THE OHIO STATE UNIVERSITY

OFFICIAL PROCEEDINGS OF THE

SEVENTH MEETING OF THE

WEXNER MEDICAL CENTER BOARD

Columbus, Ohio, October 3, 2014

The Wexner Medical Center Board met on Friday, October 3 at the Ohio Union, 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, October 3, 2014 at 10:16am.

Present: Leslie A. Wexner, Janet B. Reid, Cheryl L. Krueger, Abigail S. Wexner, 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:

I have to apologize. There was a big accident on the freeway. Hopefully no one was injured.

I would like to convene the meeting of the Wexner Medical Center Board and ask Ms. Link to note the attendance.

Ms. Link:

A quorum is present, Mr. Chairman.

Mr. Wexner:

So that we are able to conduct the business of this meeting in an orderly fashion, I would ask that the ringers on all cell phones and other communication devices be turned off at this time, and I would ask that all members of the audience observe rules of decorum proper to conducting the business at hand.

The minutes of the August 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.

I will call on Dr. Gabbe to present the accreditation items that are before the board for approval.

Dr. Gabbe:

Thank you. Good morning. You'll see after the agenda, a background memo that was prepared by Beth Bolyard and Dr. Thomas that reviews the resolutions and Medical Staff Bylaws changes we're considering this morning.

The first is the policy for both University Hospitals and the James Cancer Hospital on the management of patient complaints and grievances. This was approved by the Quality and Professional Affairs Committee of the Wexner Medical Center Board on September 24th. This describes how the responsibilities are delegated to respond to complaints from patients. The University Hospital and James Cancer Hospital processes are very similar with the exception of the composition of the grievance committee for the University Hospital.

The grievance committee is composed of the Chief Medical Officer and the Chief Officer for Quality and Safety as well as the Chief Executive Officer. The James Cancer Hospital grievance committee is composed of their physician-in-chief or designee, the patient experience director, and other members as necessary. This is an important process and the resolution proves it because it does demonstrate how we are dedicated to responding to both oral and written complaints in a timely fashion from our patients. I'd be happy to answer any questions about it. Thank you.

PATIENT COMPLAINT AND GRIEVENCE MANAGEMENT PROCESS

Resolution No. 2015-80

UNIVERSITY HOSPITALS

Synopsis: Approval of the process for managing patient complaints and grievances, 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 Wexner Medical Center provides patient care in a manner that promotes patient satisfaction; and

WHEREAS in order to promote patient satisfaction, the Wexner Medical Center is committed to resolving any patient complaints and grievances that may arise in a timely and effective manner; and

WHEREAS the proposed Patient Complaint and Grievance Management Process for the University Hospitals was approved by the Quality and Professional Affairs Committee of the Wexner Medical Center Board on September 24, 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 process for managing patient complaints and grievances as outlined in the attached policy; and

BE IT FURTHER RESOLVED, That the Wexner Medical Center Board hereby delegates the responsibility of reviewing and resolving grievances to the Health System Grievance Committee which shall be comprised of the Chief Medical Officer for the Wexner Medical Center, the Chief Quality Officer for the Wexner Medical Center, and the Chief Executive Officer/Executive Director of the hospital from where the grievance originates or their respective designee, and such other members as the Committee deems necessary to review and resolve any individual grievance.

(See Appendix VI for background information, page 187)

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PATIENT COMPLAINT AND GRIEVENCE MANAGEMENT PROCESS

Resolution No. 2015-81

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

Synopsis: Approval of the process for managing patient complaints and grievances, 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 Wexner Medical Center provides patient care in a manner that promotes patient satisfaction; and

WHEREAS in order to promote patient satisfaction, the Wexner Medical Center is committed to resolving any patient complaints and grievances that may arise in a timely and effective manner; and

WHEREAS the proposed Patient Complaint and Grievance Management Process for the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute was approved by the Quality and Professional Affairs Committee of the Wexner Medical Center Board on September 24, 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 process for managing patient complaints and grievances for units operating under the Arthur G. James Cancer Hospital and Solove Research Institute (the "James") provider number as outlined in the attached policy; and

BE IT FURTHER RESOLVED, That the Wexner Medical Center Board hereby delegates the responsibility of reviewing and resolving grievances to the James Grievance Committee which shall be comprised of Physician in Chief of the James or respective designee, the Patient Experience Director for the James or respective designee and such other members as the Committee deems necessary to review and resolve patient grievances.

(See Appendix VII for background information, page 192)

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, Mrs. Wexner, Ms. Krueger, and Dr. Reid.

Mr. Wexner:

Thank you. I will call on Geoff and Pete to present the Upper Arlington Ambulatory Care Site Lease.

Mr. Chatas:

Thank you. You may recall we were asked to come back, after answering some questions, to present the terms of the lease. We will then be happy to answer any additional questions as we move forward with the signing of the lease.

Mr. Geier:

(Presentation)

As Geoff mentioned, we were here in June and the Board authorized us to move forward in negotiations of lease. Steve gave an update last time and you have seen many of these slides before. I would like to introduce Dan Like who's our executive director for ambulatory, and is the point person for all of our care point sites.

To give a brief summary, this was part of the most competitive bid process with the City of Arlington, comprises a five-story and 100,000 square foot building on Zollinger Road. Initially, we would build out 80,000 square feet and have the remainder for services down the road that we could add. These are the services that would be contemplated. This is a large multispecialty clinic, like our other care points. We have some space for future growth, we are talking to Dentistry and Optometry about the possibility of taking some of the shelf space.

This is the financial projection that is really based on the openings of our other care points. We will be consolidating a couple of sites into this. We do have a lease on a small site on Knightsbridge. We have a building on Fishinger that is probably worth about $400,000 that we'll move our family medicine practice out of and some heart services out of Morehouse, which would be about 25% of the volume.

This slide shows the history of our ambulatory centers: CarePoint Gahanna, CarePoint Lewis Center, and CarePoint East, which Arlington will be very similar to. You can see their history, their payback, and their performance from a financial standpoint.

We are working on the land development agreement between Continental Real Estate and Upper Arlington for the lease itself. Continental will build the building. We will initially have a term of a 10-year lease, hopefully done by May, 16, 2015. We'll have fixed rent for the first five years. After the second five years, the rent goes up 10%. In year 10, we have some flexibility built-in, we can choose not to renew. We have a purchase option at that time if we want to buy the building. If we choose to renew, we have the option on three, five-year renewals. Within the lease, we would have right of first offer. If they want to sell the building they have to come to us first. If they have an offer in hand, they have to bring us that offer for a right of first refusal. As I mentioned, we have a purchase option on the building subject to

appraisals at the end of year 10. We also have an option not to renew and move the practice somewhere else.

We've got some signage rights on the building, monuments signs, to make sure it is very easily accessible and easy to see and easy to find. We think it's a great site. Dr. Ellison may speak to this, we know our physicians are very excited about this possibility. We are not short of people that want to occupy the building.

Dr. Wadsworth:

What was the comment about 10%? I just missed the context.

Mr. Geier:

The term of the lease lists fixed payments for the first five years of the lease.

It's a maximum of $21 per square foot on the finished portion.

Mr. Like:

It is $16.02 for the weighted average. This is not to exceed $20 for the first five years. If we elect not to pay several premiums, it won't be even $20 per square foot.

Mr. Wexner:

I've been talking with Geoff. I have a whole issue that goes around CapEx in the Medical Center and I am saying that for the benefit of the Board. It may have implications on the other side of the university, but we don't know what the CapEx is. How big is this facility?

Mr. Geier:

100,000 square feet.

Mr. Wexner:

It is a 100,000 square foot facility.

Mr. Geier:

80,000 square feet of it will be built out at the beginning and the remaining shelled.

Mr. Wexner:

Rounding up for government purposes, it's 100,000 square feet. I'm guessing between shell and finish, you are about $100 a square foot of real construction costs. You can calculate the amount. I know that finished office space in the community goes for $15 a square foot and probably wouldn't have 10% kickers. What I am suggesting, and I have been talking to Geoff Chatas earlier in the week, is that you have a multi-million dollar project that's a long-term 10-year lease with an option to buy, where building the building is all CapEx. You can't say that it's an expense because you're making the same commitment. I would bet, that having two or three people bid of the building, that it's about $100 a square foot, understanding where it is. You can always put it out to real estate people to lease back. Right? You can construct a purchase and lease back rather than being the captive of a builder. I just think it's just a bad deal. I didn't know about the deal. Nobody asked, I didn't ask, and nobody told.

I would like to hit the pause button. There are enough competent construction companies and people that have financial ability. I am guessing in net lease cost, we could probably reduce the cost 20%. But it's

CapEx, we're financing a capital expenditure via lease. I can't go back from rent to capitalization. If you know what the amount of rent it, you know what you've capitalized.

Mr. Chatas:

I can certainly tell you the credit impact and credit equivalent of the lease payments which is a proxy for capital.

Mr. Wexner:

If the rent is $20 a square foot and you've got so many feet, you know that the rent is. If I know what the rent is, I can reverse it to know what the CapEx would be.

Mr. Geier:

The cost of land and building is about $23 million to build it.

Mr. Like:

As the management, we do have a probation in lease, it's a not to exceed. If once the bids come in and we elect not to take certain items within the construction, there is a reduction in rent. For every roughly, $100,000 of savings we get an addition 11 cents per square foot. If we have a $1 million savings once that comes, we would get another $1.10 off of the rent, then that would equate to $18.90 a square foot.

Mr. Wexner:

I don't know how to structure whether we can approve it and pause it and give it to a committee of people. If Steve Steinour were here today he could probably figure it out pretty quickly. There's enough people in the community that do commercial construction that can tell us, in a week or so, whether the estimate of the construction costs is right or competitive. Hearing it today does not sound like a good deal, a fair deal. We just have to be good to us.

The additional point I want to make for the trustees is that if we are leasing a facility for 10 years and we have an option to buy, that is capital expenditure. Right? We're financing it by a lease. You could finance it by debt but you're making a $25 million capital expenditure.

I went back and checked and we approved it. My intention isn't to stir up the pot again. I went back and checked the number; we approved a $60 million sports medicine facility, because it was built out without the equipment in it and it was built to be fully equipped with some nominal costs of land. I checked with Gail Marsh, they aggregated $60 million and it doesn't show up in a capital budget. It shows up as cash borrowed from the medical center, cash borrowed from the university, but it's a capital expense. If I take this figure and I tie it to sports medicine, in the last three months, we have $100 million real CapEx, and a CapEx budget that says that our capital expenditures are historically $50 or $60 million. These two items are $100 million. This is just silly accounting and it's a silly way to run this enterprise when we're leasing and making cash expenditures for things that are really capital assets.

I don't know how Children's Hospital does it. I don't know what other people's experiences are but I just think this is silly. It shows up in the aggregate then we'll roll up to the university budget and I bet you don't have a $100 million CapEx item in the university budget, but in fact there is $100 million in these two items, in addition to all other capital. I am really very suspicious of the capital planning, the capital reporting, and if you would, well intended people can work around capital budgets by saying capital isn't capital.

Mr. Wolfe:

Pete, what is the business base for leasing the building? You are only going to be 10-15 minutes away from campus and with 100,000 square feet and $2 plus million a year. Honestly, I've heard a lot about the economics but no one has told this Board what the business case for building it is.

Mr. Geier:

When we went back, and I don't have the slide in here, we looked at our layout and ambulatory plan for where we draw from and where we don't draw from. That was done three or four years ago, or longer than that. We started looking at places, from an ambulatory standpoint and footprint, where we wanted to be and to track those households. That led to Gahanna, Lewis Center, which is in Delaware and a fast-growing area, and CarePoint East.

As I mentioned here, we're moving some practices in there to consolidate. I think even the bulk of the admissions that come from the Arlington zip code go to the other hospitals in town. I think we only get 25-30% of the admissions with the Arlington zip code. We are not attracting out of the Arlington zip code like others are because we do not have a presence there.

I agree with this discussion on lease versus buy and some of those reasons. The deal is set up that way because Continental has the development agreement. Since we can't borrow anymore, we are funding some of our capital out of cash flow. We are funding longer term assets just out of operating cash, we've done it a couple of times. That's really to work around this issue. There is no long-term capital left, right, we can't borrow?

Mr. Chatas:

I want to be clear, this was done because it was presented this way from Upper Arlington. If you want this site, you must do this structure.

Mr. Geier:

Yes, this was a competitive bid that we put a bid on and this is the way it was presented since the land was owned, it would be a lease. This is the way this deal was structured from the beginning.

President Drake:

I just wanted to comment on Mr. Wolfe's question. Even if we are a mile away or a half-mile away, in the ambulatory care market and patient preference, being across the bridge or out of the traffic flow or away from central campus is appealing; to be able to pop in, get your ambulatory care and get back home. The idea of distributing, even by a half a mile or a mile, means that people who are a peripheral area can say, gosh I don't have to go into the traffic and everything else that is so close to central campus. As a general principle, this would be an outreach pod for us that should be a good referral source. That would be the overarching reason to think about something here.

Dr. Reid:

It would certainly be better than one of our competitors getting it.

Mr. Chairman, what I am hearing is, it's not a pause on whether we should be in Upper Arlington, it's a pause on how we will be in Upper Arlington with regard to purchasing or leasing, if I am hearing you correctly.

Mr. Wexner:

What John Wolfe raised was the question of the strategy and I am comfortable with that. We need significant, appropriate, community care ambulatory facilities around the region because that's what communities want and that provides the feeder system. The strategic part makes sense to me and I thought we had talked about that but it could have been as the committee or the whole or maybe it was a discussion with Steve or a smaller group. That part I am comfortable with but John has to be comfortable with his objection.

I think we should go ahead because it fits our strategy. My strong position is financing capital assets out or cash or leases or capital commitments. I understand you can finance capital commitments in different ways: with debt, lease, and cash. Nevertheless, they are a capital commitment. We can't make judgments about capital allocations without looking back to understand how much capital we've been committing. If I look at the capital budgets, they are off by half of what's really happening. If I'm right, that means that we may have been spending $100 or $120 million a year in capital that never showed up in the capital budget. Then when you do the catch-up, and you look forward, you have a very different point of view.

What tweaked me on this was at our last board meeting. You have a hospitals like Doan Hall and Rhodes Hall that were built after World War II, and the notion that we can rehabilitate them and that's more effective financially than tearing them down because of low ceiling, plumbing, and air conditioning. Then I find out that the way the operating rooms were constructed, you can't even put modern equipment in them. They're not built of the size to have those things. Now you have all the issues that go around operating inefficiencies. I'll bet that it is economically a breakeven to build a new hospital because I can see ahead in a building that is that old.

Now part of the discussion was rehabilitating hospital space and what goes out of service. You have a multilevel hospital, these old buildings, and I bet that it is full of asbestos and other things. Once you open up the building, you are going to treat patients in a 50-year old building and remodel it and you're going to lose the service of those rooms, the income, and the continuity with patients. I am saying this doesn't make sense operationally. I just put it together with the discussion about our capital budget and I don't think we know the answer, but I'll bet its damn close or it could even be to our advantage.

Jerry Jurgensen raised an issue about master planning and how we didn't plan ahead. I spoke with Keith Myers and he sent me the master facilities plan that was done for the medical center four years ago. We had outside architects look at the ages of buildings and identify possible places for new buildings. The business judgment of the outsiders was that these buildings weren't salvageable. You could put the buildings in a different order and have a more efficient hospital. You have operating efficiencies, utilities, labor, and I think in the capital budget that is proposed later today, or maybe it's on hold, there was $20 or $30 million, Geoff, going into capital for those old buildings, elevators, and other maintenance.

Mr. Chatas:

Yes that's correct although on hold is also correct.

Mr. Wexner:

What I was worried about is if it all connects because it's all capital. You know, I just want to understand the details of the capital structure. I am not challenging, going forward in Arlington but there are a lot of ways to skin the cat, if in fact we are committing to $100 to $120 million and we're calling chicken fishes and you know apples oranges it's like let's just be realistic about it.

Mr. Chatas:

The number of filters you've talked about, the strategic filter, we've had those discussions, and believe it fits the strategy. The question, Les, is how you pay for it. Our filter is how does it impact the university's credit and what sources do we use? We ran it through a filter which says this is credit positive because it

has positive margin in year one. It meets the university test that we can do the lease. It doesn't answer your fundamental question though, which is how it fits in with a broader long-term capital plan. I think that is the discussion we have to have. The only question I don't know, Pete, is can we pause this for a month, do we have any risks with the City of Upper Arlington, can we can put it in the context of our broader capital discussion next month.

Mr. Geier:

Dan can probably answer that. I think there is some risk but I think we can probably manage it, if we're going to have it. I think this is a great discussion on the long-term because we struggled with it ourselves as a management team, simply because we're managing our capital out of operating cash flow because we don't have any long term debt.

Dr. Wadsworth:

We have made the decision to tear down all our buildings that are old because it's just not efficient to fix them. You'll see a lot of deconstruction happening across King Avenue. We'd rather contemplate a new build.

Mr. Wexner:

To be clear, fully intended to go forward that no post-haste, just hitting the pause button. I could get a pretty good answer to you in a couple of weeks. There are enough contractors in review to understand, maybe alternatives, to financing and to understand what the real costs are, what a return could be. I understand that someone controls the land and we're obligated to Upper Arlington but I think by just pausing two weeks we could potentially save millions of dollars. It wouldn't be a fool's ear. Do we need to vote on this or? Is there just a consensus on how we are preceding?

Mr. Chatas:

You all insisted it goes through this body and then to the Board of Trustees Finance Committee for final approval. We do not have another Board meeting until November anyhow.

Mr. Wexner:

I think for the short period of time that Geoff has been doing this job, the university should be very clear in instructions about CapEx and cash financing. I think this is not an isolated thing. I think there is some contagion here that might go across other facilities because if your capital constraint is such an obvious thing to do.

Mr. Chatas:

I will be clear though that in the last five years we put a pretty much absolute moratorium on leasing because of this. Before five years ago, we were using leasing as a substitute for avoiding capital discussions. This was done because of the unique situation in Arlington. Again if you look, most colleges were going out and saying "I can't, I don't have the capital, I can't have any debt allocation, I'll just sign a lease," and we would find out afterwards. One of the first things we did is stop that. I will assure you this is not a common occurrence anymore. Again, as I said, we were very upfront about why we're talking about a lease.

Mr. Wexner:

If I were looking at the 2014-2015 budget of the university's CapEx, this $25 million project and the $60 million sports medicine project would have showed up in the capital budget?

Mr. Chatas:

No, not in that sense. If you mean, one capital budget for the university, it wouldn't. What I am saying is there aren't a proliferation of leases out there.

Mr. Wexner:

Good. I just whispered over to Jeff, it's like your capital budget is off $100 million in these two items, the way I think about it. I'm an equally critical chairman.

Dr. Wadsworth:

Geoff, we'll figure out how to deal with it on the finance side of the committee and get a holistic look at capital.

Dr. Thompson:

We're all clear. We can review and approve at the November Board meeting.

Dr. Gabbe:

Ok, we have some amendments to approve to the *Bylaws and Rules and Regulations of the Medical Staff* for both University Hospitals and the James Cancer Hospital. If you look at the background memo, you'll see that there are some editorial changes but the primary change has to do with a change in state law that now allows physician extenders, whether they're nurse practitioners, physician's assistants, clinical nurse specialists, or nurse midwives, to enter admission orders for patients who will be admitted to the hospital. In the past, only physicians, dentists, and podiatrists could do that. These physician extenders can write an admission order but the patient will be admitted under the name of the physician or podiatrist who is supervising them and they have to notify that collaborating or supervising physician or podiatrist that there's a planned admission before the patient is admitted. Both the James Cancer Hospital and University Hospitals are changing this.

If you look under tab D, you'll see the amendments for the University Hospital and you'll note that this has been approved by the joint University Hospital and James Cancer Hospital Bylaws Committee, by the Medical Staff of the University Hospital and the James Cancer Hospital, and was approved by the Quality and Professional Affairs Committee of the Wexner Medical Center Board.

In the University Hospitals, there are a few editorial changes. For example, chart is changed to medical record and chief medical director to chief medical officer. Similarly in the James Cancer Hospital, their professional affairs committee has been changed to be the Quality and Professional Affairs Committee. The key change is the ability of physician extenders to write admitting orders under the supervision of the physician or podiatrist that is overseeing them.

AMENDMENTS TO THE *BYLAWS AND RULES AND REGULATIONS OF THE MEDICAL STAFF* OF UNIVERSITY HOSPITALS

Resolution No. 2015-82

Synopsis: Approval of the following amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals, is proposed.

WHEREAS the proposed amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals were approved by a joint University Hospitals and James Bylaws Committee on July 9, 2014; and

WHEREAS the proposed amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals were approved by the University Hospitals Medical Staff Administrative Committee on August 13, 2014; and

WHEREAS the proposed amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals were approved by the University Hospitals Medical Staff on August 14, 2014; and

WHEREAS the proposed amendments to the *Bylaws and the Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals were approved by the Quality and Professional Affairs Committee of the Wexner Medical Center Board on September 24, 2014:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves and proposes that the attached *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals be recommended to the University Board of Trustees for approval.

(See Appendix VIII for background information, page 198)

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AMENDMENTS TO THE *BYLAWS AND RULES AND REGULATIONS OF THE MEDICAL STAFF* OF THE ARTHUR G. JAMES CANCER HOSPITAL AND RICHARD J. SOLOVE RESEARCH INSTITUTE

Resolution No. 2015-83

Synopsis: Approval of the following amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, is proposed.

WHEREAS the proposed amendments to the *Bylaws and the Rules and Regulations of the Medical Staff* of The James Cancer Hospital were approved by a joint University Hospitals and James Bylaws Committee on July 9, 2014; and

WHEREAS the proposed amendments to the *Bylaws and the Rules and Regulations of the Medical Staff* of The James Cancer Hospital were approved by the James Medical Staff Administrative Committee on August 8, 2014; and

WHEREAS the proposed amendments to the *Bylaws and the Rules and Regulations of the Medical Staff* of The James Cancer Hospital were approved by the James Medical Staff on August 14, 2014; and

WHEREAS the proposed amendments to the *Bylaws and the Rules and Regulations of the Medical Staff* of The James Cancer Hospital were approved by the Quality and Professional Affairs Committee of the Wexner Medical Center Board on September 24, 2014:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves and proposes that the attached *Bylaws and Rules and Regulations of the Medical Staff* of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute be recommended to the University Board of Trustees for approval.

(See Appendix IX for background information, page 200)

Mr. Wexner:

May I have a motion to recommend the resolutions to the University Board for approval?

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

Mr. Geier:

This is the financial report for the first two months of the year through the end of August. We've not closed the books on September, although I've had a look at the volume numbers from September and they are strong across the board in the hospitals in terms of admissions and surgeries. I anticipate that when I am back here for our report for our full first quarter, it will mirror these trends and probably the same colors of the arrows.

Just going down the volume indicators on admissions, we were yellow last month, August was very strong. We were about 3.3% over last year on the same month and about 2% over budget. When I look at the occupancies of the hospitals they're all around 85%-90%. We are very full and having issues around access but the group is doing a good job.

Couple of things regarding the individual hospitals. At Harding, we're off about 50 admissions and you might say well that is relatively small but it does have an impact. One of the things that has happened with Medicaid expansion, a lot of people who needed psychiatric care and couldn't get it, are now seeking it so the length of stay in the hospital has gone from about 6.5 days to 7.5 days just because of the acuity of the people that we're seeing. The hospital is full but we're not turning them just because of the severity of the patients that are coming in.

In the Ross, we're still are seeing this shift around, and it's a nationwide trend with procedures particularly with devices on inpatient and those coded as outpatient and that's why we show the patients in beds, including observation of our total volume. For the year, the budget is to have increased admissions, next year when the facility opens, the new budget opens, and we see that ramp up, although we are down slightly year over year, but I think in September from what I can see, we'll have a strong month in admissions.

Surgical volume, combination of inpatient and outpatient, we run about 60% outpatient and 40% inpatient. On the inpatient side, only the Ross is above budget, the others are slightly below but not a lot. We had budgeted being down from the last year. Remember, we lost some surgeons but have recruited and will be back up going into the new year. For the full year, we have budgeted surgeries increasing. As I said, some of that is built into the second half of the year. On the outpatient side all the hospitals are above budget. When we add the inpatient and outpatient surgeries together, we're above budget.

From a service line standpoint, Dr. Ellison can probably comment on how busy the surgeons have been, particularly this last month, but ophthalmology, neurosurgery, and urology are really kind of leading the way on volume; ENT and orthopedics are under.

From an outpatient standpoint, we are still continuing to grow our ambulatory sites, across all the sites. We've added 10 primary care physicians which is part of a strategy of growing our primary care. We are up 10 and they are out in our ambulatory sites as we continue to grow outpatient and particularly primary care as we're moving more and more to population health.

Operating revenue per adjusted admission. We're a little concerned about that. We're digging into it. We're off budget slightly, our case mix dropped a little bit last month. One of the things that happened in our payer mix, the prison contract, moved all to Medicaid. We used to have a little better payer rate on that and that has moved. We think that has impacted a bit. We don't know whether it's a continuing trend, I think we'll have a better idea when we close up the first quarter.

From a revenue standpoint, when you drop down you can see we're slightly above budget, that's really a combination of being over budget on surgeries and outpatient visits and we're up 2.4%. Expenses, were basically flat over last year and in the month of August, our salary expense was actually under budget

compared to August of last year of about 3%. That's really a combination of initiatives that I think we have talked about with the Board, in terms of managing our overall expenses.

There are three or four things going on with respect to salary expense. One is just a much more, I think, aggressive and proactive effort at looking at the span of control in the organization, the depth of management, scrutinizing new staff hires that are coming on, and looking at consolidating staffing. The second is within all of the hospitals and it's something we're ramping up to over a 12-18 month period, managing our staffing models for particularly nursing and at the point of care. We think those are all having an impact in the number. We are actually 200 FTEs lower than we were a year ago. I would expect the expense trend to continue under budget as we continue to implement these things.

On the non-labor side, from a supply, we've talked here. We are in the middle of what we call rapid repricing. We are going through every one of our suppliers and services and asking for, and in many cases now receiving, immediate 15% reduction in what we're paying. We are having quite a bit of success with that and moving all the payment terms to net 45. We think that'll help pick up on our days cash by a few days. We are probably a third of the way, or half way into that whole initiative. Supply costs are actually lower than they were for the same period last year on higher volume. Drugs are up a little bit, about 1.5%-2%. As I said, I would expect the expense story to continue to be the same for the rest of the year.

When we add all that up, you can see our gain from operations is about $50 million, up $18.3 million. All the units are at or above budget, translates to our EBIDA to 17.6, our days cash is a little over 75 days, up from 67 a year ago, and debt service coverage number will start to come down as the final debt comes on the books a little bit later this year when we take possession of the hospital.

I would be happy to answer any questions and I know Geoff you wanted to mention the recent rating agency reports as part of the financial report.

Mr. Chatas:

Yes, we did issue $300 million of debt last week that will price somewhere in the 3.6% range. That is a bit below what we hoped, the demand was quite high. Part of it was that the rating agencies did comment fairly favorably and gave us a stable rating, which is fairly rare among academic medical centers. Not cause for huge celebration, but we're pleased we got out into the market and were able to take advantage of the rating to keep the capital costs as low as possible.

Mrs. Wexner:

Just to be clear, that is a university borrowing.

Mr. Chatas:

It's a university borrowing which we then lend to the hospital, correct. The agencies put a heavy factor on the medical center.

Mr. Wexner:

I'm curious about getting to what I think our industry standard normal terms are and what that would look like. Again, we're partially through it. Is it three days or four days or five days of cash looking forward?

Mr. Geier:

We think getting to a net 45 will add four to five days to days cash on hand, once we're completely through the supplier and services base.

Mr. Wexner:

If we added that to the projection for memory that would be equal to about a year's increment of profit? Typically we were adding three or four days a year.

Mr. Geier:

Yes. A day of cash is about $5 million, moving to $6 million because of the new building, but one day of cash calculation is $5-$6 million in cash alone.

Mr. Wexner:

Almost a year. That's a big deal.

Mr. Geier:

Our target has always been 3 days a year. Last year we were able to grow 5. Yes that is historically been the target of growth, three days a year.

Mrs. Wexner:

Your projection for this year might be what? In terms of both?

Mr. Geier:

I haven't re-projected yet. We are right at the front end of change and all the payment terms with the suppliers are actually launching it, next week. By next board meeting, I will probably have a better sense of how long it will take and the impact on the cash.

Mrs. Wexner:

But this is incremental.

Mr. Geier:

This would have been incremental to what was in the budget, yes.

Mr. Wexner:

Isn't that a simple calculation? You know what your payables are, if you had so many days, if you had annualized it when complete, it would be X days.

Mr. Chapman:

Yes, five days.

Mr. Wexner:

Five.

Mr. Chapman:

Yes, that's the calculation.

Dr. Reid:

It's huge.

Mr. Chapman:

The other thing we're doing is, in the spirit of LEAN, we told suppliers net 45 on supplies, net 60 on services. When I was at McKinsey, you get to pay me in 60 days and automatic clearing house (ACH). Everything will be ACH, we do not want paper. Any supplier we sign up will be embracing a medical center driven LEAN approach. There are a lot of small suppliers who can't do that. We're willing to accept that from the small local vendors.

We met with Johnson & Johnson earlier this week, they didn't even blink at net 45 ACH. They have nine separate divisions, each of which are $5 billion companies. It will take us some time to filter through that but once we have that configured, we could change to net 50 in a matter of a key stroke. That is what we're trying to do is eliminate paper, eliminate waste, and really work with suppliers the way in which a $2.5 billion entity ought to be.

Mr. Wexner:

Is it possible, in your experience or perhaps Dr. Drake, in these contracts to rather than having made the progress we had to go to most favorite nation?

Mr. Chapman:

In my experience, both on the McKinsey side, the President of Steris, and I get a lot of requests about most favored nations. The issue is how to actually even gather the information to determine whether you are most favored or not. Hospital Corporation of America (HCA) used to have a policy which was if we find a buy another hospital that has a price lower than ours, we will excuse that supplier from the HCA network. Kimberly Clark, you know, basically, wasn't selling too many diapers to HCA because they found one of the hospitals that they acquired had a lower price. I'd like to be able to say if we went to favored nations, we'd be able to convince anyone around this table that we are getting the favored nation pricing.

I have to tell you that it is really difficult to benchmark in that basis. We want to be priced at the most favorable term, there's a group purchasing organization (GPO) out there, we tell them what we want, and we hopefully will be getting that price. Whether I can tell you that we can benchmark that price or not, I will tell you, very difficult to do. If we have another way, we can ask for it. I'd never be able to prove to you that we got it unless we go acquire a hospital at a lower price than we do. I don't know if that was clear but that's basically what I'm saying.

Dr. Reid:

I just have a question about additional cost savings. For consulting contracts, back in the day, there was an upfront payment by the client to the consultant, and then an on-going thing. The billing process itself, they have to have completed the work and then they can bill and then itis 45 days out?

Mr. Chapman:

I can't tell you about how every professional services agreement, lawyers, consultants, and accountants are concerned. I do know at least when I was a consultant at McKinsey, we said net 60 upon receipt of invoice. There are no upfront fees, at least I don't think you have any upfront fees. I think we're away from that. It would be a net 60 upon the receipt of invoice.

Now there are some contracts which are upon completion of work, no payment, and then one big bullet payment.

Dr. Reid:

Or that you can submit the invoice for work that's completed.

Mr. Chapman:

Correct.

Dr. Reid:

It is the same kind of thing and you said that. I know that it saves tons of money as well. Especially some of the bigger consulting contracts that we had.

Mr. Chapman:

Yes, particularly on the IT side.

Dr. Reid:

Yes. Absolutely.

Mr. Wexner:

I understand the difficulty. If you have a simple arbitrage between the absolute cost of the service or the item you're buying, and the payment terms, you could have a lower price and I could pay for it in a year and my judgment would be that I'd rather have the year to pay because of the cost value of money. Having said that, just on a things-to-do list, I was whispering to Dr. Drake, whether we got together with the big teaching and research hospitals in the country, where we could exchange information. You pick up a day of cash or a few million dollars here or there, it would seem, whether you hired a consultant or you put an accountant, or someone just made the rounds now and then, just to get a sense of the market. We buy things in business and we try to say it's the most favored nation and then we have to find out if, in fact, they've been honest. I understand the problem.

Mr. Geier:

We are part of the University Health System Consortium (UHC) which is the trade group of the 125 academic medical centers. We are very active members of that. One of the keys is that UHC is also a GPO by a company called Novation. We're a member of Novation. We renegotiated our contract with our GPO to get better pricing. We do have access to benchmarking data through the GPO with others that we use. We are in some joint contracts for leveraging. A lot of it is buying the drugs through the GPO. We do have access to that to compare. We don't use the GPO exclusively, we have the option to go outside of that for the contracts.

Mr. Chapman:

To build on what Pete said. We look at those benchmarks on particularly supplies: a stent or an implantable. I would said two things. First, even the Cleveland Clinic concluded that they were incapable of actually achieving best prices and they aligned with Community Health System (CHS), a $40 billion system who contracts direct. They concluded that for a lot of these services and supplies that they are not a market maker, they'll lean on CHS. When it comes to the areas where they do make a market, like a lot of the cardiovascular rhythm management items, they go directly to the manufacturer. It is a really powerful buyer's market right now for health systems vis-à-vis the supplies. That is the first point I wanted to make.

The second point I wanted to make is that the medical center is over paying for virtually everything that it buys. When you sit down with suppliers and they're immediately granting you a 10% or 15% reduction in

price that should lead you to the following conclusion, which is there's more in there than hills. I say that not to be cavalier. We have $750 million of costs. You will hear, if we have a chance this afternoon, we already have $15 million in savings, cash on the barrel. Pete is probably spending half his time with these suppliers, sharing with them what we are trying to do. Dr. Ellison has been very helpful in having the physician community support the process but we're overpaying and that game is over.

Mr. Wexner:

Just to be clear. The question I was going to ask is, how much stuff do we buy? You're saying it's about $750 million?

Mr. Chapman:

$750 million. These will not be precise but they will be accurate: about $200 million of medical supplies, about $250 million of pharmaceutical and pharmaceutical related, and my overall favorite, about $250 million of stuff, meaning services, administrative, supplies, and so on.

The cost structure of most health systems is typically 35%-$40% as non-labor costs and that has, historically, been growing at 3%-5% largely because of the pharmaceutical situation. Our aspiration in this fiscal year, is to take $40 million out of our costs and we have $15 million as of yesterday.

Mr. Geier:

Target is 40 in the days cash on hand pickup. That's kind of the working target that we're trying to get to this year.

Mr. Wexner:

My guess, of the $750 million, if you're inefficient, there's probably about $150 million of savings, about 20%. Some of it is usage, some of it is in the buy, some of it is in inventory, some of it is in terms, but it is a very big number. If I'm right that it's 20%, the way I think about it, if its $150 million then over the next five years, you're saving somewhere between $750 million and $1 billion. This is a big deal. I can't do heart surgery or transplants and I can't even understand what the hell goes on but I can understand buying stuff and being efficient in how they're using it. I can understand the magnitude of $750 million that is just getting leaked away.

Mr. Geier:

This is actually where the physicians have been tremendous in this process. We are actually, I won't say scratching the surface, but are really digging hard into this issue or utilization. We have kind of been blunt force on the price and now getting into utilization and more on distribution, I think has more potential.

Mr. Wexner:

If I am right, it's about the magnitude of 20%.

Mr. Chapman:

I am not going to shy away from the number of 20%. What I will say is the results thus far, we'll share it with you, is that we've exceeded 20% on many of the categories that we're talking about.

Now we start getting into a couple things. First, drugs, which is again, we introduce new pharmaceuticals and as Michael knows in talking to George Barrett, there has been a discontinuity in the pharmaceutical business in terms of what is referred to as specialty drugs at which we buy quite a few and it is largely in Dr. Caliguiri's area. Genentech woke up and said we'd like to transfer 5% of the total costs of these drugs universally from our savings from distributors and medical centers to their shareholders. We are looking

at about a $4 million increase and we've done nothing to deserve it. It's just a transfer of economics. I don't say 20% is not possible, Les, but when I have $145 million in drugs and $45 million of them just lost 5%, they're 5% more expensive. I know you shake your head but that's reality.

Mr. Wexner:

I am shaking my head because there are puts and takes. What I'm saying is that just to think about, the Board can think about it, if we said there's $150 million of savings, then what resource are we putting on it to go after the $150 million and score it? If you wanted to say 22% or 25%, I'd be open to increase the bid. I think in terms of aligning people around a subject, we're trying to save $150 million through the operators, what do you know and this is why we're meeting which is different than donate another slice of toast or something.

Mr. Chapman:

Les, we are meeting with every department manager and every physician, and there is simply no ambiguity about what we're trying to accomplish.

We need to be clear that 10% of that cost is costs from the university that are transferred over, facilities cost in particular, about $75 million, of the $750 million is facilities related costs and many of those things are outside of the medical center's hands. We spend quite a bit of money on marketing and advertising, about $20 million. We just negotiated with Sachi and Sachi and have about $500,000 save.

My question is, why we are working with Sachi and Sachi? Brilliant firm but those are the sorts of design choices that we have. I can get you a better price and that's what we're focused on because you know, get the money now. But next year there's going to be questions about should we be using Después synthase or should we be using Zimmer or should we be using Stryker. That's where we need Dr. Glassman, that's where we need Dr. Ryan, Dr. Abraham, to be a part of that process. We are going after the fast cash price, next year we'll be focusing on the utilization, unless I don't think it's a bad aspiration to say 20%.

Dr. Wadsworth:

Yes, in my experience with companies I've been involved in and also some of the federal ones, 20% is an interesting number that keeps coming up if you have an inefficient bureaucracy that's built up, inevitably, over time. What we have discovered is the first 10% is easy. The next 5% is doable. The next 5% gets really hard and you have to get into really challenging fixed cost assumptions. That general theme of the scale of savings seems to recur.

Mr. Chatas:

I want to remind you, when you broaden the lens, we're talking about purchasing but when you look at the studies we've done on the savings potential when you include the people to 20% of $2 billion is $400 million which is kind of been a discussion for a year. It is fazed in, obviously, you don't achieve it all in one year.

Mr. Wexner:

If I said that whatever that number is, $200 million, $400 million, and I'd say we can get there in ten years, it's one thing to say if it's $400 million, what resource are we putting on it to get it in one year if it's possible, or six months? This is what I call a platinum chip, it's not even a blue chip and it pays forward. I agree with Jeff, when you have that kind of inefficiency, that we're finding, you're finding, that goes across the organization, very few organizations are efficient and effective and agile in one area. Generally it's the malaise or whatever it is, the attitude about effectiveness and efficiency goes across. I am guessing there's parallels in labor costs and other costs and scrutinizing university charges in marketing. That's a wow. My eyes are really strained.

Mr. Chapman:

What I'd say is that we've asked ever shared service department, administrative or clinical, every department chair, and every hospital to look at their non-labored good and services purchased. We want 15% out within the end of the fiscal year. Will we get 15% out? No. Will we get 10% or 8%? Probably. Then we'll move into the next year and the next year.

The other big non-labor cost that we could talk about is the cost of our benefits, which is a non-labor cost. I think I mentioned to the Board in June that it is about a $70 million difference between the medical center and Ohio Health or Nationwide. It is a non-labor cost in the sense that I'm paying health benefits and tuition reimbursement and all those sorts of wonderful things. At the end of the day, if you're really trying to set a game relative to the market, and insurance companies don't care that we're a state organization and don't care that we're private or for profit or academic medical center, they just about their insurance rates and their medical management costs. Out of the blocks, we're paying about for every $50,000 employee, we pay about $65,000 for that employee, the high thirties per dollar of salary, 33%. A good medical center, for profit medical center, and I'm not trying to be a for profit entity, is probably paying in the lower twenties.

If you remember back in the late 1980's when General Motors (GM) used to have a little sticker on their cars, how much do we pay more for retirement benefits and union bubble bonding? They were comparing themselves to Toyota. It reminded me when I was at GM, it's kind of analogous here, we're paying for a lab tech, you know eight, ten, twelve points more than what David Blom, or even the Nationwide Children's people are paying. That's another non-labor cost that is in our PNL, $70 million.

Mr. Wexner:

When we look at, what we would call operating profit on our revenue, isn't it about 5% or 6%?

Mr. Geier:

It varies by household, it's about 6% or 7% and then the EBIDA obviously is a different calculation but near 6-7%.

Dr. Wadsworth:

It is really important to look at the complete package on benefits, We have made major reductions in pension plans and redesigned 401Ks.

Mr. Chatas:

The big issue we have is 14% of the first 250,000 we have to pay to the State of Ohio to the pension plan.

Dr. Wadsworth:

Now you have a legislative issue that's governing it.

Mr. Chatas:

Correct, a structural one. The second piece is our health insurance costs. Those two are the bulk of the machine.

Dr. Reid:

How much do you pay people's health premiums?

Mr. Chatas:

80? It's the high 70s, something like that. Yes, we're on the more generous end of the peer group. Now we're making moves.

Dr. Reid:

Nobody does that.

Mr. Chapman:

I just want to comment to Jeff Wadsworth's point. I absolutely agree with your point of view. When I was at Steris and we were looking at this issue, it's almost like a lightning rod. We got to look at medical costs, we got to look at, what about vision, dental, tuition reimbursement, parking, and retirement benefits? If you have a bimodal distribution of population, people who are under 30, look at that benefits package a little bit differently than if you're, like me, an AARP (American Association of Retired Persons) special and I would look at that and say, how are we thinking about it relative to our population? There are opportunities to move something$ s perhaps perceived down which aren't very highly valued and move something up in terms of cost that are really highly valued but my total package is a little more efficacious and valued than otherwise might be the case. I say that because in the total benefits package of an institution, not just Ohio State, this is years ago when I was at McKinsey, no one can answer your question about total costs. When you look at it strategically, not too similar Les what you're saying about our non-labor costs, very incisive thinking will allow us to have choices that we didn't even know existed. Then we can make some decisions that are almost invisible to employees.

Mr. Geier:

I just want to clarify my comment on the operating margin. With an operating revenue of $364 million, about a $50 million. The operating margin for those two months is about 13%. It has historically been 6%-7% so at least for those two months it's improved on this calculation.

Mr. Chapman:

I wanted to answer your question. I talked to Pete about this, if we felt like we aren't putting enough energy against the purchasing efforts, we're ready to roll to add resources. Now what's interesting about that is the people who are really managing a lot of these are the department chairs, the ones who are interfacing with the suppliers, given that they have an objective this year to reduce. Now we've essentially extended the purchasing organization to include scores and scores of people who are involved in the choices that we have. I will share with you examples this afternoon. I'm pretty bullish on the purchasing side and the reason that was so important is who we keep, not dissimilar to any institution. We do focus a lot on labor and nursing metrics and physician productivity and they're looking over there and they're looking at elements of purchased services and say, how serious are we if we haven't taken on the backs of suppliers. We are very clearly taking it on the backs of suppliers and now the environment is such that people are very much along the way, if we need more help, we'll get more help.

President Drake:

Just to a word about that, I mean, these are complicated issues or very complicated, actually. But they have to be sequenced. I think that we are starting in the right place to really do the things we can do with purchasing agreements, things that we're buying, and making sure we're getting the best price as we then roll forward to change the culture around productivity and accountability but I think we have to do the first before we can do the second if people are acting in the way we wish them to. I think we're making good progress. I appreciate that.

Mr. Wexner:

You could increase the revenue of the hospital $1 billion, 5%, I realize that's greater than that, and it would be $50 million or you could say its 15% and you'd increase it $1 billion and you'd generate $150 million and that would be a pretty bold number. I just want to be sure that you don't feel starved for resource, whether its consultants, advisors, whatever, that we're organized to size the prize and maybe think about how fast the bold goal, put a timeline to get there so that we're helping you, because I think if you set up that timeline and the objective and we're on it, that's a significant contribution that if you would, civilians can make. I also think that efficient execution is strategic. Sometimes people think about strategy as just what they're going to do and I think how you're going to do it is a strategic piece and I think what we're, and again, I'm not writing the strategy of the Medical Center, but I'd really like to say one of our strategic objectives is to be effective and efficient. If you're right and you can save $150 million, that's half a billion in five years, four years, three years, I mean, that allows a whole bunch of things to happen.

Mr. Geier:

I think we will be just operationally. We had a retirement of our head of supply chain earlier in the year. We don't have a permanent leader. We have just started. I think there will be a time where we've got to have a new permanent head, probably more experienced and better qualified than we've had. Filling that position so we can sustain this over the next couple of years. We are in the process of posting that, searching for that person, we're in interim leadership right now getting it done but we'll need a permanent leader. We have called on, and the rest of the people in the Medical Center, we've actually called on other resources in hiring so I think we're pretty good with our resources now, but the permanent long term leader of the supply chain is a position that we're just beginning to look for.

Dr. Reid:

I have a question. We have talked about a lot of great things that you know are being done now, cost-savings everywhere, I'm speaking from being an old consultant here, getting a culture of cost savings, you know, is really important, meaning down to the weeds. Sometimes, the janitorial staff sees all kinds of inefficiencies but nobody asks them, you know, what those are. Jeff said, you know, getting down to that last 5%, sometimes part of that 5% if not all, the wisdom about how to get there is residing in the people who are actually doing the work. Knowing that the department heads have been spoken to and the division heads, I'm wondering if there's not some, because people can execute individually on things, I wonder if there's not some HR-driven, corporate culture of efficiency type of thing that can get rolled up. Where I've seen it done best is when individuals actually come up with a good idea and it had not been thought about before and it gets executed, they get $250 or something. You know, these are small things but it gets people, it gets all of us into thinking about those things.

Mr. Chapman:

Janet, I agree and one way we're beginning to build the conscious of awareness is putting it in terms that people can internalize and understand. For example, we spend $10 per adjusted admission on color printing.

Mrs. Wexner:

We spend $10 on what?

Mr. Chapman:

For adjusted admission on color printing. One way we could say that is that spend $1 million on color printing. The other way we can say that is that we spend $10 per adjusted admission. Everybody looks at costs per adjusted admission and they can internalize that. What we're trying to do is build the conscience around, cost per adjusted admission, and Pete didn't talk about it, but up there we've got a $17,200 cost per adjusted admission number. We're looking at a $900 per adjusted admission objective

in this fiscal year. $340 of that will come out of purchasing and $660 will come out of labor. We're focused on those. Your broader point though is as we get those savings, how do I ensure that they don't creep back in and I absolutely agree and we've also kicked around the notion of an idea, kind of, good idea award system, which the Medical Center has done in the past. But it really boils down to, you get what you measure and so we're measuring these costs per adjusted admission and sharing those data with department chairs so they know what they're contributing to that number.

Dr. Gabbe:

Those changes we've communicated across the Medical Center on some of these initiatives, especially as Tim pointed out, the color printing. There was actually a story in *Business First*, when Carrie Ghose came to the New James with us, I mentioned this and she wrote a story about that. I've done blogs on this and Beth (Necamp) has developed a communications plan that's being rolled out. The key issue, as you've emphasized, is cascading this down to the people that are doing the work on the ground. And that's where those savings will come from.

Dr. Funai:

I've actually been doing that for the last four or five months and that management engineering team is going at the unit level with staff and leaders of individual units and were calling them "what if" walks. We are bringing in leadership from diverse areas to take a look at an area that they don't have responsibility for with a new pair of eyes.

Dr. Reid:

Ah, so that they can see it differently.

Dr. Funai:

We generated about 400 different suggestions for change so far.

Dr. Reid:

You know, it sounds good. I would just suggest, you know, I think the verbiage around things like colored printing and how that translates, that makes a lot of sense. That's telling the people, look here are the cost savings that can be had. What I'm suggesting is the people telling us, here's some cost savings that you might not have thought of and you wouldn't even have known, except for that I am doing it.

Mr. Chapman:

When we meet with the department chairs, nutrition services, or clinical engineering, by the end of the year, Pete and I will be meeting with them to say, how are you going to accomplish your 15% cost reduction. Any of them comes back and says we're going to get it on price, we're going to be like really? I mean show us how. But they're going to come back, I'm sure of this, they're going to come back with opportunities to reduce demand, they're going to come back with opportunities to substitute different types of items that are either clinically or non-clinically equivalent, depending on the type of item. They own their costs, so therefore they have to tell us, Janet, this is your point, they own the costs, they have to tell us how they can reduce those costs and it's a cultural issue and it takes time but I want to build on what Dr. Drake said, we're chronically overpaying for virtually everything that we buy today so we just want to get the big buy price this year and move towards the little more complicated, what is called the value analysis utilization management type topics. I'm very confident that the non-labored pieces rocketed to the front of the class.

Geier:

In there we probably need to be for analytics a bit in that area when we move into the value analysis, we've got some but it's probably not what we need to get there. But we'll do that.

Dr. Wadsworth:

I think there's a piece that we keep coming across which is a temporal piece to make sure you have the incentives to get the longer term returns which sometimes cost money upfront. I mean, it's an obvious thing but that really changed our thinking about facilities when we stretched out and said ok if we pay now but in three or four years we're going to get this return because the pressures to get near term savings, but sometimes I'm sure you're thinking about all that. It is another piece that we had to really look at, do we have the right incentives in place for both the near-term and the longer term. Those can get confused.

President Drake:

We are getting close to the cultural barrier we have in practice with preference and patterns, which is why we spent an extra trillion dollars a year nationally. There are great big numbers there but those require the cultural change to make sure that efficiency and effectiveness are tied together at the level of the action that everyone takes on a daily basis. That is around the corner, that's the exciting piece.

Dr. Loborec:

Another potential area for cost savings as well, I think, purchasing is definitely great, is on terms on our rejected claims. I know sometimes there are clerical errors that may prevent claims from being paid and if you actually just go back and fix the coding we actually can receive that reimbursement so I think it would be helpful to know what percentage of our claims are being rejected and potentially investigate as to why and if we can re-coop some of those costs.

Mr. Geier:

I can bring that back, we actually as one of our OEE initiatives which is helping on this, not just as supply, which we started probably a year to eighteen months ago, was completely revamping the revenue cycle area. Dr. Ellison and I are leading that but we can bring that back because we've had significant gains in terms of scheduling, collection, late payments, now point of sale collection. I would be happy to bring that, the totality of that particular initiative here because it's one of the things that is helping with the cost savings. Not just the supply chain change, you're right.

Dr. Gabbe:

One of the largest areas for opportunity for us is revenue cycle management.

Mr. Wexner:

Just an anecdote, but everybody, this is a takeaway probably everybody could use. I bumped into it in a funny way because somebody suggested this, you know, one of the associates in the business of why don't you do this, this is an original thought. But about every three or four years I stop buying, just say, we're not going to buy anything, we're not going to buy light bulbs, we're not going to buy paper, we're not going to buy pencils, nothing can be bought and literally send people around the offices, looking in desk drawers, office by office, file cabinet by file cabinet, to see what's hoarded because nobody wants to run out of pencils or paper or light bulbs. Typically, we pick up, in the float, within our system, about three months of stuff because people are hoarding. It is the damndest thing. People will come back with, it must weigh a ton, you know, maybe a two cubic foot box of paper clips because people just have jars of them in their desks and you get legal pads and pencils and just, sometimes very, you know, toners, things that are reasonably valuable, occasionally pieces of equipment, you know, somebody got two

computers just in case theirs broke or something. Just silly stuff. This is such a big area of opportunity. We do this now, just every time, say you're going to do that again is very unpopular. People going through the offices with supermarket carts piled up with stuff.

Mr. Chapman:

Great idea. Yeah, we agree.

Mr. Wexner:

It has to exist here.

Mr. Chapman:

I'm holding my tongue but I used to work for these office supply companies, you know, as a consultant. One of the things, they said is one of your strategies ought to be desktop delivery. Right? Why do I want to do desktop delivery because then I can avoid the problem of having had it approved. Guess what Ohio State University Wexner Medical Center has, desktop delivery. We have changed that policy and we've moved to a different approach to that but I'm not going to say that the Wexner Medical Center is any different than Northwestern or Michigan or any of the others. But your point is a very legitimate one which is if we stopped and said not more purchases of X, non-clinical, my guess is there is an analogy to this that exists but somebody squeaks then we buy office supplies as a classic example of hoarding. I agree.

Mr. Wexner:

That's great. It's a worthwhile discussion. Again, if we say this might be a billion dollars of savings over a five year period, there's not many things that we touch that we could say, boy this produces a billion of revenue.

Mr. Chapman:

And Les, what I would say is again in my prior life, I used to call purchasing the highest ROI business in any company because what they do is they deal with cash flow and they deal with operating expenses and savings. It was always a top ten position. It is nowhere near a top ten position at the Wexner Medical Center, and quite frankly if you think about this holistically with the university, we probably have somewhere between $1.5 billion to $1.7 billion of total non-labor costs for the university. If you said its growing at 3-5 points a year, that's a $50-70 million tax. If we want to hold the line on that, your question is this, have we put enough A players against that cost structure to ensure that we feel confident that we have gotten what we deserve? You would not be the first institution, very few institutions think about it the way you are describing it. We have an opportunity and Pete and I have talked about this, to go out and get a real beef eater to really own this portion of our cost base but I'd say the same thing as well for any other medical center that I've worked with and I'd say the same thing about the university.

Mr. Wexner:

Well, I think looking around the room at the board members who are anxiously looking forward to the proposal, both in amount and talent, you know, what it is that we're looking for. I think that most organizations look at the revenue side, you want to generate, whether it's great sales or income performance where they have to have surgeons and diagnosticians and people that generate revenue. The leakage that happens on the other side, every dollar saved and a dollar earned is the same dollar. It's just not as much fun on the saving side but if we said we want to be best in the world in terms of efficiency, what would that mean and what kind of talent do you have to have, internal or external, what kind of reviews because it will always be with us. It's always been with us, it just got frosted over.

Mr. Chapman:

It is a very complex problem within healthcare because you have your pharmaceutical and therapeutic committees, you've got the introduction of new drugs and new devices. Remember now, I used to run a med device company and let me just say to you that I had six business units, six separate sales forces, calling on one purchasing department. The purchasing department tends to be a tad bit outnumbered and think about the amount of money I train my sales forces with versus how much we train our purchasing. It's an unfair equation. I believe, you're on the right point, having said that, we have a very real opportunity. Pete and I are working with the suppliers, looking them in the eye and saying we want, in ten days, a pricing proposal, net 45 ACH, no charge freight. I mean there is no ambiguity when those folks leave the room. You know, whether we get it from everyone or not, the point is the message has been conveyed and were having success.

Mr. Geier:

We have switched the long-term suppliers who didn't comply. We've already done that and we tell them upfront, we'd rather do it with you if we can keep our quality because it's a pain to change but if you won't meet it and we'll change and we have. We have changed some already.

Mr. Wexner:

I think we're in agreement. What I'm hearing you say is that there's stuff you're doing right away that's low hanging fruit and there's big dollars and in parallel, I think we're agreeing that this is a big strategic issue and I'm saying if we set our objective, we would want to be the most effective, efficient, in terms of buying. Everything we buy, goods and services, who would that talent be and how fast could we get there. The savings goes back into how we expand, you know, whether it's research, practitioners, facilities, because we get to redistribute the savings.

Mr. Chapman:

I just want to say that everybody is in absolute agreement.

Mr. Wexner:

Again, just kind of documenting this around the board. This is a major, this is a strategic leg of what we do, and I'm saying that this is strategy in a very simple but very practical form.

Mr. Geier:

Good, thank you.

Mr. Wexner:

Thank you. I appreciate the conversation.

Dr. Gabbe:

(Presentation)

Well looks like our slides went out. In your book, you have the Medical Center Initiatives Scorecard and the Performance Scorecard. This is a revised scorecard and you'll see that it has seven key priority areas: quality and service, financial viability, revenue enhancement and scale, cost management, research excellence, education excellence, and talent management. It has ten metrics and so it addresses each of our mission areas but in a focused way. The first scorecard gives you the actuals for fiscal years 2012, 2013, and 2014, it gives you our fiscal year 2015 target, and it gives you our five year target. The scorecard with the colored circles is where we stand after the first two months of this fiscal year. Under

quality and service, you can see that our inpatient mortality, with a yearend target of .61 is already at .58 which already places us among the top five UHC hospitals. Overall patient satisfaction in the first few months of this year, we've fallen short of our target. July and August are usually months where we stumble, there are many reasons why that may be the case. I just met on Wednesday to look at areas of opportunity but again, this is just two months of data.

Mrs. Wexner:

I'm just curious on that, what's really driving that?

Dr. Gabbe:

Why are we in the red? We're in the red in the inpatient because of our doctor communication and our clean and quiet scores. We're in the red for outpatient because of timely appointment scheduling and follow up with patients on their test results. And those are all being addressed.

Mrs. Wexner:

You know, this one always concerns me when it's red because, talk about things that are within our span of control, this is.

Dr. Gabbe:

I would say in terms of the doctor communication, we know what to do, we just don't do it on a consistent basis. It is in stark contrast with our nursing communication scores which are in the 90th plus percentile. As I said, we had a very good discussion about this on Wednesday. The U.S. News ranking will come out.

Dr. Reid:

Just another question, on the getting the test results back part, so we have Epic now. Right? People can actually just log on and get their test results. Is this an issue of there are not enough people signing up for the *OSUMyChart* type piece?

Dr. Gabbe:

That's an excellent question. We have over 100,000 of our patients on *OSUMyChart.* People want their test results provided in a different way. Dan is here, and leads our ambulatory services, and we are trying to assess how patients want their results provided for them in a timely way, whether it's a phone call, whether it's a letter, whether it's *OSUMyChart*. That's what we're working on now. Dan, do you want to comment from your point of view?

Mr. Like:

When we talked with Nationwide and their council it was clear, I think, *OSUMyChart* was preferred for routine results. That there was no interpretation needed but if there was interpretation needed, or non-routine labs, a phone call was by and large preferred. Certainly, *OSUMyChart* has helped in the practices that we have a high utilization.

Dr. Reid:

The area that we get dinged on then is the doctor communicating to the patient on serious results. But not on *OSUMyChart*?

Dr. Gabbe:

Exactly. For a patient at the James, they have an imaging study. That study needs to be evaluated very carefully because it may indicate the need or no need for further therapy. Those are areas where we've got to be very focused and really individualized with the patient. I think that was one of the areas of concern.

Dr. Caliguiri:

I would add to Steve's comments, at this time, Janet, with the 95-99% occupancy, I'm noticing when I'm rounding, a lot of frustration of patients waiting to get in. It had a bit of an impasse. We're trying to be more efficient in our discharges but every day, it used to be a certain part of the week, ok, we move things around but now it's pretty continuous. A lot of frustration for patients and physicians. It's a continuum of issues.

Dr. Gabbe:

That's a good point.

President Drake:

I just want to say a word about *OSUMyChart*. At home, I look at the test results and describe them, but I went to medical school. They're difficult to understand and they require interpretation and whether it's a 3.8 versus a 3.9, that's a lot. Seeing the numbers can raise as many questions or more. It's a serious issue.

Dr. Gabbe:

Well it's one that we're working on. We actually had a stand down across our entire ambulatory practices on one day to bring everyone together to focus on this particular issue. Hopefully we'll see that improve. We've already talked about days cash on hand which is the financial viability indicator. We've talked about several of the revenue enhancement issues, development dollars. Our target for the year in philanthropy, this is philanthropy only, not the Office of Sponsored Programs, is $100 million. At this point, we've raised just over $17 million. $11 million of that is from the James and $4 million of that is from the neurosciences and I think Patty you wanted to comment on recent evaluations from the *Association of American Medical Colleges* (AAMC).

Ms. Hill-Callahan:

Yes. Yesterday, we were informed for the AAMC rankings of academic medical centers that we moved from 25th to 20th. This is based on fiscal year 2013 which is really great news. It is great news for our development operation, specifically in recruiting which is what I am actively doing, to try and recruit national talent to come to the Wexner Medical Center to help us build the fundraising program.

Dr. Gabbe:

That is terrific news. That is all academic medical centers, we're now 20th. That's wonderful news.

Mrs. Wexner:

Sorry, is that $11 million including Pelotonia dollars?

Dr. Gabbe:

That would include Pelotonia dollars as well as other gifts. Obviously, not all the Pelotonia dollars would be included in that. That's correct, Patty?

Ms. Hill-Callahan:

Yes.

Dr. Wadsworth:

Could you repeat the ranking comment?

Ms. Hill-Callahan:

Sure. In 2012, we were 25th.

Dr. Wadsworth:

We being?

Ms. Hill-Callahan:

Meaning the Wexner Medical Center fundraising.

Dr. Wadsworth:

Oh, got it.

Ms. Hill-Callahan:

In 2013, we rose to 20th and to give you an idea of our competitors, Penn Medicine is 13th, Cleveland Clinic is 14th, Weill Cornell Medical College is 16th, and then the top five which you would all assume are Mayo Clinic, Stanford, Memorial Sloan-Kennering, Johns Hopkins, and UCLA.

Dr. Wadsworth:

That is a ranking based on annualized giving?

Ms. Hill-Callahan:

Right, contributions.

Dr. Wadsworth:

How non-linear is the curve? In other words, is it a J curve? So the top five, I mean, once you introduce data, we're all driven.

Ms. Hill-Callahan:

Right, I will tell you that I shared the ranking for all our grateful patient fundraising with the faculty and I say to them, what is the difference between the top five and where we are? The difference is a grateful patient fundraising program in an institution that has been doing it for 20 to 50 to 100 years. I would also look at Mount Sinai, who was 7th and when the VP went there five years ago, they were 20th where we are. There is a lot to be said for building this culture of philanthropy with our faculty.

Dr. Caliguiri:

There is a lot of recruiting right now in cancer. We're taking people from all over New York and elsewhere. I know Dr. Shapiro just went to Mount Sinai and I think it made a big difference, the philanthropy.

Mr. Wexner:

Say that again, Mike.

Dr. Caliguiri:

Mount Sinai is recruiting from all over New York. We just had the chair of surgery from Memorial here today and I was asking him how things were going and he said they're losing a lot people to Mount Sinai at Memorial and I know that's true at NYU and Columbia.

Dr. Wadsworth:

Are people are more likely to give for cancer?

Dr. Caliguiri:

What I was just told this morning, they're paying a lot more money to people, packages.

Dr. Wadsworth:

Oh sure, I understand that. I meant in terms of development dollars. There's a bias towards cancer.

Dr. Caliguiri:

Yes, you're right.

Mrs. Wexner:

Just to Jeff's point, Patty if we're at $100 million right? What would 1st through 5th look like?

Ms. Hill-Callahan:

Mayo Clinic was $119 million, they had a huge gift from the UAE; Stanford is at $434 again, a couple of $100 million gifts; Memorial Sloan Kennering is $389; and Johns Hopkins Medicine, which I would really like to beat, is at $339 million. They had a $100 million gift.

Mr. Wexner:

Where would Michigan be?

Ms. Hill-Callahan:

Let me see.

President Drake:

While you're looking for Michigan, let me also say that a lot of those are really big gifts that come in with a habit.

Ms. Hill-Callahan:

That's the difference, the $100 million gifts.

President Drake:

The nine figure gifts that come and so UCLA had a nine figure gift.

Ms. Hill-Callahan:

Right.

Dr. Reid:

Are these gifts that get counted just for the one year?

Ms. Hill-Callahan:

Yes.

Dr. Reid:

Ok, they could be way high because of one gift for the next year.

Ms. Hill-Callahan:

Yes, exactly.

Dr. Reid:

That is the J-curve.

President Drake:

That is true and that would be the UCLA circumstance. Let me say that they tend to then attract other nine figure gifts. Right? I mean, so the concept of having somebody fly over from the UAE and they would tend to fly to a place that had that focus.

Ms. Hill-Callahan:

I only have the top 25 and Michigan is not on there.

Dr. Gabbe:

Under research excellence, we have total NIH awards, our target this year is $97 million and we are about on schedule at $16.5 million to date. Education excellence, the metric is the *U.S. News Rankings*, we'll get that in April. And then, talent management is our workforce engagement survey where you can see our target of 4.15 and 4.15 for both staff and faculty which we will again get during the fiscal year 2015 year.

Mrs. Wexner:

I am a little lost on how we read the colors, right? Is this measured against what plan? I look at some of these wonder if it is really yellow? It looks like red to me.

Dr. Gabbe:

Yes, I think at two months we had the same conversation.

Mrs. Wexner:

Well not on this one thing, I'm saying in general, how do we set our measures of what is success versus what's not?

Dr. Gabbe:

Green meets or exceeds, yellow is between, up to 5%, and if it's red it means we've fallen behind by 5%.

Mrs. Wexner:

When did we set these, when did we agree on the objectives?

Dr. Gabbe:

We agreed on these at the start of this fiscal year with our medical center leadership and our chairs at our performance and accountability review group meeting.

Mrs. Wexner:

This is an internally set benchmark? It would be interesting for us to know. I don't actually know, if you ask me, what we're trying to be in any one of these, and what would we, do we understand how we're measuring ourselves in terms of success or not.

Dr. Gabbe:

If you look at the first scorecard, which is the black and white one, you can see the targets that we have for the fiscal year, and if you look at this one as well, you'll see that for example, our patient satisfaction score targets are to be in the top decile for both outpatient and inpatient. Then if you look at the *U.S. News Rankings* you can see where we want to grow and you can see for NIH, we want to be in the top 15 funded public medical schools. Then for the workforce engagement, those metrics are in the top deciles. Now some of them are set, arbitrarily, among our leadership at the start of the year. How many specialties to have ranked in the top 20 by U.S. News, how many to have ranked in the top 10, for example.

Mrs. Wexner:

I guess, Les, this goes to the bigger discussion of the big strategy discussion we have yet to have on what are our aspirations. Some of these, I understand how you get there in terms of what logical progress you can make. I would assume if we really sat around the table, this is not what our aspiration would be, or certainly, I would hope it wouldn't.

Dr. Gabbe:

If you look at the upper left corner in very small writing, you'll see that our aspirations and this is associated with our last strategic plan, were top 20 medical centers and the top 10 NCI funded cancer programs. We are 33rd among academic medical centers and NCI funding we are 15th of all the 200 medical centers.

Mr. Wexner:

Abigail's question raises a couple of issues in that, from my way of thinking, strategy isn't the goal. The strategy is the plan to get to the goal. This board is new and the question is what is the strategy and how do we get there? Then, on budgets, how do we understand where we are, what's the plan to be at this point in the year. When I have an annual budget or a multiyear strategy, I am faced to measure against as a trustee and performance always has to be measured, now I'm going back to the budget, in dollars and percents so we can be ahead a lot in percents but there could be no dollars. I deal with this in my real world, somebody says they had a 50 percent increase. You went from a dollar to two, I mean, that doesn't matter. Literally one dollar. I was flat at $100 million area, that's flat, but this other one had a 50% or 100% increase but you're celebrating a big percent and no dollars. I think this also connects in this strategy, in thinking forward, what are we going to do and how are we going to get there? I think, again, the intensity of this board raises issues and I'm not doing, I'm not making a decision on horseback, but

as an example, we could say we want to distort our resources on the efficiency side, because we could quickly become world class in efficiency. Getting to world class in reputation on the medical side, might take a few years. This strategy of being efficient and however much resource we put on it, gives us a financial enabler to feed the beast. That, I think, the review of a board teases out some of these issues because we're looking at them from a more distant perspective. Again, I'm not intending to say this definitively, but to think about, we could be world class in efficiency, big strategic initiative, obviously there's a lot of places for efficiencies, if you get that, it solves the financial problems for expansion, recruiting, and a lot of things. Now, how we would redistribute those savings into what areas so that makes strategic sense is something else. Coming back to Abigail, what are the initiatives, how do we measure them, month-by-month because somethings should have monthly goals so we can see how we deviate, and I appreciate the coloring, it's a short cut but I'd rather, for my own personal point of view, it's like don't tell me the colors, tell me the numbers, then we can explain the colors. I'm getting to net without going through a thought process. My worry is that I don't know the thought process that you're going through to get to the color, right?

Dr. Gabbe:

That is very helpful. Some of them are difficult because, for example, the NIH funds and cycles. You don't get funded then there's a big funding of grants, it's not going to be a progressive increase.

Dr. Wadsworth:

Just to follow up on Les that the other metric that's dangerous is the most improved award, which I actually once won, once, so I speak from personal experience that the lower you start, the easier it is to go up. I think a good strategic question would be, we look at the NIH awards and we see that the target's gone down. We know NIH funding is going down, but we also know there are areas where you're more likely to win on NIH funding and should this distorted funding from savings be redirected. Maybe it should be a red flag that says what's the strategy to increase it versus what's the strategy if we stay linear on how we're performing?

Dr. Gabbe:

We had a long conversation about that, about that goal this year. For example, last year we were at $108.7 million. We benefited from getting funded for the end of our clinical and translational science award and then we benefited from getting an early award from the NIH for the renewal. We had a lot of conversation about that goal. As you say, the NIH funding is decreasing, especially in specific institutes, you might look at those institutes where there might be an increase.

Dr. Loborec:

A question I had was related to the *U.S. News and World Report* rankings. In 2012 and 2013 we had 20 specialties ranked, excuse me, 10 specialties ranked, two in the top 20 and this year we only have five and one, we cut everything in half. I was wondering what's specialties were those and what are we doing to kind of address this?

President Drake:

We talked about that. Let me just say something about how I feel about *U.S. News and World Report* as a data point for serious organizations. I won't say any more than that. I would need to say you need to look at the entire range of things that are being looked at and what's the difference between being ranked 49 on reputation and being ranked 51 on reputation.

Dr. Gabbe:

I don't have the list of specialties with us and we discussed that before. Clearly we had several that dropped off the 50 list, although we had about 10 that were ranked as high performing. The highest

ranked specialty we have is otolaryngology, which I believe which was 14th. We can bring that back with more detail about the ones that were highest, the ones that fell and we'll do that. Thanks.

Mrs. Wexner:

This is always a dicey subject on rankings but I think it's like anything else. I think you cannot like or you can like them but they're a reality and I think they do affect your ability to recruit. There are halos that get developed when you have service lines that outperform. I think there are strategies that can be developed to change those rankings. I think we really worked on that at Children's we went from unranked to highly ranked, and it's not enough to say, we're really doing better. People aren't recognizing us because sometimes its stupid stuff that you need to take care of that can change it and it has a benefit.

Dr. Gabbe:

We had a long conversation about this with our performance and accountability group, we have strategies that we can bring back to you around reputations, and strategies around patient safety which has become a more important focus of the rankings now. They change every year which is always a challenge but as you know from Nationwide Children's, the reputational score is less but the safety score has increased.

Mrs. Wexner:

It is no different than the point you were making about are you putting the resources on it. If you said, we were really going to go after this and there was one person who had no other job, but to track, you know, all of this information and how people are responding and all of that, over a five year period, could you really move it? We clearly have not moved. Right? Either we say that's where we're happy to be or we need to develop a different plan.

Dr. Gabbe:

That is true. We've been relatively stable, year over year. We made the honor roll in 2009 but we have not made the honor roll since. Dr. Moffatt-Bruce, perhaps during her presentation on quality and safety, can comment on how we're changing our focus on the patient safety indicators, particularly those that are emphasized by U.S. News.

Dr. Moffatt-Bruce:

Absolutely, that is my job.

Ms. Krueger:

It might be helpful, as we look for and say there's issues with coloring but if we put in there what are the best in class. In other words, who is best in class right now in patient mortality? And so if we have that from last year, it would be really helpful to put that on this chart too so we can not only compare, how we are stacking up to our own goals and objectives but how do we compare against the best in class. That would give us some kind of benchmark as far as, we could measure this and we could measure the difference.

Dr. Moffitt-Bruce:

Absolutely.

Dr. Wadsworth:

That's a good idea because even the discussion about raising money, fundraising, you know, you'd have a sense of what's the best. I think that's a great idea.

Dr. Gabbe:

Yes, and I think Dr. Moffatt-Bruce will present that during her presentation.

Dr. Moffatt-Bruce:

I do have that, yes sir.

Mr. Wexner:

A specific thing. I'd like for the next board meeting is to look back five years in philanthropy, budget for this year, and then look at the plan for the next five. Not only the what, but how we're going to get there, what needs to be done, what resources we need or resources to replace. It is a try harder. I'd put it in terms of bold goals. If we were going to be in the top 10, if that's our bold goal, in three or five years, you might have these whopping gifts, but we'd probably have a stabilized base of X. This is where we are, and again, I would imagine, it'd be an increase of $100 million or more.

Ms. Hill-Callahan:

Right to be in the top 10, we'd need to be raising $200 million.

Mr. Wexner:

Right. That would be a significant thing and I think that's something that we could talk about, influence, and help with. It's like efficiency. It's hard for me to interview docs or come up with medical strategy but I think for the board members, I think there's things that are very practical and I think in almost every area, like savings. How much is there over time, getting this chunked out, we can see it and then measure it in years and then we can break it down to months, to have real action plans. You know, we know what the deliverables are.

Ms. Hill-Callahan:

Right.

Dr. Reid:

I have a question on the same subject. How would you describe the quality of the relationship between what's going on at the Medical Center and what's going on with Mike Eicher's group. You know, is there enough coordination?

Ms. Hill-Callahan:

Oh, there is. Absolutely. When we think of Mike Eicher's group, we think of central services and we are, in any way, shape, or form, that we can use central services to help us raise more money, we're doing that.

Dr. Reid:

Ok, that's good because I know they constantly work on new thoughts and new approaches and that can get us further.

Mr. Wexner:

The tricky thing in this is for the university, is who's the tail and who's the dog? I'm guessing in most universities, more money would be raised by medical centers than the balance of academic units, and I just think that.

Ms. Hill-Callahan:

Right. Yes, your assumption is correct. It's anywhere from 50% to 60% medicine fundraising for our peers.

Mr. Wexner:

I'm not arguing that we shouldn't coordinate but, if this is really the biggest dog.

Dr. Reid:

Oh it is there's no doubt. I'm just thinking if there are new learnings, if there are techniques or whatever. But we know where the dog is.

Mr. Wexner:

We are getting at some good stuff today.

Mr. Kasey:

(Presentation)

Thank you, Mr. Chairman. I come to you today for probably one of our last construction update meetings. I intend that we will provide at the November meeting, a full summary of the financials and schedule, and an update on putting the building into operation. We have been for many months, and many years, walking through this building with you. I'm going to tell you where we are today which is very hopeful. We still have a ways to go. You see on this budget, our contract commitments to date compared to our budget, we still have about $38 million of commitments that the budget would suggest we are yet to make. In actuality, we'll come in under this budget and so I won't give you a full forecast on that today but what has yet to commit are some of the technologies that are going into the building, some minor equipment, and then a great deal of commissioning fees to commission the building, deep clean it, and prepare it for certification. We are marching towards that goal.

The project contingent which we've watched for many months, recall that, $25 million of the project contingency, a year and a half ago was released by this Board so that we could finish out other square footages and other floors in the building which is why the 21st floor and the remaining four ORs are being completed in the building.

Yet, we anticipate that of the approximate $7 million in contingencies remaining there will be some amount that's left over. We'll come in under budget. I only add to this that in the contractors agreement, they also have a list of contingencies and what they call, holds, which were allowed as, since they are a risk contractor, contractor-at-risk, those funds will come back to us also after some level of savings are shared with the contractor. We think that those funds are currently at $9-10 million. That would be added to this amount and that will be an approximate at this date of what we think we will come in under budget. We'll tie this out in November for you though and give you a final outcome.

Mr. Wexner:

If I'm understanding, Jay, is it $10 million in total or $10 million are contingency. It's in addition to theirs?

Mr. Kasey:

It's $10 million and $7 million at this time and we think we will be close to that.

Mr. Wexner:

And then, does that just go back to the university, you just send a check over to Geoff for something for fiscal year 2017 if that happens?

Mr. Kasey:

We have debated this.

Mr. Chatas:

Yes, we've had a lot of discussions about this and the ideal will be we'll borrow less. We haven't put the final amount, the last 300, so do you size it down, do you prioritize it with other, do you add it to days cash on hand? We will come back to this board once we know the number and here are two or three options, let's discuss them.

Mr. Wexner:

Good.

Mr. Kasey:

Another number we've been reporting and the state has asked us to keep track of is the percentage of contract money spent with have contractors. These are minority owned construction or suppliers. This is really a remarkable number and I say that, you know, four years ago, the university was hitting 7% on its EDGE contracting. The state was requesting us to get to 9%. When we committed to using construction reform as a vehicle for delivering the project, we committed to the state that we would try to reach 20%. Now, I believe we will reach 30%. This goes to something, I think all of you just been talking about, if we set appropriate targets and we tell people what they have to meet, they get there. There has been some remarkable ways in which this has been done. Also, that 87% of Ohio participants for contracts, these are Ohio-based firms that have their main, or a significant office, in Ohio. That doesn't mean they aren't national firms or work on a national basis also. This is a great story to tell.

Mr. Wexner:

If you summarize that, I might give it to Mr. Wolfe to give to the legislature. I think it's a great story to tell. We got to make sure we tell it to the right people.

Mr. Kasey:

You know, we have a final report, which we hope to have prepared by the time the board meets next on the project. This will be highlighted. That final report will end up being disseminated in a variety of ways. We will get it out there.

President Drake:

It's really positive in a couple of ways, finishing hospitals on time is extraordinarily difficult because the field changes during the construction. So, that's great. So to be able to monitor it all this time and have it be finished on time and then to come in under the budget and then to be able to diversify the contractors in doing that when the conviction of wisdom would say that those two things were at odds is really a tremendous story.

Mr. Kasey:

Yes, we're very pleased with that and a sum of this is under the radar and we hope to tell our story but we'd like another month to pull it together and celebrate. I'm going on to the next page and I won't talk

about each of these individually but I will tell you that on September 26th, which was our designated date, we accepted substantial completion of contract of construction. This meant that the contractor, Turner Lend Lease, handed control of the building to us. We put our locks on the doors, which are not locks anymore, they're swipe cards, and we took control but you no longer had to wear hard hats or safety glasses or anything in the building. It is now in our control which brings with it another layer of responsibility of course to finalize substantial completion of construction is one thing, we also have, in the last two weeks, gotten the certificate from the fire marshal, certificate of completion with plumbing and medical gasses which have to be checked out, the completion and certificate from Swisslog, who is the vendor who puts all clocks and timing devices into the medical center and while it seems a minor thing, everything has to be synched across the medical center. TransVac, which produces the pneumatic tubes, we have a small tube, six and four inch tube and then we have, you may recall, the three foot tube that runs by pressurized air that delivers waste and laundry to the dock area as a lean technique. That was also completed and handed to us. Nurse call and page was completed.

Now, we have 26 elevators, new elevators in the building. 20 have been certified and we've gotten a license on, six are still being certified and we believe will be completed by the end of next week. None of those six are holding up the populating or the equipment in the building but we're still working through that as a final piece.

Staff training is scheduled for October/November. The James critical care teams have about, several thousand people they have to train in their new workspaces.

Opening events are on a list at your places, we're very excited about both the organization and the activity that those are going to produce. The James team, with Beth Necamp have been putting these together and we the project team are very excited to support them.

Then there's the moves and the clean and the facility opening dates for various parts of the building.

I won't spend much time on the equipment and the fit out of equipment, we're on process there, we're on track. I will tell you keeping with something that was mentioned earlier about our lean techniques. The store room that receives equipment and supplies, to supply this 1.1 million square feet of building is about a fourth of the size of this room. Everything is delivered to the building, comes from the manufacturer, through their shipping, delivered to us, and placed on the floor in which it is going to be used. We don't take things, move them to a warehouse somewhere, wait, move them to the building, move them in the building then move them up to their floor some other day. It's very just-in-time and greatly reduces the risk that we have when we accept equipment. That has been one of the learnings we've had which has gone very well to us.

Finally, I'll just say that the first moves of equipment into the building have already begun. One of the keys to moving things across from the medical center into the building, there are four floors that connect of the 21 floors to the existing buildings, is that everything that comes into the building has to be cleaned before it's moved into the building. We have cleaning stations at certain places ahead of moving into tunnels into the building. You will see a very new fresh building.

We are reusing 170 of our existing beds. You may recall that we're building about 420 beds, some beds will be moved in, and some beds will be relocated.

And then, just for your information, floors 9 and 21 still have to be built out. 9 is the administration floor. That's where the project team resided for these last few years, the big contractor and OSU project team. They are off the floor now and that's being build out. 21 was the floor that was added a year and a half ago, it will be completed by November 1st, in time for the cleaning and the arrival of patients.

The retail spaces include a coffee express in the main lobby, Au Bon Pain is in the lower level conference center, and the Huntington is in the lower level conference center. We believe by the time the tours are up and running, they didn't start their construction until we received the building from Turner, but we think we're on track to have those, they won't be open because they won't have business but they'll look like

they're ready to open. Then the Bistro Café is a café that is located on the 14th floor, adjacent to the outdoor terraces that the Medical Center will run.

Finally, we think it's really interesting that there will be a building flush on the 14th-17th. If you wonder what that is, we have to seal the building, this is part of a LEED accreditation item, we seal the building, we pressurize it and no one can open a door or window for about 48 hours. We measure the pressures within the building, we open it and theoretically, the ducts are all clean and we can go into a deep clean then because everything is blown out of the ventilation system. I'm going to stop there, if you have questions, I can answer them.

President Drake:

You also didn't mention, what a wonderful facility this is. I mean it's great to talk about the construction and all those things but what a great contribution this will be to our community and then also the world of science and patient care. It is really a spectacular contribution to what we can do and that's a really great day to be able to open it.

Mr. Kasey:

Thank you.

Mrs. Wexner:

Based on your previous discussion on the purial nature of the rankings, you should bump, the James should see a bump in the rankings just because of the facility.

Mr. Kasey:

Following on that and to enhance that, we're leaving some staff in the building who will do nothing but take people on tours, suggest publications, get the word out, and welcome visitors.

Dr. Gabbe:

At your place is promotional material that appeared in *The New York Times* Sunday magazine last Sunday. This was in the *Columbus Dispatch* as well and on the other side is a, I think, a very good narrative from Mike Caliguiri about the building. I apologize that this side is printed in color, Mr. Chapman told me I was allowed to do that because this was the Medical Center Board meeting. The other side was difficult to get a version that you could read but I think you will be able to read the text there.

Mr. Wexner:

Questions? Comments? Mr. Wolfe has volunteered to be the chairman of the committee which reviews the Upper Arlington building. John has large experience in looking at building projects and budgets and estimating costs. I'll ask you to cooperate with him. John may bring some other resources in and I realize the urgency, again, I'm repeating, it's not a question that we're going to do it, but we're going to do it as financially sound and sophisticated as we can and I appreciate John doing this.

If there are no other items to come before the Board in a public session, we're going to adjourn to an executive session to talk about some business sensitive issues that must be kept confidential. I think I need a motion.

Upon motion of Dr. Wadsworth, seconded by Mr. Wexner, 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. Wolfe, Mrs. Wexner, Ms. Krueger, Dr. Reid, and Mr. Wexner.

Mr. Wexner:

Thank you, we are adjourned.

Attest:

Leslie H. Wexner	Heather A. Link
Chairman	Associate Secretary

(APPENDIX VI)

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Policy Name: Patient Complaint & Grievance Management
Policy Number: 03-28
First Effective: October 14, 1991
Last Revised: September 10, 2014

Applies to: University Hospitals, Ross Heart Hospital, Harding Hospital, University Hospitals East, Dodd Hall, Ambulatory Clinics and Services

Purpose

The Ohio State University Hospitals is committed to promptly resolving complaints at the first level of contact whenever possible.

The purpose of this policy is to provide guidelines for staff to respond and manage patient/family complaints and grievances; and to define the process for responding to patient grievances according to CMS Hospital Conditions of Participation.

The Ohio State University Wexner Medical Center Board has delegated the responsibility for review and resolution of all grievances received from patients of University Hospitals, Ross Heart Hospital, Harding Hospital, University Hospital East, Dodd Hall and UH Ambulatory Clinics to the University Hospitals Grievance Committee (hereafter referred to as the Grievance Committee).

The Patient Experience Department is responsible for supporting the complaint management process and assuring patients are adequately educated regarding their rights to register complaints and concerns.

In order to achieve the highest level of satisfaction possible, and to provide protection of their rights, patients will be encouraged to report concerns.

Concerns from patients, families, visitors, or other members of the community will be received courteously, treated seriously, and dealt with promptly. The act of voicing a concern will not jeopardize the care a patient is currently receiving, nor any future access to appropriate care.

It is expected that the staff of University Hospitals (including medical staff) will respond to patient concerns promptly and offer reasonable and appropriate solutions.

Definitions

Term	Definition
Staff Present	1. Includes any hospital staff present at the time of the complaint or who can quickly be at the patients location (i.e. nursing, administration, nursing supervisors, patient advocate, etc.) to resolve the patient's complaint.
Complaint	1. A clinical care issue that is verbally conveyed by a patient or the patient's representative to staff and generally resolved within twenty-four (24) hours. 2. Minor service complaints such as housekeeping, bedding, billing issues and food. 3. Complaints regarding property loss. 4. Privacy and HIPAA complaints, unless unable to be resolved within twenty-four (24) hours.

Grievance	1. Any written complaint received from a patient or the patient's representative regarding clinical care, whether from an inpatient, outpatient or released/discharged patient. An e-mail or facsimile (fax) will be considered to be "written". 2. Verbal complaints about clinical care that are not resolved by staff at the time of the complaint, generally within twenty-four (24) hours, and made by a patient or the patient's representative. 3. All verbal or written complaints regarding: a. Abuse, neglect, patient harm; b. Hospital compliance with CMS Hospital Conditions of Participation (CoP); c. Medicare Beneficiary Billing complaints related to rights and limitations provided by 42CFR§489 . 4. Any complaint that the patient, or their representative, requests be handled as a formal grievance. 5. Any complaint where a written response from the hospital is requested by the patient or their representative. 6. Post-discharge complaints, made by a patient or their representative, related to clinical care or services during a stay shall be considered grievances, unless the complaint would have routinely been handled by staff generally within twenty four (24) hours had the communication occurred during the stay or visit. In this instance, the communication will be considered a complaint.

Policy Details

Reporting Complaints via the Hospital's Intranet Site (OneSource)

1. Whenever possible, staff members are encouraged to enter non-clinical complaints directly into the Complaint Management System on the hospital's intranet site, OneSource.
2. The Complaint Management System provides a mechanism for tracking and reporting complaint data, as well as coordinating timely follow-up.
3. All verbal or written complaints regarding quality of care issues, abuse, neglect or patient harm shall be entered into the Event Reporting System for appropriate investigation and follow-up.

Reporting Complaints via Telephone

1. Complaints about care delivered at University Hospital, Ross Heart Hospital or the Primary Care Network may be directed to the Patient Experience Department at 614-293-8944.
2. Complaints about care delivered at James Cancer Hospital may be directed to James Guest Services at 614-293-8609.
3. Complaints about care delivered at University Hospital East may be directed to UHE Guest Services at 614-257-2310.
4. After regular business hours, complaints may be escalated to the Hospital Administrative Manager or Nursing Supervisor for each location.

Procedures for Complaints

1. All clinical care complaints should be referred to the attending physician or manager for appropriate follow-up.
2. All non-clinical complaints should be referred to the appropriate department manager for follow-up.
3. Patient Experience will forward all issues regarding property loss to the Property Loss Committee and enter the issue into the Complaint Management System.
4. Privacy and HIPAA complaints will be forwarded to the HIPAA Privacy Officer.
5. When complaints cannot be immediately resolved by the staff member to whom they were reported, the complaint should be reported to the supervisor or manager for resolution and entered into the Complaint Management System.
6. Patient Experience staff will act as a liaison for the patient by representing their interests and facilitating communication with appropriate individuals within the Medical Center.

Procedure for Grievances

1. When notified, Patient Experience or the appropriate manager will respond and investigate grievances regarding patients who are currently located within the hospital setting.
2. Situations that endanger (e.g. neglect or abuse) the patient should be addressed immediately by the appropriate staff member.
3. When appropriate, Risk Management may initiate a review of a grievance.
4. Patient Experience will serve as the primary liaison to the patient, and may consult Risk Management as needed.
5. If the grievance is from a written source, or reported after the patient has left the facility, a Patient Experience Coordinator will initiate contact with the complainant.
6. Clinical Care Grievances
   a. Clinical care grievances should be entered in the Event Reporting System.
   b. Following initial contact with the complainant, the Patient Experience Coordinator will arrange a meeting between the patient, or their representative, and the attending physician to assure that the patient's concerns have been addressed and that the patient's expectations have been met.
   c. The Patient Experience Coordinator will work collaboratively with the patient, or their representative, and the attending physician to resolve the grievance.
7. Non-Clinical Care Grievances
   a. Non-clinical grievances should be entered into the Complaint Management System.
   b. Following initial contact with the complaintant, a Patient Experience Coordinator will facilitate communication and dialogue between the patient, or their representative, and the appropriate manager to assure that the patient's concerns have been addressed and their patient's expectations have been met.
   c. The Patient Experience Coordinator will work collaboratively with the patient and manager to resolve the grievance.
8. Typically, a grievance will be considered resolved when the patient is satisfied with the actions taken on their behalf.
   a. However, there may be situations where the Hospital has taken appropriate and reasonable actions on the patient's behalf in order to resolve the patient's grievance and the patient or the patient's representative remains unsatisfied with the Hospital's actions. In these situations, the Hospital may consider the grievance to be closed.
   b. Patient Experience must maintain documentation of its efforts and demonstrate compliance with this policy.

Written Response to Grievances

1. A written response to all grievances shall be submitted to the patient, or their representative, by the Patient Experience representative or other appropriate individual within seven (7) business days regarding the disposition of the grievance.
   a. Included in the written response will be:
      i. The name of the hospital;
      ii. The steps taken on behalf of the patient to investigate and resolve the grievance;
      iii. The results of the grievance process; and
      iv. The date of completion;
   b. All grievance response letters will be mailed to the patient's or patient's representative's home address unless otherwise indicated.
   c. If the grievance is received via email, the response may be sent via email.
2. There may be complications or circumstances, which will not allow every grievance to be resolved during the seven (7) day timeframe.
   a. If a response will take longer than seven (7) business days, the patient should be contacted by Patient Experience and advised that the hospital is still working to resolve the grievance.
   b. The patient or the patient's representative should be contacted a minimum of every fourteen (14) business days by Patient Experience until the grievance is responded to in writing.
   c. If the grievance is not resolved within 30 days, it must be reviewed by the Grievance Committee.
3. A copy of the written response shall be retained by Patient Experience.

Reporting Complaints via Patient Satisfaction Surveys

1. Information obtained from patient satisfaction surveys will not be considered a grievance, except:
   a. If an identified patient writes or attaches a written complaint on the survey and requests resolution (i.e. requests an act or response), then the complaint shall be considered a grievance.
   b. If an identified patient writes or attaches a written complaint on the survey and does not request resolution, then the hospital shall treat this as a grievance if the hospital would usually treat such a complaint a grievance.
2. Patient Experience will work collaboratively with the patient, or their representative, and the appropriate business unit to resolve the grievance when resolution has been requested by the patient.

Grievance Committee

1. The Ohio State University Wexner Medical Center Board has delegated oversight of the grievance management process to the Grievance Committee to review and resolve the grievances of the hospital.

2. The Grievance Committee is comprised of the Wexner Medical Center Chief Quality Officer, Chief Medical Officer and the hospital Chief Executive Officer or their respective designees to review and resolve the grievances the hospital receives.

3. The Grievance Committee functions to:
   a. Facilitate grievance resolution when necessary.
   b. Review grievances quarterly to evaluate effectiveness of the resolution process.
   c. Complete an annual summary report for presentation to the Ohio State University Wexner Medical Center Board.
   d. Submit patterns and trends to the Quality and Patient Safety Department for possible incorporation into a hospital performance improvement plan, and
   e. Recommend operational modifications to senior hospital leadership in the event an immediate correction is necessary as a result of a patient grievance.

Resources

03-23 Patient Rights and Responsibilities
04-05 Event Reporting

Staff may access the following resources on OneSource:
The Patient Experience Management System may be accessed on OneSource. Please go to OneSource -> Patient Experience -> Complaint Management

The Event Reporting Application may be accessed on OneSource. Please go to OneSource -> Clinical Care>Applications.

Patient Reporting Resources:
Patients may choose to go directly to one of the reporting agencies listed below:

The Ohio Department of Health (ODH)
http://www.odh.state.oh.us/contactus.aspx
Division of Quality Assurance – Complaint Section
246 North High Street
Columbus, Ohio 43215
Voice: 1-800-342-0553 TDD: (614) 752-6490
E-mail: HCComplaints@odh.ohio.gov

Medicare patients with concerns regarding discharge may contact:
KePRO Inc.
http://www.ohiokepro.com/contact.asp
Rock Run Center, Suite 100,
5700 Lombardo Center,
Seven Hill, Ohio 44131
Phone: (216) 447-9604
E-Mail: webmaster@ohiokepro.com

The Joint Commission
Office of Quality Monitoring
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
Office of Quality Monitoring: (800) 994-6610

To file a complaint:
http://www.jointcommission.org/GeneralPublic/Complaint/

U.S. Department of Health and Human Services
Office for Civil Rights (Region V-Ohio)
http://www.hhs.gov/ocr/
233 N. Michigan Avenue Suite 240
Chicago Illinois 60601
Voice: (312) 886-2359 TDD: (800) 537-7697
To file a complaint: http://www.hhs.gov/ocr/contact.html

Ohio Department of Mental Health
http://www.mh.state.oh.us/
30 E. Broad Street, 8th Floor
Columbus, Ohio 43215-3430
Voice: (614) 466-2596 TDD: (614) 752-9696
For information about client rights and complaints:
http://www.mh.state.oh.us/cnsmrrecovery/cnsmrrights/rights.links.html

Ohio Legal Rights Service
http://olrs.ohio.gov/ASP/HomePage.asp
8 East Long Street, 5th Floor,
Columbus, Ohio 43266-0523
Voice: (614) 466-7264 TDD: (614) 728-2553
For Assistance: http://olrs.ohio.gov/asp/olrs_RequestForHelp.asp

Contacts

Subject	Office	Telephone	E-mail/URL
Patient Experience	University Hospitals	614-293-8944	
Patient Experience	University Hospitals East	614-257-2310	
Patient Experience	James Cancer Hospital	614-293-8609	

History
Issued: October 14, 1991
Revised: September 10, 2014
Submitted by: Patient Experience Department
Approved by: UH MSAC September 11, 2014

(APPENDIX VII)

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Policy Name: Patient Complaint and Grievance Management
Policy Number:03-28

Applies to: OSUCCC - James Cancer Hospital

Policy

OSUCCC – The James is committed to promptly resolving complaints at the first level of contact, whenever possible.

In order to achieve the highest level of satisfaction possible, and to provide protection of their rights, patients will be encouraged to report concerns.

Concerns from patients, families, visitors, or other members of the community will be received courteously, treated seriously, and dealt with promptly. The act of voicing a concern will not jeopardize the care a patient is currently receiving, nor any future access to appropriate care.

It is expected that all hospital staff (including medical staff) will respond to patient concerns promptly and offer reasonable and appropriate solutions.

The James Patient Experience Department is responsible for supporting the complaint management process and assuring patients are adequately educated regarding their rights to register complaints and concerns.

The Ohio State University Wexner Medical Center Board has delegated the responsibility for review and resolution of all patient grievances to the James Hospital Grievance Committee (hereafter referred to as the Grievance Committee).

The purpose of this policy is to provide guidelines for staff to respond and manage patient/family complaints and grievances; and to define the process for responding to patient grievances according to CMS Hospital Conditions of Participation.

Definitions

Term	Definition
Complaint	A clinical care issue that is verbally conveyed by a patient or the patient's representative to staff and generally resolved within twenty-four (24) hours. Minor service complaints such as housekeeping, bedding, billing issues, and food. Complaints regarding property loss. Privacy and HIPAA complaints, unless unable to resolve within 24 hours.

Grievance	Any written complaint received from a patient or the patient's representative regarding clinical care, whether from an inpatient, outpatient, or released/discharged patient. An e-mail or facsimile (fax) will be considered to be "written". Verbal complaints about clinical care that are not resolved by staff at the time of the complaint, generally within twenty-four (24) hours, and made by a patient or the patient's representative. All verbal or written complaints regarding: abuse, neglect, patient harm; hospital compliance with CMS Hospital Conditions of Participation (CoP); Medicare Beneficiary Billing complaints related to rights and limitations provided by 42CFR§489; Any complaint that the patient, or their representative, requests be handled as a formal grievance. Any complaint where a written response from the Hospital is requested by the patient or their representative. Post-discharge complaints, made by a patient or their representative, related to clinical care or services during a stay shall be considered grievances, **unless** the complaint would have routinely been handled by staff generally within twenty four (24) hours had the communication occurred during the stay or visit. In this instance, the communication will be considered a complaint.
Staff Present	Includes any hospital staff present at the time of the complaint or who can quickly be at the patients location (i.e. nursing, administration, nursing supervisors, patient advocates, etc.) to resolve the patients complaint.

Policy Details

I. REPORTING

A. Reporting Complaints via the Hospital's Intranet Site

1. Whenever possible, staff members are encouraged to enter non-clinical complaints directly into the Complaint Management System on the Hospital's intranet site, O*neSource*.
2. The Complaint Management System provides a mechanism for tracking and reporting complaint data, as well as coordinating timely follow-up.
3. All verbal or written complaints regarding quality of care issues, abuse, neglect or patient harm shall be entered into the Event Reporting System for appropriate investigation and follow-up.

B. Reporting Complaints via Telephone

1. Complaints about care delivered at OSUCCC – James may be directed to James Patient Experience at 1-614-293-8609.
2. After regular business hours, complaints may be escalated to the Administrative Nursing Supervisor.

C. Reporting Complaints via Patient Satisfaction Surveys

1. Information obtained from patient satisfaction surveys will not be considered a grievance, except:
   a. If an identified patient writes or attaches a written complaint on the survey and requests resolution (i.e. requests an act or response), then the complaint shall be considered a grievance.
   b. If an identified patient writes or attaches a written complaint on the survey and does not request resolution, then the hospital shall treat this as a grievance if the hospital would usually treat such a complaint as a grievance.

II. RESPONDING

A. Procedures for Complaints
   1. All clinical care complaints should be referred to the manager and attending physician (when appropriate) for appropriate follow-up.
   2. All non-clinical complaints should be referred to the appropriate department manager for follow-up.
   3. Patient Experience will forward all issues regarding property loss to the James Property Loss Committee and enter issue into the Complaint Management Database.
   4. Privacy and HIPAA complaints will be forwarded to the HIPAA Privacy Officer.
   5. When complaints cannot be immediately resolved by the staff member receiving the complaint, the complaint should be immediately reported to the supervisor or manager for resolution and entered into the Complaint Management System.
   6. Patient Experience staff will act as a liaison for the patient by representing their concerns and facilitating communication with appropriate individuals to achieve a satisfactory resolution.

B. Procedure for Grievances
   1. Patient Experience or the appropriate manager will respond and investigate grievances regarding patients who are currently located within the hospital setting.
   2. Situations that endanger (e.g. neglect or abuse) the patient should be addressed immediately by the staff member(s) present in order to minimize patient risk.
   3. Patient Experience will be responsible for investigating grievances and will consult with Risk Management when appropriate but Patient Experience will retain its role as the primary liaison to the patient.
   4. If the grievance is from a written source, or reported after the patient has left the facility, a Patient Experience Coordinator will initiate contact with the complainant.

C. Clinical Care Grievances
   1. Clinical care grievances should be entered in the Event Reporting System.
   2. Following initial contact with the complainant, the Patient Experience Coordinator will facilitate communication and dialogue between the patient, or their representative, and the attending physician or manager to assure that the patient's concerns have been addressed and that the patient's expectations have been met.
   3. The Patient Experience Coordinator will work collaboratively with the patient, or their representative, and the attending physician or manager to resolve the grievance.

D. Non-Clinical Care Grievances
   1. Non-clinical grievances should be entered into the Complaint Management System.
   2. Following initial contact with the complainant, a Patient Experience Coordinator will facilitate communication and dialogue between the patient, or their representative, and the appropriate manager to assure that the patient's concerns have been addressed and that the patient's expectations have been met.
   3. The Patient Experience Coordinator will work collaboratively with the patient or their representative and manager to resolve the grievance.

III. RESOLUTION

A. Typically, a grievance will be considered resolved when the patient is satisfied with the actions taken on their behalf.

B. However, there may be situations where the Hospital has taken appropriate and reasonable actions on the patient's behalf in order to resolve the patient's grievance and the patient or the patient's representative remains unsatisfied with the Hospital's actions. In these situations, the Hospital may consider the grievance to be closed.
   1. A letter will be sent from a designated hospital leader to the patient or patient representative containing adequate information as to the decision that the grievance is considered closed.
   2. Patient Experience will maintain documentation of the efforts made to respond

and resolve the grievance(s).

IV. WRITTEN RESPONSE

A. A written response to all grievances shall be provided to the patient/representative, by the Patient Experience Coordinator or other appropriate individual within seven (7) business days of receipt of the grievance.
   1. The written response will include:
      a. The name of the hospital contact person;
      b. The steps taken on behalf of the patient to investigate the grievance;
      c. The results of the grievance process; and
      d. The date of completion;
   2. All grievance response letters will be mailed to the patient's/representative's home address unless otherwise indicated.
   3. If the grievance is received via email, the response may be sent via email.
   4. There may be complications or circumstances that will not allow every grievance to be resolved during the seven (7)-day timeframe.
      a. If a response will take longer than seven (7) business days, the patient should be contacted by Patient Experience and advised that the hospital is working to resolve the grievance.
      b. The patient or the patient's representative should be contacted a minimum of every fourteen (14) business days by Patient Experience until the grievance is responded to in writing.
      c. If the grievance is not resolved within 30 days it must be reviewed by the Grievance Committee.
   5. All written responses will be retained by Patient Experience.

V. GRIEVANCE COMMITTEE

A. The Ohio State University Wexner Medical Center Board has delegated oversight of the grievance management process to the Grievance Committee.

B. The Grievance Committee is comprised of an adequate number of qualified members to review and resolve the grievances the hospital receives.

C. The committee functions include:
   1. Facilitate grievance resolution when necessary
   2. Review grievances quarterly to evaluate effectiveness of resolution process
   3. Complete annual summary report for presentation to The Ohio State University Wexner Medical Center Board.
   4. Submit patterns and trends to the Quality Management Department for possible incorporation into hospital performance improvement plan
   5. Recommend operational modifications to senior hospital leadership in the event an immediate correction is necessary as a result of a patient grievance.

Resources

Related Policies

03-23 Patient Rights and Responsibilities
04-05 Event Reporting

Related References

CFR §482.13 (a)(2)

Staff Reporting Resources

Staff may access the following resources on OneSource:

Complaint Management Database
Event Reporting Application

Patient Reporting Resources

Patients may choose to go directly to one of the reporting agencies listed below:

The Ohio Department of Health (ODH)
http://www.odh.ohio.gov/contactus.aspx
Complaints- Healthcare Facilities and Nursing Homes
246 North High Street
Columbus, Ohio 43215
Toll Free: 1-800-342-0553
TTY: 1-614-752-6490
E-Mail: HCComplaints@odh.ohio.gov

KePRO Inc. http://www.ohiokepro.com/aboutus/contacts.aspx Ohio KePRO Rock Run Center, Suite 100
5700 Lombardo Center
Seven Hills, Ohio 44131
Phone: 1-216-447-9604
E-Mail: webmaster@ohiokepro.com

Joint Commission on Accreditation of Healthcare Organizations
http://www.jointcommission.org
Office of Quality Monitoring The Joint Commission
1 Renaissance Boulevard
Oakbrook Terrace, Illinois 60181
Office of Quality Monitoring Toll Free: 1-800-994-6610
To File a Complaint: http://www.jointcommission.org/report_a_complaint.aspx

U.S. Department of Health and Human Services- Office for Civil Rights
Region V- Ohio http://www.hhs.gov/ocr Office for Civil Rights
233 N. Michigan Avenue, Suite 240
Chicago, Illinois 60601
Phone: 1-312-886-2359 TYY: 1-312-353-5693
To File a Complaint: http://www.hhs.gov/ocr/civilrights/complaints/index.html

Ohio Department of Mental Health
http://mha.ohio.gov/
Ohio Department of Mental Health
30 E. Broad Street, 8th Floor
Columbus, Ohio 43215
Phone: 1-614-466-2596 TYY: 1-614-752-9696
E-Mail: questions@mh.ohio.gov
For Information about Client Rights and Resources:
http://mha.ohio.gov/Default.aspx?tabid=157

Ohio Legal Rights Service http://www.olrs.ohio.gov Ohio Legal Rights Service
8 E. Long Street, 5th Floor
Columbus, Ohio 43266
Phone: 1-614-466-7264 TYY: 1-614-728-2553
For Assistance: http://www.olrs.gov/need-our-help

Applies to: OSUCCC – James

OSUCCC-James Patient Experience
For further questions regarding the hospital's policy on Patient Complaint Management, please contact James Patient Experience.
Phone: 1-613-293-8609 Toll Free: 1-866-993-8609
E-Mail: James.PatientExperience@osumc.edu

Contacts

Subject	Office	Telephone	E-mail/URL
Renee Jones	Patient Experience	614.293.8609	Renee.jones@osumc.edu

History

Issued: October 1991
Revised: September 2014
Submitted by: Patient Experience
Approved by: James MSAC September 12, 2014

PREPARED BY: Patient Experience

AUTHORIZED BY:

_____
Chief Executive Officer Date

_____
Executive Director for Administration Date

(APPENDIX VIII)

Bylaws Committee: July 9, 2014
MSAC: August 8, 2014
Medical Staff Vote: August 14, 2014
Quality & Professional Affairs Committee: September 24, 2014
Wexner MC Board: October 3, 2014
UBOT:

Arthur G. James Cancer Hospital and Richard J. Solove Research Institute
(as of June 6, 2014)

Governance edits:
Add Wexner to Ohio state medical center board.

Change professional affairs committee to quality and professional affairs committee in all applicable sections.

Change chart to medical record in two sections.

3335-111-07 Categories of the medical staff.

(8) Licensed allied health professionals:

(a) Clinical privileges may be exercised by licensed allied health professionals who are duly licensed in the state of Ohio and who are either:

(i) Members of the faculty of the Ohio state university, or

(ii) Employees of the Ohio state university whose employment involves the exercise of clinical privileges, or

(iii) Employees of members of the medical staff.

(b) A licensed allied health professional as used herein, shall not be eligible for medical staff membership but shall be eligible to exercise those clinical privileges granted pursuant to these bylaws and in accordance with applicable Ohio state law. If granted such privileges under this rule and in accordance with applicable Ohio state law, other licensed allied health professionals may perform all or part of the medical history and physical examination of the patient. Licensed health care professionals with privileges are subject to FPPE and OPPE.

(c) Licensed allied health professionals shall apply and re-apply for clinical privileges on forms prescribed by the medical staff administrative committee and shall be processed in the same manner as provided in rule 3335-111-04 of the Administrative Code.

(d) Licensed allied health professionals are not members of the medical staff but may write admitting orders for ~~, shall have no authority to admit or co-admit~~ patients ~~to~~of the CHRI when granted such privileges under this rule and in accordance with applicable Ohio state law. If such privileges are granted, the patient will be admitted under the medical supervision of the responsible medical staff member. Licensed allied health professionals are not members of the medical staff and shall not be eligible to hold office, to vote on medical staff affairs, or to serve on standing committees of the medical staff unless specifically authorized by the medical staff administrative committee.

No changes (e) through (k).

(APPENDIX IX)

Bylaws Committee: July 9, 2014
MSAC: August 8, 2014
Medical Staff Vote: August 14, 2014
Quality & Professional Affairs Committee: September 24, 2014
Wexner MC Board: October 3, 2014
UBOT:

Arthur G. James Cancer Hospital and Richard J. Solove Research Institute
(as of June 6, 2014)

Governance edits:
Add Wexner to Ohio state medical center board.

Change professional affairs committee to quality and professional affairs committee in all applicable sections.

Change chart to medical record in two sections.

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specifically authorized by the medical staff administrative committee.

No changes (e) through (k).