wide significance.

As fiscal year 2014 draws to a close, the university remains financially strong. Tuition revenue is stable as student applications and enrollment continue to grow. However, there are a number of challenges that we must manage. State subsidy revenue continues to decline in real dollars. We anticipate continued pressure on government expenditures for research and student financial aid. The anticipation of nominal growth from traditional government revenue sources, coupled with our intent to maintain student affordability, create an imperative to continue to explore alternatives to traditional financial strategies. The university must also consider leveraging core assets into incremental revenue while continuing to explore non-traditional revenue opportunities. A strong focus on both revenue enhancement and expense streamlining is required to ensure that resources are in place to fund our strategic initiatives while maintaining a strong balance sheet.

The OSU Health System continues to strengthen its financial position in advance of the opening of the new James Cancer Hospital and Critical Care Tower (CCCT) scheduled for December, 2014. The fiscal year 2015 Health System budget meets aggressive targets to deliver improvements in profit margin, cash on hand and debt service ratios. Numerous expense control and productivity initiatives have been implemented or will be implemented during the course of fiscal year 2015. These measures are critical in order to manage operating risk associated with transitioning into the new facility and the uncertainty surrounding the impact of federal insurance exchanges and Medicare rate reductions.

We continue to explore new revenue opportunities in addition to the leased parking funding, century bond funding, and current affinity contracts. We continue to focus on our financial investment strategies, streamlining activities and procurement strategies in order to maximize the funding available to advance our goals of Teaching and Learning, Research and Innovation, Outreach and Engagement, and Resource Stewardship.

Mission

We exist to advance the well-being of the people of Ohio and the global community through the creation and dissemination of knowledge.

In fiscal year 2013 we invested $483 million into our long-term investment pool as a result of leasing our parking operations to a third party. From the investment yield, we expect to distribute $20-25 million per year to be used to fund faculty initiatives and research, transportation and sustainability, scholarships and invest in our university Arts District.

This document presents The Ohio State University's Fiscal Year 2015 Budget for approval. The Budget is presented on a consolidated basis with the university and Health System also presented as unique

operating entities. This document also provides narratives on the overall budgeting process, and the key drivers of revenue and expenses budgeted for fiscal year 2015.

STRATEGIC CONTEXT

The fiscal year 2015 budget is built upon the foundation of The Ohio State University strategic plan. The plan outlines four core goals, with a specific focus for investment across three discovery themes: Health and Wellness, Energy and Environment, Food and Production Safety.

Core Goals

Four institution wide goals are fundamental to Ohio State's mission and future success and must be reflected in all that we accomplish:

- **Teaching and Learning**: to provide an unsurpassed, student-centered learning experience led by engaged, world-class faculty and enhanced by a globally diverse student body.
- **Research and Innovation**: to create distinctive and internationally recognized contributions to the advancement of fundamental knowledge and scholarship and to solutions of the world's most pressing problems.
- **Outreach and Engagement**: to establish mutually beneficial partnerships with the citizens and institutions of Ohio, the nation, and the world so that our communities are actively engaged in the exciting work of The Ohio State University.
- **Resource Stewardship:** to become the model for an affordable public university recognized for financial sustainability, unsurpassed management of human and physical resources, and operational efficiency and effectiveness.

Discovery Themes

Health and Wellness: will allow faculty from Ohio State's seven health sciences colleges and the Wexner Medical Center to work with partners across the university in nutrition, social work, health education, and public policy, to cite but a few examples. These experts will focus on such issues as disease prevention, community health, and health systems.

Energy and Environment: will create an unprecedented interdisciplinary collaboration of experts spanning the university and touching upon every specialization to fully address issues related to energy and environment. By working with experts beyond the university, Ohio State faculty will lead the way in developing scientific and policy responses to the global need for energy and the associated effects on the environment.

Food Production and Security: will draw on Ohio State's unique expertise in food, agricultural, and environmental sciences as well as the arts and sciences, health sciences, business, law, and beyond. Working with partners within and outside the university, these experts will focus on enhancing the quality of food and animal feed and ensuring an adequate.

Discovery Themes at The Ohio State University

The university's move to eminence will be founded in the university's three discovery themes of **Health and Wellness**, **Food Production and Security**, and **Energy and Environment**. These themes are based on special, broad, and deep expertise across the university. Through these discovery themes, Ohio State will focus its resources and activities on finding durable solutions to issues of global as well as regional importance. The discovery themes are essential elements of Ohio State's strategic planning. The initial area of focus for all three of the Discovery Themes will be data analytics.

Data analytics is a process of collecting, organizing, integrating and examining vast amounts of information in order to extract insight. With today's increasingly large, complex, and diverse data sets, problem-solving is more data driven than ever. In this environment, the ability to find, analyze, and interact with these data will be the difference-maker in accelerating the pace of change—from disease prognosis to smart materials; from environmental mapping to sustainable energy systems; from bioinformatics to precision agriculture. As part of this focus, the university has established a new interdisciplinary undergraduate major in data analytics. This major was designed by the Colleges of Arts and Sciences, Engineering, Medicine and Fisher College of Business. With this new degree offering, Ohio State becomes the first university in the country to offer an undergraduate degree in data analytics.

Faculty from every college and all six campuses of the university will be encouraged to actively contribute to these discovery themes. Meanwhile, as these colleagues concentrate their efforts on the issues the discovery themes are meant to address, they and others will continue to advance our understanding of history and philosophy, languages and cultures, and the arts as they pursue excellence in our core goals. Our programs in medicine, agriculture, veterinary sciences, engineering, business and many other fields of study are rich and strong because they are grounded by excellence in the arts, humanities and physical as well as social sciences.

Strategic Finance: Planning for Success

In recent years, we have launched a number of successful initiatives to increase the resources available to support the core academic mission. Revenue generation initiatives have included the establishment of unique partnerships and collaborations, such as the affinity agreements with organizations such as Huntington Bank and Nationwide Insurance; innovative financing strategies such as the issuance of $500 million in century bonds; asset monetization strategies such as the 50-year parking concession agreement; and strengthening the endowment through diversification and value orientation strategies.

Going forward, The university must increasingly focus on generating additional revenue from traditional and innovative sources, including continued exploration of asset monetization opportunities, enhanced funding, continued exploration of public/private partnerships, technology commercialization and endowment growth.

We will also continue to build upon successful cost containment strategies that have included strategic procurement initiatives such as reducing the number of suppliers in our database; leveraging the buying power to negotiate more aggressively; implementing systems designed to improve operational efficiencies; lean process reengineering; and supporting the university's sustainability efforts by moving to paperless systems.

Fiscal Year 2015 University Budget: Key Themes

The Fiscal Year 2015 Budget continues our commitment to hire 500 new tenure or tenure-track faculty by 2023 who will be specializing in disciplines that support the Discovery Themes. Start-up funding is also budgeted to assure that the university can hire the best faculty for our programs. The fiscal year 2015 budget includes a $20 million investment in Data Analytics focused around Discovery Themes.

Fiscal year 2015 will be the second year of the State of Ohio's new funding model for higher education. The recommendations were developed by the Commission on Higher Education under the leadership of former President Gee. This new model emphasizes degree completion as the main driver for funding and course completions as secondary. It will also reward the ability of the university to retain the best and brightest in Ohio after graduation. The state has increased its pool of funding allocated to state colleges and universities by 1.6% in fiscal year 2015. The university continues to assess the impacts of the funding model change within the context of growth in distance education and other non-traditional programs across the state.

The budget also focuses on additional compensation for faculty and staff, increasing the institutionally funded financial aid for undergraduate students, supporting colleges with additional revenue generated from tuition dollars, funding for increased benefit costs and priority requests for support operations, all while assuring that general funds are balanced.

The Fiscal Year 2015 Budget Plan outlines important aspects of the university's financial strategy in the year ahead. The budget plan, coupled with our Annual Financial Report, presents our current financial state and our future opportunities and challenges. It illustrates our financial path for achieving our vision of being the world's preeminent public comprehensive university.

Fiscal Year 2015 Budget: Financial Statements

The fiscal year 2015 budget includes a consolidated financial statement in addition to discrete financial statements for each of the following segments:

- **The Ohio State University**
- **The Ohio State University Health System**
- **The Ohio State University Physicians Practice Plan**

Given the operational differences between segments, we will provide narratives around the key drivers for each segment.

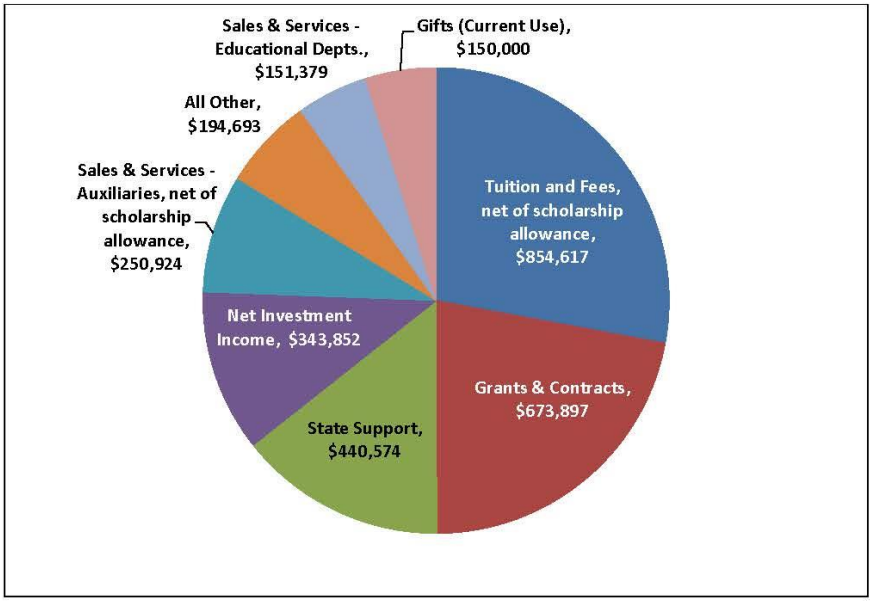
Consolidated Financial Statements

$ in Thousands	Fiscal 2014 Projected Actual	Fiscal 2015 Budget	$ Change	% Change
Operating Revenues				
Tuition and Fees, net of scholarship allowance	$ 830,864	$ 845,307	$ 14,443	1.7%
Grants & Contracts	673,874	673,897	22	0.0%
Sales & Services - Educational Departments	151,218	151,379	161	0.1%
Sales & Services - Auxiliaries, net of scholarship	236,577	250,924	14,347	6.1%
Sales & Services - Health System & OSUP	2,449,527	2,604,490	154,963	6.3%
Other Operating Revenues	46,594	46,594	0	0.0%
Total Operating Revenues	**$ 4,388,655**	**$ 4,572,591**	**$ 183,936**	**4.2%**
Operating Expenses				
Salaries	$ 2,295,369	$ 2,401,271	$ 105,902	4.6%
Benefits	679,624	723,169	43,545	6.4%
Fee Authorizations	155,338	163,314	7,976	5.1%
Student Aid	145,032	148,329	3,297	2.3%
Supplies & Other	1,428,635	1,494,768	66,134	4.6%
Depreciation	264,000	278,600	14,600	5.5%
Total Operating Expenses	**$ 4,967,998**	**$ 5,209,451**	**$ 241,453**	**4.9%**
Operating Gain (Loss)	**$ (579,343)**	**$ (636,861)**	**$ (57,518)**	**9.9%**
Non-Operating Revenues (Expenses)				
State Share of Instruction	$ 355,287	$ 352,651	$ (1,357)	-0.4%
State Line Item Appropriations	86,807	86,644	(162)	-0.2%
Non-Exchange Grants	74,765	76,272	1,508	2.0%
Gifts (Current Use)	149,412	150,000	588	0.4%
Net Investment Income	352,916	278,976	(9,064)	-2.6%
Interest Expense on Plant Debt	(79,050)	(76,401)	2,649	-3.4%
Other Non-Operating Revenues (Expenses)	5,000	-	(5,000)	-100.0%
Total Non-Operating Revenues (Expenses)	**$ 945,137**	**$ 868,143**	**$ (76,994)**	**-8.1%**
Net Transfers from OSU Health System	**$ -**	**$ -**		
Income Before Other Changes in Net Assets	**$ 365,794**	**$ 231,282**	**$ (134,512)**	**-36.8%**
Other Changes in Net Assets				
State Capital Appropriations	$ 40,165	45,000	$ 4,835	12.0%
Private Capital Gifts	8,530	15,000	6,470	75.9%
Additions to Permanent Endowments	46,338	51,000	4,662	10.1%
Total Other Changes in Net Assets	**$ 95,033**	**$ 111,000**	**$ 15,967**	**16.8%**
Change in Net Assets	**$ 460,827**	**$ 342,282**	**$ (118,545)**	**-25.7%**

University Financial Statement (*excluding Health System*):

$ in Thousands	Fiscal 2014 Projected Actual	Fiscal 2015 Budget	$ Change	% Change
Operating Revenues				
Tuition and Fees, net of scholarship allowance	$ 830,864	$ 845,307	$ 14,443	1.7%
Grants & Contracts	673,874	673,897	22	0.0%
Sales & Services - Educational Departments	151,218	151,379	161	0.1%
Sales & Services - Auxiliaries, net of scholarship	236,577	250,924	14,347	6.1%
Other Operating Revenues	46,594	48,137	1,543	3.3%
Total Operating Revenues	**$ 1,939,128**	**$ 1,969,644**	**$ 30,516**	**1.6%**
Operating Expenses				
Salaries	$ 1,318,907	$ 1,359,952	$ 41,045	3.1%
Benefits	396,322	415,260	18,938	4.8%
Fee Authorizations	96,634	98,852	2,218	2.3%
Student Aid	145,032	146,344	1,312	0.9%
Supplies & Other	616,911	636,008	19,097	3.1%
Depreciation	188,200	194,800	6,600	3.5%
Total Operating Expenses	**$ 2,762,006**	**$ 2,851,216**	**$ 89,210**	**3.2%**
Operating Gain (Loss)	**$ (822,878)**	**$ (881,573)**	**$ (58,694)**	**7.1%**
Non-Operating Revenues (Expenses)				
State Share of Instruction	$ 355,287	$ 352,651	$ (2,636)	-0.7%
State Line Item Appropriations	86,807	86,644	(162)	-0.2%
Non-Exchange Grants	74,765	76,272	1,508	2.0%
Gifts (Current Use)	149,412	150,000	588	0.4%
Net Investment Income	352,916	278,976	(73,940)	-21.0%
Interest Expense on Plant Debt	(79,050)	(76,401)	2,649	-3.4%
Other Non-Operating Revenues (Expenses)	5,000	-	(5,000)	-100.0%
Total Non-Operating Revenues (Expenses)	**$ 945,137**	**$ 868,143**	**$ (76,994)**	**-8.1%**
Net Transfers from OSU Health System	82,155	70,284	(11,871)	-14.4%
Income Before Other Changes in Net Assets	**$ 204,414**	**$ 56,854**	**$ (147,560)**	**-72.2%**
Other Changes in Net Assets				
State Capital Appropriations	$ 40,165	45,000	$ 4,835	12.0%
Private Capital Gifts	8,530	15,000	6,470	75.9%
Additions to Permanent Endowments	46,338	51,000	4,662	10.1%
Total Other Changes in Net Assets	**$ 95,033**	**$ 111,000**	**$ 15,967**	**16.8%**
Change in Net Assets	**$ 299,447**	**$ 167,854**	**$ (131,593)**	**-43.9%**

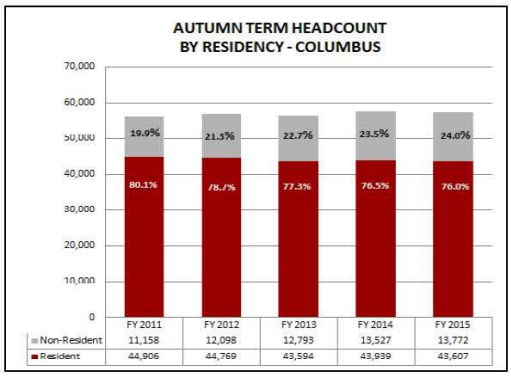
University Revenue Sources



Tuition and Fees

Gross tuition and fees, before scholarship allowance, are expected to increase by $19 million, or 1.9%, to $996 million. The increase is driven by both an increased mix of non-resident students and increased fees for fiscal year 2015. Undergraduate and graduate Masters/PhD instructional and mandatory fees will not increase in fiscal year 2015. Instructional fees for tagged masters and professional students are scheduled to increase 2.0%. For all student levels, the non-resident surcharge will increase 5.0% across most colleges.

The university is committed to maintaining tuition affordability. However, the limited increases are necessary to partially cover inflation and to provide continued investment in excellence within the core academic mission. Tuition and fees provide more than 70% of university revenue available to fund the core academic mission. The remaining 30% is largely provided through the State of Ohio instructional subsidy (SSI). SSI has continued to decline, when adjusted for inflation, in recent years.



Enrollment - The university continues to execute against the most recent Enrollment Plan, which was implemented in fiscal year 2012, to increase the quantity, quality and diversity of the student body. The Plan has been successful in meeting those objectives and in providing higher levels of new students to offset the temporary decline in existing students due to semester conversion in fiscal year 2013. Enrollment has since stabilized and enrollment for fall 2014 (fiscal year 2015) is expected to be essentially flat versus fiscal year 2014. With many students taking advantage of the free credit hour option in May term, summer revenue-generating enrollments and credit hours continue to lag behind pre-conversion levels.

STUDENT ENROLLMENT FOR AUTUMN TERM

AUTUMN FY 2011 - FY 2015

Headcounts	2011	2012	2013	2014	2015	1 YR Chg	1 YR % Chg	5 YR % Chg
Columbus	56,064	56,867	56,387	57,466	57,379	-87	-0.2%	2.3%
Lima	1,530	1,306	1,131	1,077	1,036	-41	-3.8%	-32.3%
Mansfield	1,405	1,388	1,265	1,204	1,204	0	0.0%	-14.3%
Marion	1,816	1,525	1,273	1,259	1,161	-98	-7.8%	-36.1%
Newark	2,562	2,677	2,390	2,315	2,325	10	0.4%	-9.3%
ATI	700	666	612	643	656	13	2.0%	-6.3%
Grand Total	**64,077**	**64,429**	**63,058**	**63,964**	**63,761**	**-203**	**-0.3%**	**-0.5%**

Regional campuses, which account for 10% of the university's enrollment, continue to be negatively impacted by several factors including the semester conversion, continued poor economic conditions in the communities they serve, the decreasing number of high school graduates and the competition from community and technical colleges. As a result, fiscal year 2015 enrollments are projected to decline an average of 1.8% over fiscal year 2014 levels.

Undergraduate Fees - Resident instructional fees will not increase in fiscal year 2015 at all of the Ohio State campuses. Also, the general and mandatory fees, including the recreation fee, student activity, student union facility fee, and COTA bus fee will again not change in fiscal year 2015.

Graduate and Professional Fees - Masters and PhD instructional fees will not increase in fiscal year 2015. Some graduate and professional students pay a higher or differential instructional fee based principally on market demand and market pricing. Revenue generated from these increases is earmarked to support the graduate and professional programs that generate the fee income. Most differential fees are expected to increase 2%, while some are budgeted to increase between 3% and 6% in fiscal year 2015.

Non-Resident Surcharges - Effective Autumn term fiscal year 2015, the non-resident surcharge will increase 5.0% for most undergraduate, graduate, and most professional programs at each campus. Exceptions to this include the Colleges of Law and Optometry, which will see no increase, four graduate business programs, an on-line FAES program and an on-line Engineering Program that charge a flat non-resident surcharge.

Program, Technology, and Other Fees - Several colleges and academic programs have established additional fees to support specific programs and initiatives. These include program fees designed to provide financial support for specific programs, technology fees, international student fees, and course fees and distance education fees.

Comparison with Selective Ohio Peers - Among Ohio's public universities, Ohio State ranks highest in academic reputation, yet has the second lowest undergraduate student fees among Ohio's six public four-year universities with selective admissions. Given the continued commitment to keep tuition affordable by not raising resident undergraduate rates in the 2014-15 academic year, Ohio State will continue to have one of the lowest student fees among the selective public institutions. This makes Ohio State an excellent value for students and taxpayers.

UNDERGRADUATE RESIDENT FRESHMEN TUITION & FEES - AY 2014 & AY 2015
FULL-TIME RATES FOR OHIO SELECTIVE PEER INSTITUTIONS

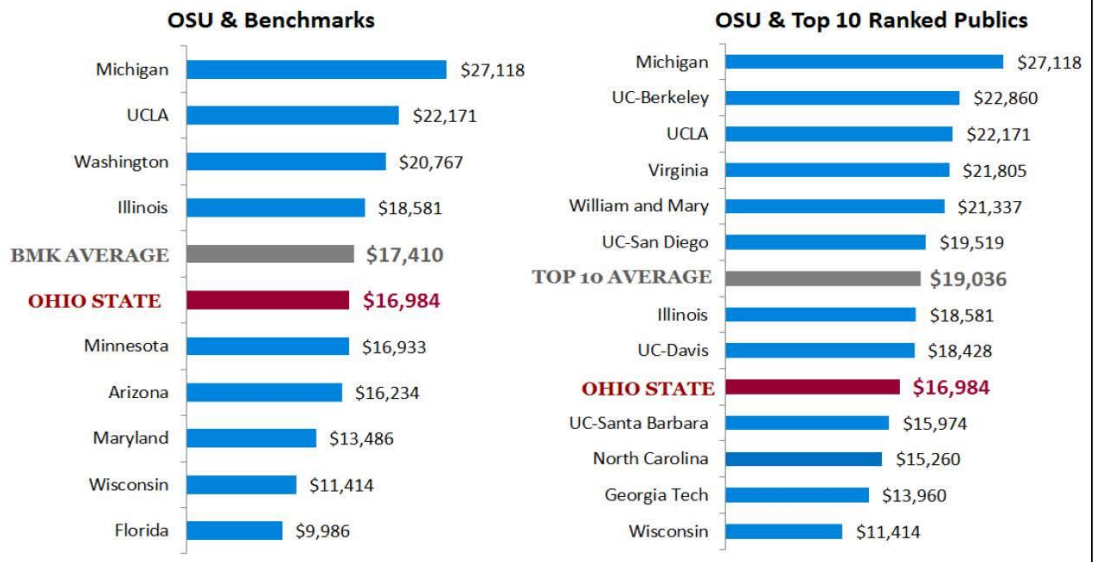
Ohio Peer	US News Rank*	2014	2015 (Est.)	% Change
Miami	71	$13,748	$14,015	1.9%
Cincinnati	117	$10,784	$11,000	2.0%
Ohio University	101	$10,446	$10,602	1.5%
Bowling Green	166	$10,590	$10,590	0.0%
Ohio State	**33**	**$10,037**	**$10,037**	**0.0%**
Kent State	182	$9,816	$10,012	2.0%
Average		$10,903	$11,043	1.3%

Sources: Ohio Board of Regents Fall Survey of Student Charges (AY 2014); campus representatives and campus websites (AY 2015). FY 2014 Tuition and Fees are the published institution rate for resident new freshmen.
** UG Academic Reputation Rank (formerly known as the Peer Assessment Rank) is based on scores from the U.S. News and World Report's 2014 Best Colleges Rankings.*

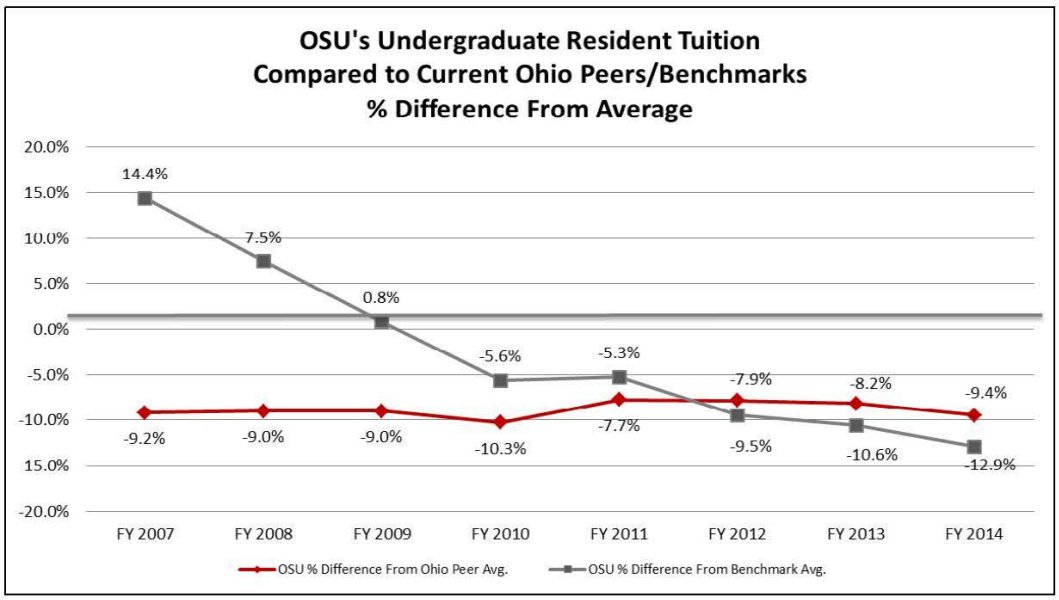
Comparison with Benchmarks and Top Public Schools - In comparing Ohio State with our peer institutions on tuition and fees (latest data available is fiscal year 2012), revenues per student FTE were 2.4% below the average of OSU's benchmark institutions and 10.8% below the top 10 ranked public institutions' average.

Ohio State ranks below the benchmark and top ten ranked publics averages in tuition and fee revenues per student FTE (-2.4% Benchmarks; -10.8% Top 10).

TUITION AND FEE REVENUE PER STUDENT FTE: FY 2012



Source: IPEDS Finance Survey and Fall Enrollment Survey. Includes all tuition and fees assessed against students for education purposes, encompassing all levels of students, all residency types, as well as all technology, program, course, clinic, etc. fees. Benchmark institutions are considered OSU's peers or aspirational peers as they represent high quality institutions that most closely resemble OSU in organization and mission. Top ten ranked public schools are based on the U.S. News and World Report's 2014 Best Colleges rankings (National University) and incorporates the scoring for all indicators.



Sources: AAUDE, IPEDS, & Ohio Board of Regents

Again, even among other highly ranked institutions across the nation, Ohio State continues to be an excellent value for students.

State Share of Instruction (SSI)

The SSI allocation is the State of Ohio's primary funding support for enrollments and degree completions at its colleges and universities. SSI funds campuses on the basis of several criteria including successful course completions, indexed by financially and academically at-risk students, degree completions with added funding for degree completions by at-risk students, research activity, and a number of other criteria intended to advance the goals of the State.

In total, the State is appropriating approximately $1.82 billion for SSI in fiscal year 2015, an increase of $28.5 million or 2% over fiscal year 2014. In total the university will receive $354 million in SSI funding for fiscal year 2015. This is roughly $1.4 million below fiscal year 2014; driven by the reduction in State stop-loss funding for regional campuses.

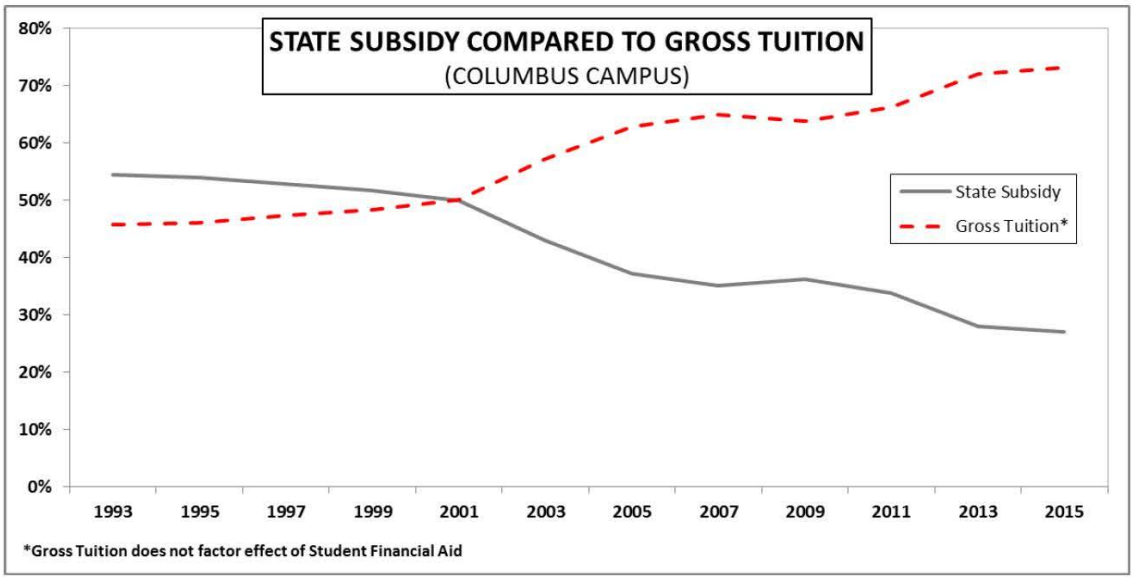
In the fall of 2012, Governor Kasich asked former President Gee to chair a committee comprised of the presidents from Miami University, Ohio University, Wright State University, and Shawnee State University to recommend changes to the State Share of Instruction (SSI) formula to better align it with the goals of the state. The committee was tasked with finding ways to use the formula to support the following objectives:

- Increase participation rates
- Encourage the best and brightest to attend
- Improve graduation rates
- Make higher education more affordable
- Graduate students with the skills they need
- Encourage graduates to stay in Ohio

In fiscal year 2014, the first year of implementation, the formula shifted to rewarding degree recipients, adopted a universal three year average as the basis of calculation for the distribution of the allocations, adopted STEM weights to degree completions, and removed the re-allocation of funds from campuses to those whose allocations had dropped below a certain threshold.

In fiscal year 2015 the formula will combine the regional campus allocations with the main campuses, award proportional degree credits for transfer students, award associate degree credits for all campuses, and implement degree credits for out of state graduates that remain the in the state. In the next biennium the formula will remove all remaining earmarks currently in the formula.

The university is assessing the impact of the funding changes on its campuses and is engaged in discussion with the Interuniversity Council of Ohio and the Board of Regents on ways that the funding formula can better meet the needs of the State.



State Line Item Support

In addition to SSI funding, the university also receives funding directed to specific purposes. In fiscal year 2015 the university expects to receive $ 86.6 million in line item funding. This is roughly flat to our fiscal year 2014 projections.

In total SSI and line item support to the university are expected to be down $1.5 million from fiscal year 2014. On an inflation-adjusted basis, State funding per resident student continues to trail historical levels.

Capital Appropriations

The university also receives capital appropriations from the state to improve the physical infrastructure of the university. The state capital budget process occurs in the off years from the state budget process. The fiscal year 2015-16 capital process allocated approximately $99.2 million to the university, of which approximately $45 million is expected to be received in fiscal year 2015 and will be used to fund such projects as the renovations of Oxley and Pomerene Halls to support Discovery Theme recruitment, renovations at the regional campuses and other infrastructure projects.

Grants and Contracts

For fiscal year 2015, revenue from grants and contracts is planned at $674 million, essentially flat from the fiscal year 2014 forecast. Grants and contracts revenue is administered in two ways: recorded by individual units in segregated grants and contracts funds, or as sponsored projects administered by the Office of Sponsored Projects.

Of the $674 million, $487 million is administered by the Office of Sponsored Projects and $187 million is administered directly by colleges and support units. Projects administered by the Office of Sponsored Projects typically have more stringent process and documentation requirements than projects that are directly administered through the colleges and support units.

Sponsored Research Programs

The university secures funding for sponsored research programs from a variety of external sources. External grants are awarded by federal, state and local agencies along with private foundations and corporate sponsors. Revenue for sponsored research programs administered by the Office of Sponsored Projects is expected to decrease slightly by $3 million, from $490 million projected in fiscal year 2014 to a budget of $487 million in fiscal year 2015. This is due primarily to decreased governmental funding and elimination of ARRA funds.

The sponsored research revenues discussed above include facilities and administrative (F&A) recoveries which are projected to be $99 million, a $2 million, or 1.5%, decrease from fiscal year 2014 levels. F&A costs are recovered from most sponsored programs to offset the cost of maintaining the physical and administrative infrastructure that supports the research enterprise at the university. Because some direct cost expenditures do not recover F&A, direct and indirect cost expenditures do not necessarily align when comparing expected revenue streams.

Agencies differ in how they award funds to the university. Some sponsors will provide all spending authority at the beginning of a multi-year award whereas others tend to fund in annual increments; therefore, awards and expenditures do not necessarily track together.

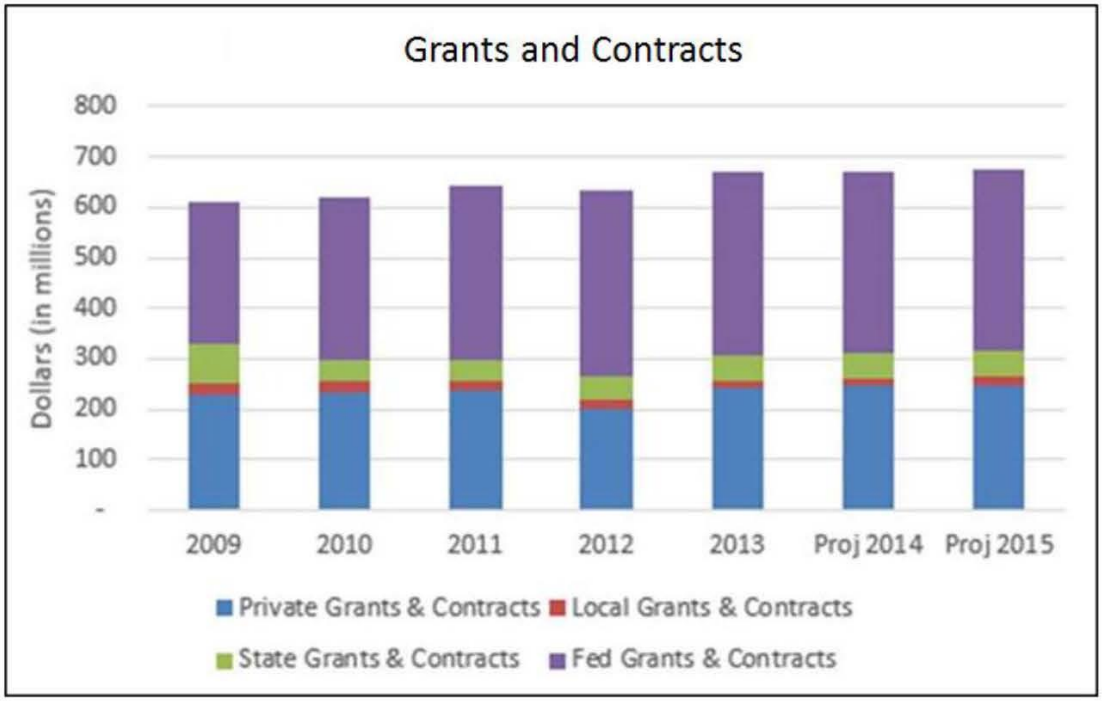
Not unexpectedly, awards from not-for-profit entities that provide grants from funds they raise from charitable donations (e.g. American Cancer Society) are also trending downward. In addition, State funding is also being redirected toward private enterprises and not toward research development at universities.

The university is working to mitigate ongoing downward trends using two primary strategies. First, we are actively focusing on increasing the competitiveness of researchers through activities internal to the university, including facilitating multidisciplinary research to take advantage of the breadth of expertise at the university; establishing new centers focused on current and emerging research challenges; creating a proposal development center; and establishing and maintaining cutting edge core facilities to support our growing community of research-intensive faculty. The second strategy involves building external relationships that will help grow the university's portfolio of federally-funded research, expand strategic partnerships with industry and promote and develop the Ohio Technology Consortium (OH-Tech).

College / Support Unit Administered Grants and Contracts

Revenue for grants and contracts administered directly by individual colleges and support units is expected to increase slightly from $184 million projected for fiscal year 2014 to $187 million budgeted for fiscal year 2015.

The following graph represents the trend for each component of Grants and Contracts since fiscal year 2009.



Sales and Service Revenues

Sales and Services of Educational Departments - Sales and services of educational departments are expected to remain flat versus fiscal year 2014. This revenue consists largely of clinical revenue in colleges such as Optometry and Veterinary Medicine and non-college departments such as Recreational Sports and OARNET.

Sales and Services of Auxiliary Enterprises - Student Life and Athletics comprise the majority of sales and services of auxiliary enterprises. Operating Revenue from sales and services of auxiliary enterprises are expected to increase $14 million, or 6.1%. Athletics revenue is budgeted to increase $10 million driven largely by increased football revenue from ticket sales ($3.6M), incremental Big Ten bowl revenue ($2.4M) and guaranteed payment for the away game with Navy ($1.8M).

Student Life increase in Sales and Services is primarily driven by room and board revenue from planned fee increases averaging 4.2% on most services in fiscal year 2015. The increase is necessary to cover increased debt payments associated with the new North Residential District and to cover basic inflation for supplies and services. University leadership has asked the Office of Student Life to reduce costs, beginning in fiscal year 2015, with a target to reduce on-going costs by $1.8 million.

UNIVERSITY BUDGET: EXPENSE

Salaries and Benefits

Salaries - Salary expense is expected to increase by $41 million or 3.1% over fiscal year 2014 projections. Faculty and staff salary guideline increases of up to 2.0% have been included in the budget for fiscal year 2015.

Salaries expense is planned to increase by $28 million in colleges, including guidelines increases and a $7.5 million investment in the Data Analytics Discovery Theme. The remaining $13 million increase is attributable to support units, including guideline increases and investments in areas such as proposal development and compliance efforts in the Office of Research, OSU Online, Advancement and a full year of fully staffed Office of Integrity and Compliance.

In an effort to drive increased efficiency and ensure that funding is maximized to support the core academic mission, The university has indicated that it will only fund 50% of any net increase to salary and benefits within support units through the current budget allocation model. For instance, if a support unit proposes an aggregate 2.0% increase, the unit will have to fund 50% of that dollar value, effectively 1.0%. It is expected that the unit will deliver cost savings in order to offset the other 50%.

Consistent with prior years, the approved salary guidelines take into consideration the financial condition of the university as well as statistics of the current labor market. The university continues to employ its philosophy of setting faculty salaries at a level that will maintain or advance Ohio State's position nationally for the highest quality faculty, and to set staff salaries to be competitive with the local employment markets.

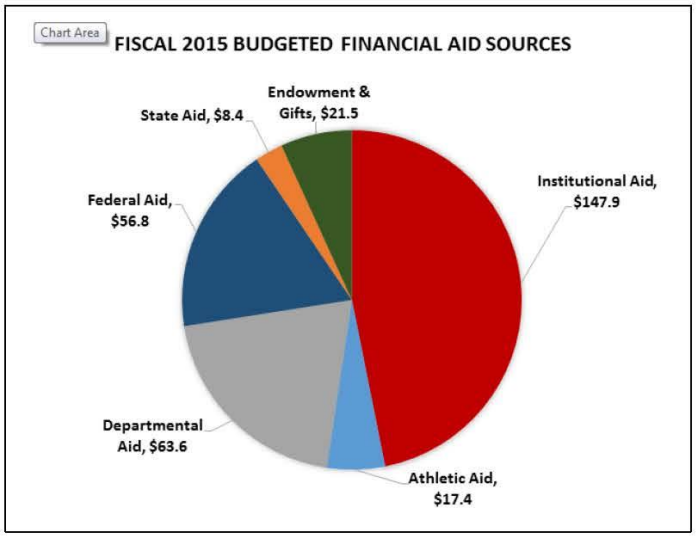
Benefits - Benefit costs are expected to increase by $19 million or 4.8% over fiscal year 2014. Benefits are driven by the 2% salary guideline increase, which directly affects the retirement plan contribution expenses and a 7% average rate increase on other benefit plans combined. Benefits include the university's contribution to employee retirement plans, various medical, dental, vision, life and disability plans, employee and dependent tuition plans and university expense related to compulsory plans, such as workers' compensation and unemployment compensation.

Retirement Plans - University employees are covered by one of three retirement systems. The university faculty is covered by the State Teachers Retirement System of Ohio (STRS Ohio). Substantially all other employees are covered by the Public Employees Retirement System of Ohio (OPERS). Employees may opt out of STRS Ohio and OPERS and participate in the Alternative Retirement Plan (ARP) if they meet certain eligibility requirements. Under each of the plans, the university contributes 14% of the employee's pay to the plan annually, while the employees contribute 10%. Vesting varies by plan.

Medical Plan - The university is self-insured for employee health insurance. Fiscal year 2015 medical plan costs are budgeted based on historical cost trend data, projected employee eligibility, and expected plan changes associated with governmental regulations. Given these factors, we are projecting a 7% increase for fiscal year 2015 across all medical plans. The university will continue to monitor the impact the new health care laws will have on the university as an employer as legislation and regulations evolve.

Student Financial Aid

Financial aid is a critical investment of resources that keeps the cost of education manageable for students. The Ohio State University engages both the federal and state governments in conversations to stress the importance of financial aid and reasonable loan programs for students. Interactions with donors also stress the importance of gifts that support financial aid.



The financial aid plan seeks to advance two specific goals for the university: to invest in the quality, quantity and diversity of students in order to continue to move Ohio State towards its goal of being in the top ten public universities in the country; and to invest in students to fulfill our role as the land grant university for the State of Ohio, whereby access to college is afforded to those students with limited resources. The university continues to work to support both goals and continues to develop the appropriate balance in moving the university towards eminence. Fundraising efforts are also underway through various initiatives including the Ohio Challenge in which all 88 Ohio counties are raising funds to recruit students from each county to attend Ohio State.

Ohio State expects to distribute a total of $315 million of financial aid, excluding graduate fee authorizations, to students in fiscal year 2015. Sources for the aid include institutionally funded aid, federal and state programs, and gifts and endowments. The university financial statements present a portion of financial aid, in accordance with GASB accounting requirements, as an allowance against gross tuition and, in the case of Athletic scholarships, an allowance against Auxiliary sales. For fiscal year 2015, $169 million of the $315 million of financial aid has been presented as allowances.

Institutionally funded financial aid is expected to increase by $9.4 million, or 6.8%, in fiscal year 2015 to a total of $147.9 million. These increases are driven by further investments in financial aid to support the Enrollment Plan, funding for need-based financial aid, funding for the Eminence Financial Aid program for high-performing students, and for the inflationary costs of room and board.

Federal financial aid, which consists primarily of Pell and some Supplemental Educational Opportunity Grant (SEOG) grants, is expected to increase $0.9 million, or 1.6%, to $56.8 million in fiscal year 2015. State financial aid is expected to hold steady at approximately $8.4 million in fiscal year 2015 and is driven by funding levels for programs such as the Ohio College Opportunity Grant (OCOG). Donor and other funds are also expected to remain flat in fiscal year 2014 at $21.4 million.

Athletic scholarships are planned to remain roughly flat at $17.4 million. The remaining $63.6 million in financial aid is administered directly by colleges for graduate fellowships and departmental awards.

Fee Authorizations

Fee Authorizations are an additional component of student aid directed toward graduate student appointments. Total University Fee Authorization expense is expected to increase by $2.2 million or 2.3% in fiscal year 2015. This is driven by a larger number of planned graduate appointments versus fiscal year 2014 and by the incremental cost to fund this aid for some resident and non-resident students.

Supplies & Other Expenses

Supplies and Other Expenses are projected to increase $19.1 million or 3.1% versus fiscal year 2014. However, fiscal year 2014 Other Expenses include a one-time $10 million insurance payment for tornado damage at Wooster. Once fiscal year 2014 costs are adjusted for this one-time proceed, costs are planned to increase by $9.1 million or 1.5%. The primary drivers are a $7.8 million increase in utilities cost versus fiscal year 2014. Other increases include $1.0 million to support development of OSU On-line programs, $0.8 million for new programs in the College of Public Health and $1.4 million to develop a marketing plan and implement new software in the Office of Enrollment Services.

Utilities - Columbus campus utilities expense is expected to increase by $7.8 million, or 8.1%, in fiscal year 2015 to $103 million. The increase is driven primarily by increases in debt service associated with utilities projects, such as the addition of more efficient cooling plants, and increases in purchased power costs. The university's internal budget model contains a mechanism to smooth changes in rate, both increases and decreases, charged to colleges and units in order to provide for less volatility in annual funding and facilitate planning.

The Wexner Medical Center and major auxiliaries such as Student Life and Athletics are not charged for utilities by the assignable square foot but are directly billed for specific utilities based on meter data. This direct billed revenue is deducted from the total utilities expenses in calculating the rate per assignable square foot paid by other units.

The university has contracted with Johnson Controls for a pilot project to install energy conservation measures in five energy-intensive buildings: Biomedical Research Tower, RPAC/McCorkle Aquatics Pavilion, Scott Lab, Physics Research Building, and the Veterinary Hospital. The total minimum guaranteed energy savings for these buildings will be $1 million annually after the project is completed.

Building Maintenance and Custodial Services - Services provided include repairs resulting from normal wear and tear, including plumbing, central HVAC and electrical systems, elevator repair and maintenance, and maintenance of the building envelope, including windows, foundations, walls, and floors. Maintenance expenses are expected to increase by $400,000, or 2.0%, in fiscal year 2015 to $32.3 million. The increase is driven primarily by increased salaries and benefits for university maintenance staff.

Custodial expenses are expected to decrease by $200,000, or 0.2%, in fiscal year 2015 to $16.5 million. For fiscal year 2015, contract services will provide custodial services for approximately 56% of Columbus campus buildings.

Maintenance and Renewal - In an effort to keep pace with maintenance needs for newer buildings and prevent additions to the deferred maintenance backlog, the POM rates provide annual funding for a preventative maintenance pool and a second fund for a deferred maintenance endowment. Annual funding set aside for preventative maintenance pool will remain at $4 million in fiscal year 2015.

The deferred maintenance endowment was established to provide funding for future maintenance on buildings constructed after 2000. $6 million will be added during fiscal year 2015 to the quasi endowment established for this purpose. The addition in fiscal year 2015 will increase the principal balance to

approximately $43 million. Distributions of up to $1.5 million from this fund will be expendable beginning in fiscal year 2015 for any in-scope deferred maintenance.

University Overhead

Overhead is charged to non-general funds units to help fund centrally-provided services. In fiscal year 2015, $73 million is expected to be allocated via internal charges to fund centrally-provided services, an increase of $1 million from fiscal year 2014. Since overhead is an intra-university allocation, entries are eliminated in the financial statement consolidation process.

Specific expense categories comprising the overhead rates include Facilities Support, Administrative Support, and Specialized Support (Health Administration and Student Services). Different overhead rates are calculated based on participation in the different expense categories. The base rate includes all expense categories; other rates are calculated to include only those expenses applicable to those units. For example, the regional campus rate includes only the insurance, academic administration, and central support expense categories. For fiscal year 2015, the rates ranged from 2.8% for the Wexner Medical Center to 5.7% for most earnings operations.

For all units except the Wexner Medical Center, overhead is calculated based on the overhead percentage times net revenue. Net revenue is defined as revenue less direct pass through costs. The Wexner Medical Center's overhead is charged a dollar amount based on actual prior year expenses, in order to be compliant with federal Medicare reimbursement policies. The calculated overhead rates for fiscal year 2015 are stable compared with fiscal year 2014 rates, reflecting moderate growth in both revenues and allocated overhead costs.

Advancement

The university launched the public phase of its $2.5 billion *But for Ohio State* campaign in October 2012. The fundraising campaign invites those who believe in Ohio State to invest in our students, our faculty, and our potential. By supporting Ohio's land-grant institution, alumni, friends, parents and partners can help us secure educational opportunities for futures generations of students and meet the enormous challenges we face as a society. Campaign proceeds will be used to fund scholarships to attract the most promising students, elevate faculty, create modern learning environments, promote multidisciplinary research, and drive high-impact innovation.

In fiscal year 2015, the university expects to raise aggregate fundraising dollars of $390 million, including pledges and certain private contracts, by engaging a variety of constituents, including students, faculty and staff, alumni, friends, corporate partners and private foundations. The Advancement strategic plan focuses on aligning fundraising with communications and alumni/constituent engagement to use innovative funding approaches with Ohio State's partners across all facets of the university.

The Advancement related line items of the fiscal year 2015 financials exclude pledges of $58 million where we do not expect to receive cash in fiscal year 2015. In addition, $106 million of the $390 million of expected fundraising is recognized in grants and contracts within the fiscal year 2015 budget.

Financial Services and Investments

The Office of Financial Services manages cash, short and intermediate term investments and other funds totaling over $2.0 billion. They also oversee a debt portfolio of $2.5 billion. In performing these functions,

the office serves as internal bank to the university taking deposits, issuing debt, investing operating funds and approving loans. The internal bank is a framework for coordinating these activities and providing a consolidated view of the associated assets, liabilities, revenues and expenses.

The Office of Investments manages the Long Term Investment Pool (LTIP), which totals over $3.4 billion and includes gifted endowment funds, designated funds and a significant portion of operating funds. Through a partnership with external managers, the Office of Investments has adopted an asset allocation model for the LTIP that groups assets into four broad categories. This model enables the investment team to build a portfolio of specialized investment teams around the world to implement our strategic allocation and to be responsive to changing market conditions.

Investment Income - Investment income on cash, short and intermediate term investments is budgeted at $12.0 million, a $1.0 million increase over our fiscal year 2014 forecast. The fiscal year 2015 budget reflects the continued low interest rate environment.

The LTIP is budgeted to return $278 million, at an 8.0% return, in fiscal year 2015. The LTIP has produced a 10.6% return, or $333 million in the first 10 months of fiscal year 2014, net of investment expenses. This compares to an 11.6% return or $319 million for the full fiscal year 2013.

Debt - The proceeds of past debt issuance have been utilized to fund major construction projects including the Wexner Medical Center expansion and dormitory refurbishments, as well as significant campus infrastructure improvements .

The debt is comprised of a mix of tax exempt and taxable bonds. Over 82% of the outstanding debt balance is comprised of fixed rate obligations ranging between 1.2% and 4.85%. The remainder is variable rate agreements. The variable rates, most of which are subject to change every seven days, averaged 0.05% through the first ten months of fiscal year 2014 and have a 15 year average of 1.5%. Under the terms of the variable rate agreements, the rates cannot exceed 8% or 12%, depending on the issue.

In fiscal year 2015, we plan to issue approximately $300 million of new debt to complete the funding of the Wexner Medical Center expansion. The university expects to incur approximately $95 million of interest expense on plant debt in fiscal year 2015, an increase of $10 million over fiscal year 2014 projected levels. Approximately $19 million will be capitalized resulting in a net expense of $76 million for fiscal year 2015.

Health System

$ in Thousands	Fiscal 2014 Projected	Fiscal 2015 Budget	$ Change	% Change
Operating Revenues				
Inpatient Services Revenue	$ 3,772,520	$ 3,814,830	$ 42,310	1.1%
Outpatient Services Revenue	3,124,178	3,206,653	82,475	2.6%
Deductions from Patient Revenue	(4,824,240)	(4,849,093)	(24,853)	0.5%
Other Operating Revenue	65,811	84,807	18,996	28.9%
Total Operating Revenues	**$ 2,138,269**	**$ 2,257,198**	**$ 118,929**	**6%**
Operating Expenses				
Salaries	$ 717,436	$ 766,293	$ 48,857	6.8%
Benefits	222,543	243,397	20,854	9.4%
Professional Fees	103,733	106,453	2,720	2.6%
Supplies	264,325	269,585	5,260	2.0%
Drugs & Pharmaceuticals	155,070	180,568	25,498	16.4%
Services	275,116	277,807	2,691	1.0%
Residents	47,995	48,833	838	1.7%
University Overhead	48,358	49,808	1,450	3.0%
Depreciation & Amortization	77,739	104,107	26,368	33.9%
Interest	9,448	26,647	17,199	182.0%
Total Operating Expenses	**$ 1,921,762**	**$ 2,073,498**	**$ 151,736**	**7.9%**
Operating Gain (Loss)	**$ 216,507**	**$ 183,699**	**$ (32,807)**	**-15.2%**
Net Non-Operating Revenue	1,017	1,607	590	58.0%
Excess of Revenue over Expenses	**$ 217,524**	**$ 185,306**	**$ (32,217)**	**-14.8%**
Medical Center Investments	(118,174)	(100,000)	18,174	-15.4%
Change in Net Assets	**$ 99,350**	**$ 85,306**	**$ (14,043)**	**-14.1%**

The 2015 OSU Wexner Medical Center Health System (Health System) operating budget generates margins and cash flows sufficient to meet or exceed the Health System's three strategic financial targets. The first goal is to earn an EBIDA margin of at least 12%. The fiscal year 2015 budget generates a 14% EBIDA margin. The second goal is to increase the number of days of cash on hand by three days. The fiscal year 2015 budget results in a three day increase from $339 million to $374 million. The final target is to achieve a debt service coverage ratio of 4:1. The budget results in a 4.3:1 debt service coverage ratio.

Cancer and Critical Care Tower Opening

The opening of the new James Cancer Hospital and Critical Care Tower (CCCT) scheduled in December 2014 represents one of the final phases of the $1.1 billion dollar Medical Center Expansion project. This twenty one story, one million square foot facility will open 348 new beds, will contain 14 operating rooms, expanded radiation therapy units, and over 100 ambulatory exam rooms. The CCCT has been designed to provide state of the art care to patients, support teaching and research activities close to the bedside and provide a comfortable and nurturing environment for families.

The opening of the CCCT poses financial challenges in 2015 that will be alleviated in 2016 as the Health System anticipates return to normal day to day operations. The opening of the CCCT frees beds currently used in the existing James facility and in Doan Hall. When James patients move to the new facility, a backfill plan is in place that will make more beds available for University Hospital, while also reconfiguring space to house the Brain and Spine Hospital, privatizing some existing dual occupancy rooms and decompressing faculty office space.

The impact of the opening on both University Hospital (UH) and The James are significant and will be discussed below. The expense of opening the building will begin early in the fiscal year, likely depressing traditional margin levels in the first six months. Upon opening, The James is projected to fill beds quickly and is expected to reach planned operating levels in the fourth quarter. Critical care cancer patients currently treated by University Hospital will transfer to the new tower, lowering revenues and some expenses to UH. UH backfill is expected to occur over a slightly longer period. Due to historic bed constraints across the health system, physician referral patterns to the Medical Center may take time to build.

Revenue Drivers

Overall revenue is budgeted to increase approximately 5.5% compared with the current year rate of 5.8%. Activity increases account for approximately 3.2% and rates account for 2.3% of fiscal year 2015 growth. Outpatient activity growth is expected to be consistent over the fiscal year, while the majority of inpatient growth will occur when beds become available in the second half of the fiscal year.

Medicaid Expansion has been favorable for the Health System as patients previously covered under charity programs now have coverage. Medicaid rates have been cut to offset the large increase in enrollment, but the 2015 budget anticipates positive outcome from this increased volume. Overall charity care write offs will drop significantly if this trend continues. The impact of federal insurance exchanges continues to remain unclear. There is significant risk that new enrollment is heavily skewed toward high deductible plans, which will drive all hospitals' bad debt costs to unprecedented levels. Overall, management believes that exchanges will not have a significant impact on the Health System in 2015.

Medicare rates will decrease slightly in certain service areas. The 2% federal sequestration reduction on Medicare payments is expected to remain in effect. Some federal cuts legislated under ACA have been deferred, although the Health System experienced a sizable cut in state funds intended to support safety net hospitals. Managed care arrangements are negotiated through the end of 2015 and in some cases

into 2016. The payment increases for managed care contracts provides most of the 2.3% rate growth noted above. There are no planned price increases in this budget.

Expense Drivers

Expenses before interest and depreciation will grow by 5.9% compared to the current year growth of 5.7%. The fiscal year 2015 budget includes estimated one time expenditures of $17 million for the CCCT opening. Excluding those costs, expenses will grow at approximately 4.8%, of which 3.2% will be activity driven and 1.6% rate driven. Increases under the ONA contract provide a 3% salary growth for nursing. Salary increases averaging 2% overall will be given to employees earning less than $250,000. Excluding pharmaceutical costs and increases for a new retail pharmacy, non-salary costs will decrease after accounting for volume increases.

Extensive expense reduction is anticipated in the 2015 budget. Some interventions are fully implemented such as improved coding, new staffing models in the hospitals, centralized imaging to increase throughput and improve patient satisfaction, and reducing pharmacy costs. We continue to focus on growth initiatives in the areas of cancer, outreach/hospital affiliations, ambulatory expansion, neurosciences and primary care in order to protect the value of our franchise. Many additional interventions are in implementation or will be launched soon including increasing physician productivity requirements, reducing the cost of unfunded research faculty, evaluating organizational span of control and layers of management, embracing and implementing a "true" shared services model for clinical and administrative shared services, and aggressively overhauling our supply chain activities.

EBIDA and Profitability

With the opening of the CCCT, depreciation and interest expense will increase from $87 million to over $131 million and debt service will exceed $90 million. The increase in depreciation and interest expense reduces the 2015 operating margin. Knowing that the opening of the building would have material impact on operating margin, the Health System has historically utilized EBIDA (Earnings before Interest, Depreciation, and Amortization) as a metric to provide comparability across fiscal years. The Health System set an aggressive target to grow 2015 EBIDA by 3% while it faces the challenges of bringing the new building on line. Although margin decreases from $216.5 million in 2014 to $183.7 million in 2015, EBIDA increases from $304 million to $314 million, indicative that the clinical engine will continue to produce cash for the university.

Cash Management

Although EBIDA is expected to grow 3%, that will not be sufficient to service the increased debt, grow cash by three days and fund other working capital needs. Therefore, funds available for program and capital investment are being reduced. The Health System will lower its support for clinical and academic activities by $20 million in 2015 and will maintain its capital budget at $68 million, the same as 2014 levels. These reductions will be offset by improved productivity. As 2015 unfolds, cash growth will be monitored closely; should estimates of revenue and expenses result in unfavorable cash flow, further reductions in operations or investments will be considered.

2015 will be one of the most challenging and potentially unpredictable budgets in recent years. Uncertainty in the hospital industry and the midyear opening of a $1.1 billion facility combine to create a difficult forecasting process. However, this budget is predicated on our fundamental financial strength, our ability to control costs, and the strength that the OSU Wexner Medical Center brand carries locally and state wide. Although it is aggressive, it is certainly achievable.

OSU Physicians, Inc.

$ in Thousands	Fiscal 2014 Projected	Fiscal 2015 Budget	$ Change	% Change
Operating Revenues				
Net Patient Revenue	$ 264,232	$ 301,106	$ 36,874	14.0%
Other Operating Revenue	47,026	46,186	(840)	-1.8%
Total Operating Revenues	**$ 311,258**	**$ 347,292**	**$ 36,034**	**11.6%**
Operating Expenses				
Staff Salaries and Benefits	$ 73,095	$ 76,419	$ 3,324	4.5%
Supplies and Pharmaceuticals	25,531	28,227	2,696	10.6%
Purchased Services, Management Fees, Other	31,973	36,357	4,384	13.7%
Occupancy and Utilities	8,063	8,849	786	9.7%
Depreciation	4,438	4,662	224	5.0%
Interest	513	452	(61)	-11.9%
General Administrative Overhead	8,090	10,313	2,223	27.5%
Total Operating Expenses	**$ 151,703**	**$ 165,279**	**$ 13,576**	**8.9%**
Provider Expenses	198,695	214,286	15,591	7.8%
Excess of Revenue over Expenses after Provider Expenses	**$ (39,140)**	**$ (32,273)**	**$ 6,867**	**-17.5%**
Net Non-Operating Revenue	3,779	2,557	(1,222)	-32.3%
Medical Center Investments	36,019	29,716	(6,303)	-17.5%
Change in Net Assets	**$ 658**	**$ -**	**$ (658)**	**-100.0%**

OSU Physicians, Inc. is a multi-specialty faculty practice bringing outpatient care to Central Ohio communities with physicians focusing on personalized healthcare, patient satisfaction, research and education.

The fiscal year 2015 budget for OSU Physicians, Inc. includes an increase in operating revenue of $36 million, or 11.6%, based on an expected 13% increase in volume, as measured by work relative value units (WRVUS), a system for measuring physician productivity. Provider related expenses are budgeted to increase $15.6 million, or 7.8%, due to 62 new physicians that either recently started in fiscal year 2014 or will start in fiscal year 2015.

University Budget Process

THE BUDGET PROCESS AT THE OHIO STATE UNIVERSITY

For the Fiscal Year 2015 Budget Plan, the university continued to implement a revised budgeting process that encompasses all funds of the university. This approach affords a holistic view of all operations of the university in an easily understood format that will enable the university to highlight the evolution of funding sources. This will allow leadership to make informed strategic decisions in a timely manner.

This all funds, total operating budget will provide the base framework for evaluating the activities of all academic and support units within the university, allowing proactive responses to changing economic issues as they arise.

Budget System

The university uses a budget system that is comprised of two components: a modified Responsibility Center Management (RCM) model and the strategic investment of central funds. This structure allows for decentralized decision making and control of financial resources at the colleges and support units. The modified RCM budget model assigns substantial control over resource decisions to individual colleges and support units. The underlying premise of the university's decentralized budget model is entrusting academic and support unit leaders with significant control over financial resources, leading to more informed decision making and better results and outcomes for the university as a whole. Through this decentralized model, colleges in particular are incentivized to increase resources by teaching more credit hours and increasing research activity.

The OSU Health System and OSU Physicians, Inc. prepare their budgets based upon projected activity and associated costs. External factors, such as government regulations and reimbursements rates, as well as contractual agreements with health care payers also play an integral part in developing the health system's budget.

"As the university's sources of funding continue to evolve, it has become evident that a consolidated view of all sources of funding received and monies spent is necessary to make informed decisions in a timely manner."

Fund Accounting

The university's budget is developed and managed according to the principles of fund accounting. We manage over 19,000 active expendable funds and over 4,800 endowment principal funds through a robust accounting system. Revenue is segregated into a variety of fund types, the use of which is governed by the restrictions of the specific fund. Some fund types are unrestricted, including general funds and some earnings funds. Others have restrictions derived from the source of the revenue, including grants and contracts received from government agencies, foundations, and other outside sponsors. Individual funds are set up to ensure strict adherence to the terms of the grant or contract that governs these funds.

Endowments are another type of restricted fund, where separate funds are set up to preserve the corpus or principal of the gifts. As those funds earn investment returns, annual income distributions are made out of the endowment fund and into a current fund for spending in accordance with the donors' restrictions. The segregation of each gift allows the university to ensure the funds are spent appropriately and to enable reporting to donors on the activities that their funds support.

Although emphasis was placed on including all university funds in the fiscal year 2015 budget process, general funds continue to remain a key component of the budget. General funds can generally be used for any university purpose whereas restricted funds are more specifically targeted. These funds play a major role in the budget, as they cover many expenses in the colleges and support units for which it is

difficult to raise money. The main sources of general funds are tuition and other student fees, state support of instruction, indirect cost recovery, and overhead charged to earnings units.

Allocation of Funds

Each college and support unit receives a portion of general funds in support of both academic and administrative functions. The process for allocating the funds is administered through the Office of Financial Planning & Analysis under the guidance of the Chief Financial Officer and Provost. General funds are allocated to colleges and support units on a marginal basis under an established set of criteria. In other words, increases (or decreases) in the pool of general funds available each budget year are allocated back to colleges and support units as increases (or decreases) to their base general funds budgets.

Marginal changes in revenue are allocated to colleges based on three primary funding formulas. The first funding formula for colleges utilizes a model to distribute undergraduate marginal tuition and state support. Sixty percent of the funding is allocated based on total credit hours taught, while forty percent is allocated based on the cost of instruction. This budget allocation method takes into account the fact that some courses have a higher cost for delivery and are, thus, allocated a greater share of the funding. The other two primary funding formulas allocate graduate tuition and state support based on credit hours in fee-paying categories (tuition) and type of course taught based on cost of instruction (state support). As a college teaches more of the share of total credit hours, it receives a larger share of the incremental funding. Conversely, if a college's share of the hours taught declines, the college's allotted share of incremental funding will correspondingly decline. Colleges will receive their share of revenue on indirect research cost recovery, based upon the college's share of research revenue. Fee revenue from learning technology, course and program fees are provided directly to colleges based upon course.

Support units are funded through a combination of central tax, specific activity-based assessments charged to colleges and an overhead rate charged to auxiliary and earnings units. The central tax, assessments and overhead charges are designed to provide the funds necessary to maintain support services such as payroll services, central human resource services, and student life services. Support units are generally ineligible for marginal revenue changes because the funding formulas rely on credit hours taught; instead, support units must request additional funding during the annual budget process to support new services or mandates.

Auxiliaries and earnings units are expected to operate at a break even or better margin and generally do not receive general fund support. One exception is the Office of Student Life which does receive general fund support via special Student Activity, Ohio Union and Recreational Facility fees that were enacted to specifically advance the student experience.

Regional campuses develop their own individual campus budgets primarily based on the student tuition and fees received from the regional campus students, the State Share of Instruction they expect to collect and costs directly incurred to operate those campuses.

University-wide initiatives and special requests by colleges and support units are funded through the formal budget process or through central reserves established to fund campus-wide projects that benefit the entire population or advance the mission of the university.