WEXNER MEDICAL CENTER BOARD

Leslie H. Wexner
Abigail S. Wexner
Cheryl L. Krueger
Hiroyuki Fujita
John W. Zeiger
Janet Porter
Stephen D. Steinour
Robert H. Schottenstein
W.G. Jurgensen
Cindy Hilsheimer
Michael J. Gasser (ex officio, voting)
Michael V. Drake (ex officio, voting)
Bruce A. McPheron (ex officio, voting)
Michael Papadakis (ex officio, voting)
K. Craig Kent (ex officio, non-voting)
L. Arick Forrest (ex officio, non-voting)
David P. McQuaid (ex officio, non-voting)
Mark E. Larmore (ex officio, non-voting)
Andrew M. Thomas (ex officio, non-voting)
Elizabeth O. Seely (ex officio, non-voting)
Susan D. Moffatt-Bruce (ex officio, non-voting)
Mary A. Howard (ex officio, non-voting)
William B. Farrar (ex officio, non-voting)
Martha C. Taylor (ex officio, non-voting)
Amanda N. Lucas (ex officio, non-voting)

Location: Richard M. Ross Heart Hospital
Ross Heart Hospital Auditorium

Time: 9:00am-1:00pm

Public Session

1.	Approval of April 4, 2018, Wexner Medical Center Board Meeting Minutes	9:00-9:05am
2.	Access, Affordability & Excellence: Building and Supporting the Next Generation of Physicians - Dr. Kent	9:05-9:30am
3.	College of Medicine Report - Dr. Kent	9:30-9:45am
4.	Health System Operations Report - Mr. McQuaid	9:45-10:00am
5.	The James and OSUCCC Update - Dr. Farrar, Dr. Pollock	10:00-10:10am
6.	Health System Financial Summary and FY19 Budget Review - Mr. Larmore	10:10-10:25am
7.	Recommend for Approval the WMC Standard Care Arrangement and Ratification of Committee Appointments - Ms. Krueger, Dr. Thomas, Dr. Thompson	10:25-10:35am
8.	Recommend for Approval to Enter into Professional Services/Construction Contracts - Mr. Kasey	10:35-10:40am
9.	Recommend for Approval to Purchase Real Property - Mr. Kasey	10:40-10:45am

Executive Session 11:00am-1:00pm

THE OHIO STATE UNIVERSITY

OFFICIAL PROCEEDINGS OF THE

TWENTY-FIFTH MEETING OF THE

WEXNER MEDICAL CENTER BOARD

Columbus, Ohio, April 4, 2018

The Wexner Medical Center Board met on Wednesday, April 4, 2018 at the Richard M. Ross Heart Hospital in Columbus, Ohio, pursuant to adjournment.

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Minutes of the last meeting were approved.

Dr. Thompson called the meeting of the Wexner Medical Center Board to order on Wednesday, April 4, 2018 at 9:00 a.m.

Present: Leslie H. Wexner, Janet B. Reid, W. G. Jurgensen, Cheryl L. Krueger, Abigail S. Wexner, Stephen D. Steinour, Robert H. Schottenstein, Alex Shumate, Michael V. Drake, Bruce A. McPheron, Michael Papadakis, K. Craig Kent, L. Arick Forrest, David P. McQuaid, Mark E. Larmore, Andrew M. Thomas, Elizabeth O. Seely, Susan D. Moffatt-Bruce, Mary A. Howard, William B. Farrar, Martha C. Taylor and Amanda N. Lucas. David B. Fischer was absent.

Dr. Thompson:

I'll convene the meeting of the Wexner Medical Center Board. I will note that a quorum is present. In order to conduct the business of the meeting in an orderly fashion, I would ask any sound on cell phones and other devices be turned off at this time. I would ask that all members of the audience observe rules of decorum proper to conducting the business at hand. First item on the agenda would be the minutes of the January 31, 2018, meeting of the board. They were distributed to all members. If there are no additions or corrections, the minutes are approved as distributed. Mr. Wexner, I turn it over to you and Dr. Drake for the next item on the agenda.

Dr. Drake:

The next item is Teaching and Learning: Medical Education and Service. Dr. Kent?

Dr. Kent:

Thank you. As you know, we always begin our meeting by highlighting a fantastic program that we have at the Wexner Medical Center, and I'm really excited about today's presentation. The theme of this board meeting is Teaching and Learning, and when you think about medical school, you imagine a classroom where a student learns anatomy and physiology or a hospital or ambulatory center where a student learns clinical care. But in today's world, being a medical professional goes beyond this — way beyond the health of an individual patient. Health care providers today have a responsibility to their community because we all know that a healthy community leads to healthy patients. So, in the College of Medicine at The Ohio State University, we teach our students how to support the health of their community. We have specific curriculum designed for this purpose. Medical students are asked to participate in community service curriculum that includes 30 hours in the first year of medical school, and then an additional 30 hours in the second year of medical school. Many of these students continue on in the third and fourth years of medical school with these initiatives. In fact, students from all of the health professional disciplines provide community service, including those in physical and occupational therapy.

Through our curriculum in the medical school, collectively, our students provide an amazing 20,000 hours of community service each year. That's an incredibly impressive number. The curriculum calls for our students to develop and implement specific health initiatives to assist underserved populations at community sites throughout Columbus and the state. On average, our medical students develop and participate in 30 community projects each year. Around the table, you have a booklet that shows all of the initiatives we developed last year and this year, a total of 60 different initiatives. These projects range from programs that target childhood obesity to creating paradigms that allow seniors to better navigate a very complex health care system. Through these efforts, our students touched over 9,000 individuals in the community each year. Again, an incredibly amazing number.

We have with us today four of our students who are eager to tell you about their projects, their teams that they've created and how they participated in the medical school curriculum. Please give a warm welcome to our students Kyle Smith, Grace Lartey, Jaron Hansen and Lauren Chen. Thanks for coming.

Mr. Smith:

Good morning, everyone. My name is Kyle Smith. I'm a third-year physical therapy student here at Ohio State. I'm here today to highlight the Ohio State Student Therapy Clinic, which is a pro bono therapy clinic run by physical therapy students under the supervision of PT faculty. All of our experiences in the clinic are part of the physical

therapy service-learning curriculum. How the clinic actually functions is second-year students are the ones actually treating patients in the clinic, while third-year students provide supervision and guidance during those treatment sessions. So this really provides a great opportunity for second-year students to get hands-on clinical experience, while giving the third-years a chance to take on more of a mentorship role and see patient care from a different prospective. The overall mission of the clinic is to improve lives by providing pro bono therapy services to those who are underserved and underinsured around the Central Ohio area. The clinic opened in 2015, in collaboration with PrimaryOne Health, and is located on Parsons Avenue. Being located in that area gives us a great opportunity to reach out to a wide variety of individuals around Columbus from different socioeconomic and educational backgrounds. Many of these individuals don't have the means to obtain sufficient health care or maybe have run out of therapy visits through their insurance companies. That's where we can step in and provide an avenue that may otherwise not be available to these patients.

During my second year there, I was lucky enough to work with a 45-year-old gentleman who was eight months out from having a stroke. He had used up all of his therapy visits through his insurance company, but was still really motivated to get better. He was living by himself, needed a cane to get around, had difficulty getting up and down his stairs and carrying his groceries, and was really struggling to complete all his daily activities. We were able to work with him for the entire year and saw great improvements. By the end of the year, he no longer needed his cane in his house, and he felt comfortable and safe with all of his daily activities. This is just one example of the kind of impact we can have on those who come to see us at the clinic, and it really provides us with a great feeling that we are reaching out to help the community.

This year alone, we provided close to 200 therapy sessions, which is a number that has grown each year of the clinic's existence. For me, personally, I'm just really thankful that Ohio State allows us, through our PT program, to be a part of this clinic and it has inspired me to continue treating this patient population going forward, as I graduate and move forward in my career. Thank you.

Ms. Lartey:

Hello everyone, my name is Grace Lartey. When I was 15 years old, back in Ghana, my mom told me the story of how she lost my twin brother seven months into the pregnancy, due to pregnancy-related complications for which she could not access health care right away. While this story encouraged me to go into health care, it also points out the fact that due to lack of access to health care, as well as cultural disparities, people of African descent have trouble accessing health care and do not usually get health care until it is a matter of life and death. As a result, when I moved to Columbus, I resolved to — through health care — do something about access to health care. I was fortunate enough to become a part of an organization known as Sisters Across Borders, where the main aim was to bridge the gap and health disparities through health care as well as screening for preventative medicine. As a medical student, I was fortunate enough to be in a place like Ohio State, which gives us the opportunity to impact our society through the community health education part of our curriculum.

As part of that, some of my classmates and I went and worked with Sisters Across Borders in the Ghanaian community here in Columbus. We were interested in cardiovascular disease, which as you may know is the No. 1 killer of people of African descent here in the United States. We organized screening programs where we screened for hypertension, high blood pressure and high blood glucose, which predispose people to cardiovascular disease. We also provided education on diet and exercise aimed at helping them improve their risk factors. Through this, an old lady who had recently emigrated from Ghana was able to find out that she not only had high blood pressure, but also had developed diabetes, having gone from being very active on her farm in Ghana to becoming sedentary while taking care of her grandchildren. We not only screened her for those things, but also got her connected to the health care system to prevent the further complications associated with her disease.

As a result, we were able to reach quite a number of people. This goes to show that people in these neighborhoods, as well as such backgrounds, actually do benefit a lot from programs such as the one that we organized, and I look forward to continuing this throughout my medical career. Thank you.

Mr. Hansen:

Hello, my name is Jaron Hansen. I am also a second-year medical student here at The Ohio State University College of Medicine. Like Grace, I had the opportunity to be involved in a community health education project. In 2013, a cooperative that included the city of Columbus and The Ohio State University known as Partners Achieving Community Transformation found that less than 60% of East Side resident adults achieved post-high school education, and as a result had the accompanying health and socioeconomic results. In 2015, this same cooperative launched a program known as Health Sciences Academies. This was implemented in seven East Side schools and with a specific focus on preparing graduates for post-high school education and careers, especially in the health sciences and health industries. This is a really exciting program designed to gear them toward these careers and provide some success in their lives. Our group had the opportunity to work at East High School and we went to the newly founded board there and proposed a program where we would bring young professional students from the health sciences to meet with these students. We met with about 20 students over about four months and provided some hands-on activities and interactive experiences with them.

For example, we shared all the instruments doctors use during a physical exam and for taking vitals and blood pressure, and they loved getting their hands on those tools and doing something they probably never thought they could do. In the beginning, a lot of the students weren't that interested, but as we were able to mentor them and be there for them, their attitudes really changed. They expressed a lot of confidence that they could achieve those kind of professions, that they could change their lives and do something like this. They were asking very interesting questions and type of questions like, "What can I do now to prepare? How will I know what would be a good fit for me? What can I do to get some help financially, to get some help academically, so that I can do this and be like you guys?" It was really inspiring to me and I'm happy that OSU gave me the opportunity to be involved in this community. As a future physician, I am very excited to take a more active role in my community and in shaping future health professionals that may just need an encouraging role model to succeed. Thank you.

Ms. Chen:

Hello, my name is Lauren Chen. I'm a second-year medical student at The College of Medicine here at OSU. Last summer, I had the opportunity to work on a community health project in collaboration with a nonprofit called Healthy Asian Youth. This program is an after school and summer program that provides a safe and environmental education for children from low-income families in primarily Cambodian communities around Franklin County. Since undergrad, I've really gotten to know these kids from my time spent as a teacher for this program's summer camp, and I realized that many of them lacked access to quality health care and education, and this puts them at a higher risk of developing unhealthy lifestyles and, later on, health complications.

Coming back as a medical student, one of my goals was to tackle these obstacles by implementing a series of workshops focused on nutrition, mental wellness, physical fitness and substance abuse prevention. Our data has shown that this initiative was successful and led to real behavior changes among the kids in the form of decreased amount of TV watched, decreased consumption of sugary beverages and an increase in reported amount of exercise. But, more so than the data, one moment that I want to leave with you guys from my experience was our workshop on mental wellness.

A group of the little Cambodian girls at the camp had recently lost their 12-year-old brother to suicide. When we did our workshop on mental wellness, we had all the kids practice self-relief strategies in the form of yoga, making stress balls and passing along written compliments to each other. At one point, we allowed all of the kids to share their experience with stress at home, or in the family, or at school. At that point, I thought the girls were really engaged in the activity and it was a very cathartic moment for them.

After the summer, our group wanted to continue building our relationships with the almost 80 kids at the summer camp, so we were able to establish a medical students' club and I'm happy to report that we've not only been able to continue our fun activities with the kids, but we are able to set up a health screening event and distribute personal hygiene kits to over 50 kids and their families. So, in the end, I am grateful and I'm proud to be part of a medical school that has afforded me the opportunity to continue my

passion for caring for the kids that I love, and helping them grow up to become advocates for their own health. Thank you.

Dr. Kent:

Thank you to all of you. I just want to re-emphasize a couple of statistics. The first is 20,000 hours of contribution by our students to the community each year, and 9,000 individuals in the community that are touched by these students every year. It is really impressive. I also want to recognize Deb Larsen and Dan Clinchot who are the genesis behind the curriculum that's been developed. Dan, would you like to say a few comments here as the person who really created this program and has moved it forward?

Dr. Clinchot:

Members of the board, I just want to thank you for having us here. As you can see, and in your book, if you look at some of the titles of the amazing things that our students do — they are a powerful workforce to fight against health disparities. They work with community agencies throughout Franklin County and southern Delaware County to really try to impact the lives of those less fortunate, and they make a big difference as evidenced here because we require them in the curriculum to actually study the impact of their efforts. Across the College of Medicine and the School of Health and Rehabilitation Sciences, we really, I think, make a huge difference for the community and instill that in the graduates that we have. Thank you.

Dr. Kent:

Thanks, Dan. We have time for a few questions.

Mr. Schottenstein:

I have a comment and a question. My comment is — these are four of 60 initiatives that represent outreach into the community; I've been involved at Ohio State for a long time, and I had no idea we were doing this. It's absolutely extraordinary. We talk about the importance of telling our story and properly marketing our achievements within the greater community, and I think that there's certainly a place for this to be told. I think it's just absolutely wonderful. The question I have is how common is this in colleges of medicine across the country? How old is this program here at Ohio State? You mentioned several years ago that we really ramped this up. If we looked at other benchmark institutions and their respective colleges of medicine, would we find this kind of outreach and engagement by the college?

Dr. Kent:

Great question. Dan, do you want to take that?

Dr. Clinchot:

There is no doubt, when you look at colleges of medicine, most have a requirement for volunteer activity. This is very different. This is service learning, where the students actually have a curriculum that supports it. We initiated this in 2012, and we were actually one of the leaders in this community health education project back then. We've produced workshops nationally to show other schools how to do it, and I would say there's no other school that has a program like this, that requires as many hours over two years to work through the entire process with a community agency. So we actually are bringing free work to those agencies to impact the health care of the people they serve.

Dr. Kent:

Dan is being only slightly modest. I think we're the national leader. It's something that's been very creative and I think we've been able to diffuse to medical colleges throughout the country. This is a really fantastic place to be.

Mr. Schottenstein:

It's outstanding. It's just really terrific.

Dr. Wadsworth:

Those were four great presentations, thank you, and they were all quite different. The education one, in particular, I'm really taken by because sometimes a simple intersection with somebody that introduces the vision for what could be is a turning point. My question is, as you meet all these people who need help, there must be occasions when great complexities arise as to the backgrounds they're in, the families they're in, maybe drug-related or violence — how do you deal with that kind of additional issue?

Ms. Lartey:

At least for the project that we were engaged in, it was not just a collaboration between Sisters Across Borders and The Ohio State University College of Medicine, but it also connected health professionals of African descent to those communities. So those people were still available to them. We connected them to the health care system through those people, as well as organizations like the Central Ohio Diabetes Association, who gave us the supplies as well as reached out to the people who were found to have some of these conditions.

Dr. Wadsworth:

The reason I ask is, we hear these tragedies about families and homes that nobody's aware there's a problem and it's just something to be aware of and how far do you carry that responsibility?

Dr. Kent:

The students are connected to the social network of Columbus and the communities that they're involved with so …

Dr. Wadsworth:

So there are places to turn.

Dr. Kent:

When they exit, there are others that continue on with the care.

Dr. Clinchot:

That's exactly right. For example, the current first-year students are working on some opioid projects with the Columbus health department. What happens is, as the students interface, they then know how to access free or low-cost resources and how to refer those individuals. So, it's not as if the students are out there alone on an island, they have their list of people who will help them.

Dr. Wadsworth:

Terrific stuff. That's great.

Dr. Kent:

Other questions?

Mr. Steinour:

Just one if I could? Do we sustain involvement over the years with these organizations or do you try and rotate with emerging needs?

Dr. Clinchot:

The specific criteria for these projects is that the students have to create it in a way that is self-sustaining by the actual agency itself, or something that becomes an ongoing project for students that they would pass on to the next year of students. We have a combination of both — some that the agency itself can continue to run; some that we commit our students will pick up the project, like the Health Sciences Academies.

Mr. Steinour:

It's remarkable work. Thank you all very much.

Dr. Kent:

Could I have another round of applause for Dan, Deb and our students?

Ms. Hill-Callahan:

Another way that we showcase the wonderful things that are happening at the Wexner Medical Center is by telling the story of our researchers. WexMed Live is a TED Talk-style event that the Wexner Medical Center does in partnership with the Alumni Association, and it's our opportunity to bring the Wexner Medical Center on the road to the community, to our supporters and to our friends. We've held five events, one in Columbus, Cleveland and Cincinnati and two in Naples. We've trained 17 faculty in this TED Talk style and we have shared 10 areas of research expertise. We wanted to bring a bit of WexMed Live to you today, so here is a quick snapshot.

Video Plays

What you may not have gotten from that video is the energy in the room from not only the presenters, but also the individuals who were in the audience. Following the talks, guests are invited to discovery areas where they are able to have a little bit of food and continue the conversation with the researchers.

I wanted to share with you one quick story about Dr. Ian Valerio. He is one of our surgeons. He is also a commander with the United States Navy Reserve. He had two tours in Afghanistan and he absolutely wowed the crowd in Naples. He was talking about his research and how he was inspired by our wounded warriors, and he shared stories through his research, about how patients are able to jump, walk and dance, and the crowd leapt to their feet when he spoke and were truly, truly inspired. It really sent a message to all of us that people need to know the story of our researchers at the medical center. To date, 800 individuals have attended these events. We've had 1,000 views on Facebook Live. We've been able to get our brand out to different constituencies that we wouldn't normally be able to reach. One thing that surprised us is how excited the faculty are to be trained in this new way of presenting and how, in the beginning, they're a little like, "That's not normally how I present my research," but by the end, they are grateful.

My call to action to all of you is that we are bringing WexMed Live to Columbus on June 13. There will be four presenters at the Ohio Union. Save-the-date cards have gone out, and we hope that all of you will be there.

Now, I would like to give the mic to Dean Kent to make a special announcement about a couple who has taught us a lot about many things, including philanthropy.

Dr. Kent:

Thank you, Patty. Today, I'm going to introduce a couple that I couldn't be more grateful for what they have given to our university and our medical center. More than 6 million Americans live with heart failure and about 8 million Americans have irregular heart rhythms. Patients with heart failure often have arrhythmias, and people that have arrhythmias have heart failure, so the treatments are really complex because of the interaction between these two diseases.

At Ohio State, we have probably one of the best electrophysiology programs in the country. It's one of the highest-volume programs and it's really fantastic. We also have one of the best heart failure programs in the country. It's nationally known and has had an incredible amount of innovation. We leveraged the strength of these two programs and created a unique, one-of-a-kind center that's focused on clinical care and research, and it intersects these two diseases. We believe that with this intersection and this center, which combines research in these two diseases, we'll be able to make dramatic discoveries. It's my pleasure to share with the board today a transformational gift by two generous donors whose relationship with The Ohio State University and the Wexner Medical Center can be accurately described as family.

They've become familiar faces to many of us, must notably Dr. Ralph Augostini, Dr. Peter Mohler, Dr. Tom Ryan, Dr. Bill Abraham, as well as myself. I'm pleased to introduce Corrine and Bob Frick and announce the creation of the Corrine and Bob Frick Center for Heart Failure and Arrhythmia. Bob and Corrine, would you stand up and wave to everyone?

Thank you for that applause, but I'm not done yet. Over the past year, I've come to know Bob and Corrine, and if there is anything I can say about these two individuals, it's that they are incredibly humble. The gift is being made from their hearts and with their belief that no patient should die of heart disease. This extremely generous gift in the amount of $18 million will move the needle in so many ways. The mission of the center that they've created is to provide collaborative, innovative and coordinated clinical care, research and education in the specialties of heart failure and arrhythmia. The funds will be used to support a large and diverse research laboratory with innovative technology. Three new endowed chairs will be created — the Corrine Frick Research Chair in Heart Failure and Arrhythmia, the Bob Frick Research Chair in Heart Failure and Arrhythmia, and the Bernie Frick Research Chair in Heart Failure and Arrhythmia. Last year, with the support of this gift, we opened the Frick Hybrid Electrophysiology Suite, which is one of the only dedicated hybrid operating rooms in the nation. And for those of you who don't know what a hybrid operating room is, in this procedural room, you can do a catheter-based intervention to affect an arrhythmia at the same time that you do open heart surgery. In fact, we've done quite a number of these innovative procedures since the opening of the room, and we're one of the leaders in the nation in this type of therapy.

Bob's late brother, Bernie — one of the research chairs is named in his honor — died of sudden cardiac arrest at the age of 60, after battling issues with arrhythmia for years. Bernie was an educator, adored by his family and missed dearly by his wife, Diane Frick. Diane and her four daughters are with us today as well as Amy, Bob Frick's daughter. Would all of you please stand and be recognized?

The Bob and Corrine Frick Center for Heart Failure and Arrhythmia will be transformational in advancing the care of patients with cardiovascular disease. As a result of this gift, I'm confident that progress will be made in the treatment of these two very severe conditions. Bob and Corrine, you're creating a future of cardiovascular medicine that will improve people's lives. People will live to see tomorrow because of the treatments that you've made possible. They will live to see their children and their grandchildren grow up because of the innovation that you created. The legacy you are leaving is truly remarkable. So, please join me in thanking Corrine and Bob for their generous philanthropy and their tremendous contributions to The Ohio State University.

Dr. Drake:

Thank you very much. We are fortunate to have a chance to work with many people in our lives and we are fortunate to have many supporters of this university. But I've had a chance to spend many hours with you, Bob and Corrine, over the last couple of years, and one of the things that touched me most about your support is that you are real people. You have worked to put yourselves in the position that you are in, and you have created the opportunities you have had to be able to contribute in the way that you do, by your own focus, work and values over the decades. I appreciate that very much. I also appreciate the thoughtfulness of your own research and how you have looked into what we can do as a university to make a difference. The pointed nature of your gift has identified and focused on areas where we can really make that marginal progress and take the step from A to A-plus. The reason you focused on this area in which to make us better is that you understand and can see the effect that this will have on people far beyond our vision, far beyond our horizon. There will be many, many thousands of people in our community and across the country who benefit from your focus and your hard work, your dedication and your generosity, and I want to say — on behalf of all of us — how much we appreciate your support and look forward to working with you for many years to come. Thank you very much.

Now, we have a report on the James and the Comprehensive Cancer Center. We will start with Dr. Farrar.

Dr. Farrar:

Thank you, Mr. President. I appreciate the opportunity to make some brief comments on what's been happening at the James over the past few months, and I'll be followed by Dr. Pollock. One thing that Dr. Pollock and I have tried to do since moving into our positions is in regards to communication. Both of us have had numerous meetings with not only faculty, but staff around the James, to see what issues we need to address in order to improve in the near future. We've also had great communication with Mr. McQuaid, Mr. Larmore, Dr. McPheron and Dr. Kent. We meet on a regular basis and it's been a pleasure getting to know them, but also getting to know and identify areas that we can cooperate and streamline operations for the entire medical center. Personally, I've been very pleased and honored to take part in those meetings and communications.

In regards to hospital operations, just last month, the James was awarded Magnet designation for nursing. This was the second time; the first time was in 2013. This is the American Nurses Association's highest and most prestigious distinction that a health care organization can receive for high quality of care, nursing excellence and innovation, and nursing practice. We turned in all of our required information last August, and this January we had a site visit from the Magnet team and we really just blew them away. They could not imagine how caring our nurses were to the patients and their families. They were impressed that 92 percent of our nurses had a BSN. And our nurses, over the past four years, published in 64 publications and they just raved about all of those attributes. Only 8 percent of hospitals obtain this designation, so we're pleased that the James was able to re-get this award.

Along the same line, our recent patient satisfaction scores have been outstanding. Our inpatient score was 98 percent, our ambulatory score was 94 percent, and I have to throw in mammography since I'm close to the Breast Center, and they had a 99 percent satisfaction score. It doesn't take many negative comments to bring down those numbers, so this speaks highly not only of our nursing staff, but also our faculty that take care of the patients in the James.

The other thing to talk about is our clinical trials. We have a great clinical trials team led by our Clinical Trials Office. This year, it appears that 19 percent of our patients will be put on clinical trials. That may not sound like much, but the national average is between 4 percent and 5 percent, so we do a fantastic job of putting patients on clinical trials.

The other thing that I want to mention, before turning it over to Dr. Pollock, is many of you have probably heard of our effort in digital pathology. Dr. Parwani was hired in 2015 from the University of Pittsburgh to head this program with Inspirata, the company that helped developed a lot of the scanners. Digital pathology is converting traditional glass slides into high-resolution digital images. So in the near future, pathologists will not be looking at the conventional glass slide — it will be on a computer. They call it the pathology cockpit, where they'll have a screen with the patient's information and the digital pathology and different diseases, molecular studies and everything.

This digital pathology makes turnover time a lot faster, so you may not have to wait six or seven days to get a report back, it may be back within 48 hours. It's also easy to get molecular studies. A good example is what's called the AQUA score, which is a test we use on breast cancer patients once they have their surgery to determine if they will benefit from chemotherapy. It takes three weeks to get that test back. If you're a patient waiting to know if you're going to get chemotherapy or not, that's a big deal. With this digital pathology, they feel that within a very short period of time we'll be able to do a very similar study with the molecular pathology and molecular studies, and we'll have that same information in two to three days. So that's just the type of research that's going on, and you're going to hear more and more about digital pathology in the coming years. It's really going to make an impact on how we treat patients and how effectively and quickly we can treat patients.

Just a couple other things. We're working very hard on two items — a strategic plan, which is occupying quite a bit of our time, as well as a West Campus ambulatory building. We're working on finalizing a lot of things for that. So there's a lot of activity going on at the James. I also just want to point out our development team. I was able to participate in the Buckeye Cruise for Cancer, which happened about two months ago, and it was a very successful cruise. Last year, they broke a record, raising $2.5 million on a five-day cruise, which is pretty outstanding. This year, they raised $3 million, so every year it goes up and I think that speaks highly of our development team, which really put on a

fantastic cruise. As you know, Pelotonia, is up and running. I'm sure we're all already signed up for Pelotonia, but if you haven't, please do. Also, our development team recently participated and attended the National Association of Cancer Centers Development Officers' meeting and our development team was recognized as having a banner year last year in terms of raising money. The final numbers aren't out yet, but the thought is that we'll be among the top five cancer centers in raising money, so they just continue to do a fantastic job. I'll quit there, my five minutes is up. Now, I'll turn it over to Dr. Pollock.

Dr. Pollock:

Bill, thank you for those kind words, and Mr. Wexner, I appreciate the opportunity to provide the board with a brief update on some of the things that have been happening in the cancer center itself. A very careful fund flow analysis was conducted over the past several months to look at how funds potentially flow from the James Cancer Hospital to the cancer center for support. It was certainly a learning experience and I appreciate Dr. Drake and Dr. McPheron conducting this. It enabled us to ultimately learn much about how this can be handled going forward, and it resulted in a very strong package of resources that Ohio State has offered in support of the cancer center and its research programs. I'm grateful to both of you for having conducted this and for making these resources available.

It is always a little bit tricky inheriting an administrative structure, so we have had to prioritize what our most important tasks are. We have created a committee within the cancer center that is aggressively pursuing the Cancer Centers Core Grant renewal, which will be site-visited in 22 months.

There are two strategic plans that are being developed. One is the larger university effort led by Gail Marsh. And then, one is in a little bit more granular detail for the cancer center itself over an even longer timeframe. We've created the infrastructure to do that analytic work and ultimately produce the written documents that demonstrate our conclusions. We have also completed the recruitment of our external advisory board. This is a 12-member group that provides us with direct advice on an annual visit basis, as well as in between. Ten of the 12 members are directors of other National Cancer Institute Comprehensive Cancer Centers including for the first time ever, the president and CEO of Sloan Kettering, who is graciously giving his time to be of help to us.

A number of faculty recruitments involving several colleges have been launched and some have been concluded, including the College of Engineering, the College of Pharmacy, the College of Veterinary Medicine, the College of Nursing and most importantly, the College of Medicine. I want to give Craig [Kent] and his associates credit. We have worked out very tight communication mechanisms. We are back and forth in person and with email exchanges on an almost daily basis to keep tabs on the many recruits that have shared interests that straddle the cancer center and the College of Medicine. This has been very, very important, not only in the retention of some very prominent senior faculty, but in terms of planning for recruitments going forward. Craig, I really appreciate it, it has made the job a lot easier, certainly.

Administratively, as Bill [Farrar] alluded to, we have created a new entity. We call it the G8 because there are eight of us and it straddles both the cancer center as well as the James Cancer Hospital. We meet every Friday morning for two hours to look strategically at issues and how we can best position both of these now separated administrative entities on behalf of the cancer program as a whole. We've also created a cancer center executive committee that meets for an hour before the G8 meetings, so Friday mornings are busy with administrative meetings.

Several new programs are now in the process of being developed, including a cancer immunotherapy center and a cancer engineering program that will pull on not only the College of Medicine but also the College of Engineering and others of the 11 colleges with which the cancer center has active faculty sharing in collaboration. I would like to acknowledge that the James Foundation Board has made a very generous commitment to helping fund the cancer immunotherapy effort going forward. So, it's been a busy couple of months, but I'm deeply enjoying the opportunity. I very much enjoy reporting to Bruce [McPheron] as my boss and Dr. Drake at the next level up and this has actually been a lot of fun. Thank you very much for the opportunity.

Dr. Wadsworth:

Just as a question of curiosity. You know that digital image processing, image recognition, automated counting has been around quite a while. I was wondering what the particular challenges are with the molecular study that you're researching — is it irregular-shaped statistics?

Dr. Farrar:

I'm not sure. Right now, they have gone back and copied or scanned about 500,000 slides on 39,000 patients.

Dr. Wadsworth:

It's not a question of starting or … it's not the process of doing the imaging, it just hasn't been addressed up to now?

Dr. Drake:

A lot of it, Jeff [Wadsworth], has been moving from the 20th to the 21st century. The technology has been there for quite a while in different ways. But adapting it to pathology slides, getting the right slide collection, making those things available in a way that an average pathologist can use them in his or her practice on a regular basis, has really been a change in the culture. What made you a great pathologist in the past was what you carried in your brain and how you could look at the slides faster and better than somebody else. Now what you can do is have — on digitized slide banks — the best examples in the world of what you want to look at, and compare those side-by-side with the material from which you wish to make the diagnosis. And you can have the most recent studies nearby to help you in choosing the right diagnosis and ways that you might guide the therapy going forward. So it's pulling all of the things we have together into a place where the pathologist has them right at his or her fingertips, and then it's constantly updated — like a Google Maps sort of thing — that lets you know which way you can move forward fast.

Dr. Wadsworth:

So that's consistent with other histories, where the human ability to recognize something … it has taken a long time for the digital process to accurately repeat that.

Dr. Drake:

Right. So there is the concept of the robotic system being able to get a pretty good idea, but then layering over that the aspects of judgement and nuance, which are the aspects that the pathologist offers.

Dr. Wadsworth:

Thank you.

Dr. Farrar:

It has become a very good tool for helping other hospitals, not only around this area, but also across the country and internationally. It used to be if a pathologist in China couldn't identify something, and there's an expert in the United States, they'd have to mail the slides over. Now, in a matter of minutes, the pathologist can look at the slides on the computer, call that person back, and have a conversation to make a diagnosis a lot quicker.

Mr. Schottenstein:

I have a question for Dr. Pollock. First of all, both reports were great reports. Your leadership is very much appreciated on all fronts. This is a governance question about this external advisory board you mentioned that's in place for the comprehensive cancer center. Briefly, could you explain to us, did we have that before? And if not, why not, and what will be the role of this board? How do you see them functioning going forward? What sort of a big picture will they play in the journey of our cancer center?

Dr. Pollock:

We did have such a board before, but there's always turnover in the membership. About two-thirds of the members of the board needed to be replaced. They function as a peer group, if you will, to give us very specific advice, particularly about the Core Grant and how we should position programs within the Core Grant. But also, it's an informal network. We have many questions that will come up where we want input from other cancer center directors about some of the day-to-day operational issues, strategic issues and interfacing inside the beltway. Those types of questions become very important. So having a ready group of peer experts who you can turn to for advice, and who turn to you for advice, positions us as an institution with a cancer program that has very high national visibility.

Mr. Wexner:

Everyone, I think, communicates the appreciation of the university and the medical center board. Both of you came into a very tense situation, and the fact that you both understood the university hospital system and the cancer hospital, and in such a short period of time had grabbed it by the horns and are leading so effectively, is very appreciated. The quality of your leadership is most appreciated, the quality of your report is appreciated, and anything that we can do to help you be more effective, speaking for the board, we are at your disposal. So, Bill and Raph, thank you very much.

Dr. Pollock:

Thank you.

Dr. Drake:

Thanks very much, appreciate it. College of Medicine, Dr. Kent?

Dr. Kent:

I'll begin by expressing my enjoyment and appreciation in working with both Bill and Raph. It has been tremendous. We have these Thursday afternoon meetings and we get so much accomplished, it's incredible. I get great advice about the college and I'm able to provide insight to the cancer center, and it has been a really collaborative relationship, so thank you both for allowing that to happen.

For the College of Medicine report, I have a couple of things. The first is that you remember, probably several board meetings ago, Dr. Fujita asked, "What do you do well at the Wexner Medical Center?" He asked us to come up with a list of our research programs that were nationally known, visible and in our top group. At our last board meeting, we handed out that list, and I hope you've had a chance to review and see that we're excelling in a number of really fantastic areas. For this board meeting, we created a separate list, which is of our top differentiated clinical programs, or what we'll call clinical programs of distinction. I think you all have this list in your board books. There's 14 programs, and I'm sure I'm in trouble with someone because you know there's one that I didn't include, so consider this a work in progress. As some of our other programs continue to grow and become nationally recognizable, we will certainly add to the list.

It was an enjoyable process to create this list. The first thing we had to do was create a definition of what we would think of as a clinical program of distinction, so we used a number of different criteria. The first is volume. One of the things that's very clear is the more you do of something, the better you are at it, and there are quite a number of different diseases and treatments that we have incredibly high volume. A second area that differentiates a program is one where you have a certain technical expertise. For example, our electrophysiology program, we do over 5,000 procedures a year, and our EP interventionists are extraordinarily talented and have better outcomes than the average interventionist just because of the high volume and the skill that they've created.

A third area that differentiates the program is the ability to integrate research, or clinical innovation, along with clinical care, and we do that very well and it's really a center point to many of the programs that we've included in the list. So, please have a chance to review the list, you know I'm available to have conversation about any of these programs, but we're very proud of all of these programs and the leadership that's been able to create this for the Wexner Medical Center.

Now I'm going to move on and tell you about one of those programs. At each of our board meetings, I like to feature one of our research or clinical programs. This time, I want to talk about our Robotic Surgery program. Innovation is a key part of our strategic plan, and robotic surgery is a very innovative technique that's being used at a number of centers around the country to provide a level of very differentiated care. There is no doubt that our robotic program at Ohio State is a national leader. You may or may not know much about robotic surgery, so we will play the video that will give you a sense of what it's all about.

Video Plays

It's somewhat of an alien concept that the surgeon is not next to the patient, right? There's almost a Star Wars sort of element, moving the levers and the operation is going on maybe five or six feet away. As you can see, though, our surgeons do it very well. So why has robotic surgery been an advance? There are a number of different reasons. One is that with many types of procedures that the robotic surgeons perform, there are fewer complications, and the death rate is actually reduced in these kinds of minimally invasive interventions. A second reason is because it's less traumatic. The length of stay is reduced, the number of long-term complications is diminished and people can return to work at a faster rate and be able to resume their normal lives.

The other point that was alluded to in the video is that you can get into smaller spaces. If you could imagine operating on the larynx — that's the place right between the mouth and the trachea — and if you wanted to approach that from the mouth, it's pretty hard to get at, unless you have very, very fine instruments, which a robot provides. So our ENT surgeons, one is sitting next to me now, have become experts at laryngeal surgery using a robot, which really differentiates us nationally in terms of what we can perform.

If you look at our specific program at the Wexner Medical Center, we have a total of 40 surgeons that represent 11 different specialties that are involved in the robotic program. Two-hundred residents or fellows each year are trained by our robotic surgeons, so these people come from all over the country to learn these techniques. Over the last 10 years, the robotic surgery program has expanded into one of the highest volume programs in the country. In 2012, we did over 1,600 cases a year, which put us second worldwide. Over the past five years, that number has continued to expand, and now we do 1,900 robotic procedures at the Wexner Medical Center each year. Our current volume puts us in the top five of all academic medical centers in the country. Our surgical training program is best in class. In fact, every year we have several institutions, this past year it was Dartmouth and UCLA, that come to visit us and see how we train our surgeons.

We have research efforts that are ongoing. We're constantly trying to expand robotic surgery so that we can use it in other spaces and techniques and in different diseases. We're also in the process of developing new instruments and techniques for the existing procedures. In February of last year, OSU hosted a symposium called the Integration of Robotic Surgery in Academic Medical Centers, and over 200 surgeons and administrators from various parts of the country came to Ohio State to learn how to be successful in robotic surgery. We are fortunate today to have the program's leader, Jeff Fowler. He is a professor in the Department of Obstetrics and Gynecology, and it's really Jeff's innovation and his 40 surgeons that have made this program tremendous. So Jeff, would you please stand and be recognized by the board?

That concludes my report, and I'm happy to take any questions.

Dr. Reid:

Robotic surgery is just amazing. You know, pretty soon, hips, shoulders and all that will be done through robotic surgery. But I know one of the research areas has been to try to get tactile sensation, so that when you're operating and moving those tools around, you can actually feel if a tumor is firm or soft. Are we doing that kind of research?

Dr. Kent:

Jeff, do you want to take that question?

Dr. Fowler:

Thank you, I appreciate that Dr. Kent. It's really a team effort. This type of complicated surgery requires a lot of support. The reason we're successful is a lot of experienced surgeons that are homegrown here and the teams that support them, and so that's what the program supports.

To answer your question, which is excellent, the visual enhancement in high-definition 3D really overcomes a lot of that lack of haptic feedback, which is the ability to feel. So you can see what you're doing and with experience, you can tell how hard you're pulling on things and whatnot. To your point about consistency of a tumor, and feeling that that still needs further development — each few years, there are progressive advancements in the technology, so we have increasingly better ability to perform more complicated procedures and have the tools that you're mentioning.

Dr. Reid:

Thank you.

Dr. Wadsworth:

I'm familiar with the da Vinci Surgical System. Do you have other machines? Are other machines starting to compete with the da Vinci, which has dominated the field, I think, for many years? Just curious about the competition space for developing new tools.

Dr. Fowler:

The only vendor for the procedures that Dr. Kent mentioned is Intuitive Surgical, which makes the da Vinci Surgical System, and they've been out since the late 1990s and the early 2000s. There's a lot of chatter or discussion about other big companies being out there, but we really haven't seen even their beta products yet. One of the big problems is that the individual robotic system that you saw is, it's not one patent, it's hundreds of patents within it, so it's very complicated. So we don't have a competitor yet. It'd be nice as far as cost; it's a very expensive system. There are other robotic technologies used in medicine and orthopedic surgery for separate types of procedures or robotic-automated technology, you mentioned digital pathology. As far as the procedures that Dr. Kent was speaking to, it's Intuitive Surgical only.

Dr. Wadsworth:

I know they survived a class-action lawsuit last year through the claim that there were tiny metal particles that were moving around. That was a big case, but it's a wonderful machine and congratulations on having so many people involved in it.

Dr. Kent:

I do think it's a matter of time, though. There will be other technologies that come along.

Dr. Wadsworth:

I thought the Canadians were developing a competitor.

Dr. Kent:

Oh, I think there's a number of different innovations that are underway. I suspect within the next three or four years, it is Intuitive Surgical that we will see competition, which will be great because it will lower the cost. The machine we currently have, though, is tremendous as you can see from the results.

Dr. Wadsworth:

Yeah, and we were involved in the software development of the early machines at the Oakridge Lab, by the way.

Dr. Porter:

What we know with robotic surgery, too, is that it's not the robot. It's really the skill of the surgeon doing the procedure, and that volume matters in terms of outcome, right? So tell me about the credentialing process you have to assure that your 40 surgeons are doing a minimum number of procedures and becoming facile so that outcomes really do improve.

Dr. Fowler:

That's an excellent question. Nationally, that's a big issue and has been an issue of litigation either against the company or individual surgeons. So it is a big issue and a tough health system responsibility. Here at Ohio State we have specific credentialing criteria, even for the students that come into the room. We have credentialing criteria for the surgical trainees, the residents or fellows. They have to pass computer simulation tests, online tests, and sit in didactic live and dry labs. For the attending surgeons, they have to be credentialed to perform the analogous surgical procedures, open or laparoscopic. In other words, via some other technique other than robotic. The attending surgeons also have to go through prescribed online and on-site live training course on animals or cadavers. And then, we have to go through at least five proctored procedures where a surgeon with experience is watching them do the case.

Dr. Kent:

It is a very sophisticated process, but we're the place where people come to train. I would say we are probably one of the top centers in the country in terms of training, where people will come to learn robotic techniques. So I think your surgeons are pretty well credentialed.

Dr. Fowler:

Yes, fortunately, we have great staff at Ohio State and that helps a lot in those regards.

Dr. Kent:

Well, thank you. Another round of applause for Jeff, and that concludes my report.

Mr. Wexner:

David?

Mr. McQuaid:

Yes, good morning, everyone. I want to spend my time this morning in the operations report to continue on the theme of teaching and learning, and to spend some time in the graduate medical education space. Across the country, 120,000 residents and fellows train in our medical centers and health systems. Here at Ohio State, we have 886 residents across 142 programs. I've asked Dr. Scott Holliday to join me this talk about what's referred to as the Main Residency Match, and how we recruit residents into our programs and talk about that big day in March every year. That's exciting for graduating medical students and we have some great and interesting statistics on that. Importantly for the health system, these residents are on the front lines of patient care. In their learning through our teaching and training, they have to be able to cite quality and safety issues, and they need to intervene as appropriate. They need to be able to work on interdisciplinary teams and, for example, learn transitions of care. So we take deep pride in the training that we give our residents and that clinical learning environment is really, really important.

I've asked Dr. Holliday to spend a little bit of time talking about how, through the Accreditation Council for Graduate Medical Education, we just went through a clinical learning environment review. Dr. Holliday is the associate dean for Graduate Medical Education and he's also a clinical associate professor of both internal medicine and pediatrics. Scott?

Dr. Holliday:

Thank you for the time to chat with you today. For those of you who are not familiar with the match process, it is a pretty exciting time when everyone across the country learns their fate when it comes to residency and fellowship training programs. Our medical students receive letters, and they all open them at the same time across the country, and everyone finds out where they're going and where the computer has matched them based on their interviews and their preferences through the process.

We are excited to share that we had an outstanding match this year. We had set some metrics around match this year and the quality of applicants that we're attracting here. As we look at attracting applicants, we are competing with all of the other institutions to get the best and the brightest across the country. We set a goal of getting at least 27 percent of our new residents and fellows across the institution who were either from a top 30 *US News & World Report* top research institution or Alpha Omega Alpha, which is the national honors society for medical schools across the country. We met and exceeded that goal. We had 29.3 percent of our new incoming residents and fellows who met those metrics.

In addition to that, we also had a lot of other great qualities in some of our other applicants, from members of the Gold Humanism Honor Society and folks who have demonstrated great interpersonal and communication skills. We have attracted many people from Ohio who will likely stay in Ohio and take care of our patients and our communities here in the state. And then, lastly, we reached out more broadly across the country. Each year for the past several years, we've actually increased our reach of residents from outside of the Midwest, so we are starting to show a lot more penetration of our residents coming from outside of the Midwest. So we are really starting to show our national presence in graduate medical education.

As Mr. McQuaid mentioned, I'll also talk about the clinical learning environment. We had a review from the ACGME, which is the Accreditation Council for Graduate Medical Education, just a few weeks ago, March 13th through the 15th. What they do is they come here and they look at our institution — and they do that with all of the institutions — to show how we can put a mirror up to us and let us see what we're doing well, but it also pushes us to do a little bit better. The goal of the program is to encourage six focus areas. First, patient safety, so how well we're keeping our patients safe while they're here getting excellent care from all of those potential pitfalls that could happen, whether it's medication errors or communication errors, or other things that may impact the care of the patient and safety. The second metric is health care quality and health care disparities. They look at how we're teaching the next generation of physicians to understand that data is important when you're managing patients, and the importance of applying that data and improving based on what you know.

Supervision of residents and fellows, what is our landscape around supervision? Transitions of care, so when patients are traveling from different areas of our hospital, from the ICU to a medical-surgical floor, or from the OR to the PACU. How is that communication made so that we're ensuring our patients are kept safe, and that the high quality of care continues as the patient moves throughout our system? But also, how do we ensure that we're providing excellent communication as providers change at end of duty shifts, etc.

The fifth category is wellbeing, and that's a new category for the ACGME and not something that had been stressed in the past. This was brought on by a lot of literature that shows burnout rates among physicians, residents and fellows, as well as other health care professionals, has continued to increase. We've sadly seen institutions who have lost multiple residents and fellows in the span of a year to suicide, so it's not a light issue. We want to make sure that we're paying attention to wellbeing. And finally, the last issue that they look at is professionalism. When they come and do these site visits, they're designed to be formative, so they come in very frequent cycles. So, every 18 to 24 months, the ACGME comes in with a team to give us a very thorough, kind of quick biopsy of our environment and the learning environment and how we're meeting expectations in those six areas. It's not really a site visit that anyone ever aces. It's designed to push us to not sit on our laurels and continue to be the best that we can.

We had had our last site visit back in July of 2016, and we focused on a few areas in response to some of the feedback we received then. We focused on how we onboard our new residents and fellows, indoctrinating them into quality and safety and cultural

changes and expectations for our trainees. We spent time on quality improvement education, making sure that they understand the importance of data to their regular, daily clinical habits, and providing some resources around support and wellbeing.

We had our site visit a few weeks ago, and I'll quickly go through those six focus areas and what they identified as some of our successes. On patient safety, they commented a lot about how our priorities were very aligned. They met with residents, they met with fellows, they met with faculty members, they met with nurses and they really talked about how people were on the same page and aligned around the corporate enterprise scorecard around areas that we want to improve in patient safety. They saw that our residents had a strong working knowledge of safety science and were able to really have in-depth conversations when it came to things like root-cause analyses and things that really allow them to demonstrate firm knowledge and working knowledge in health care or in patient safety. And they saw that we've increased in our resident and fellow reporting of safety issues and concerns, and good catches to prevent issues across the institution. Certainly, as they identify successes, they also identify opportunities that we have to improve. One of the things they mentioned in the area of patient safety was looking at how we share local fixes. We're an institution where folks are very busy and when they have a problem, they want to find a local solution that fixes the problem, and they do a great job of that. But how do we help share that knowledge from that local fix so that others in other units who might be experiencing the same issues learn to improve as well? And how do we increase opportunities for experiential learning for our residents and fellows, getting them involved in projects and committees or activities while they're busy with other clinical activities?

In health care quality, some of the successes they identified were residents and fellows again had a great working knowledge of quality improvement and had some good exposure to the quality improvement process. They saw where some of our programs were providing great data on health care quality and the care they're providing, and really, we got the opportunity to highlight some of our healthy communities work around health care disparities and areas we're trying to improve within the community. They identified some opportunities we have for better integrating residents and all of our front line staff into some of those quality improvement initiatives. When you think about a lot of the work that's done in our quality improvement area, it is done in committee work and in meetings during the day when folks are taking care of patients. So it's important to try to find ways to pull all those front line care providers, like the residents, fellows, nurses and busy young clinicians, into those discussions and share their expertise and their experiences to help things improve.

When they talked about care transitions, they saw that we very effectively communicated around patient transitions from place to place when patients were going from the OR to the PACU, or other areas within our institution. And they commented on our crew resource management and our simulation training around team-based communication, and saw that as a way to continue to push forward effective team communication. They also saw that we had some opportunities where some of our folks demonstrated expertise when it comes to communication at the time of handout between providers. We could share some of those best practices across other areas to improve some of that communication.

Around supervision, they saw that residents felt adequately supervised. In fact, in some situations, they felt over-supervised — not surprisingly there — and they felt the faculty was very accessible to the needs of the residents and fellows. Some of the opportunities we saw in that area, from the information they provided, was that we need to look at mitigating some of the supervising challenges, when faculty members are providing care in clinical settings away from the medical center. So at some of our distance sites, how do we coordinate that so we have better oversight over the residents? And then, as we look at a busy institution with high acuity and high volume of patients, we also want to look at how we better counterbalance work intensity with wellbeing, and how do we monitor that for our trainees moving forward, to set them up for their future?

Moving to wellbeing, the next area, they saw that we have been doing small pilots to improve resiliency amongst residents. We have reduced burnout in those small groups by about 22 percent in some of the earlier inventions that we have been involved with. They saw some of our resources from our GME Ombuds Program, and our stress, trauma and resilience program in our employee assistance program to help support folks that are having challenges in the workplace. And then planning around our medical center-wide health and wellness program. We're able to talk with Dr. Gabbe as well as

some of our other members of the team that's working on how we roll out a better support system for our entire medical center.

So, for opportunities, they saw that we need to continue to work on that program and really bring that to the institution, and also provide some screening tools for identifying early at-risk individuals. And finally, the last piece was on professionalism, and they saw that we had done a lot of work around professional behavior in the onboarding of our residents and fellows. They felt we were doing a great job when it came to mitigating and intervening when unprofessional behavior relapses did occur, in rare situations. In other opportunities, they felt that increasing some of our inter-professional activities would be beneficial for community and teamwork across teams.

Mr. McQuaid:

Great. Any questions for Dr. Holliday?

Dr. Drake:

In looking at things like average length of stay and operations in the hospital, one of the places where the residents are particularly critical is in things like timely submission of orders to keep the whole flow going. So it's an important addition to their education and their patient care for them to understand operations, so that it doesn't gum up the works. It's good to see that we're working on it.

Mr. McQuaid:

Yeah, I just want to thank Dr. Holliday and the entire faculty that has spent so much time in the area of teaching and learning for this next generation of clinicians. Their deep commitment to their success is palpable, and their energy and their thought and the time they put in is critically important to us. So I'm very grateful to you, Dr. Clinchot, and the team in the educational space. Thank you very much.

Dr. Drake:

Great, and now we're on to Mr. Larmore.

Mr. Larmore:

Good morning, everyone. I'm pleased to report our financial results as of the end of February, eight months through our year. My first slide has four statistics. As you can see, our admissions and surgeries continue to track ahead of our budget and prior year. To highlight on the surgeries, you can see almost 30,000 surgeries through eight months. About 40 percent of that is on the inpatient side and 60 percent on the outpatient. The good news is our inpatient surgery, year-over-year, has grown 5 percent and our outpatient is up about 0.5 percent. So the focus on bringing more elective surgeries in-house is turning out well.

Our outpatient visits are growing year-over-year, just slightly behind our budgeted number. On the bottom right, our worked hours per adjusted admission is actually up three hours over the prior year, and one over our budget. The main driver here is we have been struggling this year with length of stay. But I am happy to report, although we've not closed the books for March, that our length of stay in March was the best that it has been all year, so there has been a lot of focus on that.

On the next slide, operating revenue is running 2.8 percent above budget and 10 percent above prior year. The good news is that our controllable costs year-over-year are growing at 8.5 percent, which yield our margin. You can see that we're actually running 12.8 percent ahead of budget and 43 percent ahead of prior year. So, we did anticipate most of that in the budget, but we're actually tracking ahead of that. And then, as we continue to plan for the major capital program that we have coming on board, you can see that days cash on hand year-over-year has grown from 120 days to 144 days, or an increase of about $225 million in cash, so good results there.

The next slide is for the health system. There is a $155 million bottom line compared to the budget of $137 million, so we are $17 million ahead of budget. We were at $108 million last year, so we are $46 million ahead. You can see some variances went to our budget, which is good news actually. Our revenue is running $54 million ahead and our

volume is ahead, so we're spending a little bit more on salary costs. As we're bringing new beds online, the challenge of how fast we can hire always exists. So, there's a little more spend on agency nurses than we had anticipated. The big number below that is the drug spend, and clearly as the cancer program continues to grow on the ambulatory side, the last two to three years we've seen significant increase in drug pricing, especially in the cancer field, so we're seeing that. But that expense actually yields revenue, so it's an explainable variance. A couple of new treatments have hit the market in the last year, which have put a strain on the expense side, but we are dealing with each one of those. The cost of these therapies or drugs are so high that we're actually having to negotiate case-by-case with the insurance companies to make sure we get paid for them. So there's an administrative burden for that, but so far, it's going well.

The next slide is the combination of all three enterprises. Each one of the business units is showing a financial improvement year-over-year. The margin rate in the business unit varies, but it varies in all medical centers. My challenge to each one of the operating officers is to improve their bottom line each year and we're seeing that this year, so that's great news.

The physician practice is running about $8 million ahead of target, a little soft on the revenue side but the expenses are running below target. The College of Medicine is running about $4.6 million ahead of where we had expected. Net at the medical center combined is about $30 million ahead of where we had expected to be. The last slide is the balance sheet, and again this is the medical center, so all three entities together. All good news. I spoke about the growth in cash; we continue to pay down debt. Since the beginning of the year, we've paid down $39 million of debt and our net assets have grown about $185 million. So, all in all, positive results on the balance sheet.

I'll take any questions that you have on the financials.

Mr. Steinour:

A great job, obviously, on this. I know there have been a number of initiatives and the entire team has been involved in delivering those initiatives. There have also been some payer challenges, which periodically we've had conversations around. I don't know if, either on the initiatives side or on the challenge side, there's some information in this session that you'd want to share.

Mr. Larmore:

Most of our commercial contracts we try to do in three-year increments. We are in negotiations with two of our large payers currently. Each payer always feel that they pay us too much money, and we always feel like we need increases from them. We talked a lot earlier in the meaning about data, and who has data, and how much data is out there. The large insurance companies have data now and with all the coordination of benefits, it's hard to keep a secret what your rates are between your payers. So, part of our challenge is making sure that we keep all of our commercial carriers in line, because they actually feel it. As they lose a contract with a large employer, they feel that it's because they're paying too much and the health systems are giving other payers better rates. So, it's a challenge we deal with every year, but it's all good. A work in progress.

Mr. Steinour:

You've just done a terrific job, Mark [Larmore] and the finance team. The coordination and collaboration that's going on across the enterprise now is very much appreciated. Obviously, these are outstanding results and that's coming off a record year. To see a plus 10 off a record year is very unusual, so congratulations to the entire team.

Mr. Larmore:

Definitely a team effort.

Mr. Wexner:

Jay, you have a couple of proposals to make to the board?

Mr. Kasey:

Yes, thank you, Mr. Wexner. The next two items on the agenda support the university and the Wexner Medical Center's strategic plans to create innovative health care delivery models. We're requesting a recommendation to the University Board of Trustees for approval on both items, which are on the Finance and Master Planning & Facilities committee agendas this week.

The first item is a request to acquire vacant land for development of additional ambulatory care facilities in Franklin County. The proposed property is located on the southeast corner of State Route 161 and Hamilton Road in Columbus. The total land area is about 31.5 acres. The site is zoned commercial planned development and the university has filed a rezoning application to obtain entitlements allowing construction of medical facilities. The acquisition price is $11 million and is consistent with being below two appraisals, which the university received for the same property.

APPROVAL FOR ACQUISITION OF UNIMPROVED REAL PROPERTY

Resolution No. 2018-78

LOCATED AT STATE ROUTE 161 AND HAMILTON ROAD
IN FRANKLIN COUNTY, OHIO

Synopsis: Authorization to purchase approximately 31.59 acres of unimproved real property located at the southeast corner of State Route 161 and Hamilton Road in Columbus, Franklin County, Ohio, is proposed.

WHEREAS the property is located at the southeast corner of State Route 161 and Hamilton Road in Columbus, Ohio; and

WHEREAS the property will be utilized for the construction of an ambulatory care facility, which is a key component of the Wexner Medical Center's strategic plan; and

WHEREAS the acquisition will be contingent upon the university obtaining entitlements allowing construction of medical facilities; and

WHEREAS it has been recommended by the Office of Planning and Real Estate, in coordination with the Wexner Medical Center, that the university purchase the land; and

WHEREAS funds for the acquisition will be provided by the Wexner Medical Center:

NOW THEREFORE

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

BE IT FURTHER RESOLVED, That the president and/or senior vice president for Business and Finance be authorized to take any action required to effect the sale of the property and to negotiate a purchase contract containing terms and conditions deemed to be in the best interest of the university.

Dr. Drake:

I would like to make a comment. We appreciate the support that we receive broadly throughout the community and, in this particular case, we really appreciate the contribution that the Wexners are making of real property to make it possible for the university to move forward. That gift is a very important part of this and we appreciate that support so much, so thank you.

Mr. Kasey:

The second request is a recommendation to the University Board of Trustees for professional services to begin the actual design of the facilities anticipated for the regional ambulatory site that we just described. This is a $4 million request, which will allow for design through design development of a community-based ambulatory center. The program is approximately 200,000 gross square feet consisting of ambulatory surgery, endoscopy, primary care, specialty medical and surgical clinics, and related

support services. The design, with adjustments, may also be deployed on future ambulatory sites as the medical center moves forward with its strategic plans. Those are the two requests at this time.

APPROVAL TO ENTER INTO PROFESSIONAL SERVICES CONTRACTS

Resolution No. 2018-79

WEXNER MEDICAL CENTER REGIONAL AMBULATORY FACILITIES

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

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

	Prof. Serv. Approval Requested	Total Project Cost	
WMC Regional Ambulatory Facilities	$4.0M	TBD	Auxiliary Funds

NOW THEREFORE

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

BE IT FURTHER RESOLVED, That the president and/or senior vice president for Business and Finance be authorized to enter into professional services contracts for the project listed above in accordance with established university and state of Ohio procedures, with all actions to be reported to the board at the appropriate time.

Dr. Thompson:

I'll entertain a motion to recommend both of these resolutions to the University Board of Trustees. And I will now call the roll.

Upon the motion of Mr. Schottenstein, seconded by Mr. Shumate, the Wexner Medical Center Board members adopted the foregoing motion by voice vote. Mr. and Mrs. Wexner abstained.

Dr. Thompson:

The motion carries. The next item on the agenda, Ms. Krueger.

Ms. Krueger:

Thank you. Last week, the Quality and Professional Affairs Committee met, which is also known as QPAC, to discuss a variety of items. Beth Bolyard walked us through a detailed look at the amendments to the bylaws and rules and regulations of the medical staff at the UH and the James. Members of QPAC voted to approve these amendments. To give you a little more detail, I've asked Dr. Thomas if he would give us a brief overview.

Dr. Thomas:

Thanks, Ms. Krueger. There are two separate medical staffs within the medical center, due to the need for the James PPS exemption, so we have two different sets of bylaws and rules and regulations. However, we have one joint bylaws committee, so a lot of those items are parallel in both sets of bylaws. We try to move forward and group the changes together when we do this. These amendments have been reviewed by the bylaws committee as well as the individual medical staff administrative committees for the James and University Hospitals, and then as Ms. Krueger mentioned, this resolution was approved at a meeting of the Quality and Professional Affairs Committee.

Many of the changes, which you have in your packet — it's a document that's 43 pages long — many of the changes are really housekeeping items, changes in titles, changes in structure. There are a couple of key items. One relates to the retention of medical records. You could imagine, in the olden days when we did not have electronic medical records, we needed to keep paper charts for an extended period of time. We used to keep those for 21 years, and what had become the industry standard is we rent a large warehouse to store them in. What has become a national standard is to have a 10- year retention policy. This change will allow us to move to a 10-year retention policy. For minors, however, we do retain them for the full 21 years, age of majority, plus a couple of years just for legal purposes. Obviously, with electronic medical records, each year then we're able to get rid of one year's worth of medical records, since they're now stored digitally for that 10-year period.

Obviously, we are not purging things out of our digital electronic medical records, but there are advances like that that allow these changes in our bylaws to move forward. I'd be happy to take any questions. Since this has been reviewed by many committees, I wasn't going to go through much more detail.

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

Resolution No. 2018-80

Synopsis: The amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals are recommended for approval.

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 October 9, 2017; 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 December 13, 2017; 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 January 5, 2018; 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 Quality and Professional Affairs Committee of the Wexner Medical Center Board on March 27, 2018:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Board hereby approves and proposes that the attached amendments to the *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.

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. 2018-81

Synopsis: The 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 are recommended for approval.

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 October 9, 2017, and the James Bylaws Committee on December 1, 2017; 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 December 8, 2017; 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 December 22, 2017; 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 March 27, 2018:

NOW THEREFORE

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

Mr. Wexner:

Andy, thank you.

Dr. Thompson:

All I need is a motion to recommend these resolutions to the University Board of Trustees. This can be done by voice vote.

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

Dr. Thompson:

The motion carries.

Ms. Krueger:

Great, thank you. QPAC also voted to approve this resolution with regard to the trauma program verification that resides with the Wexner Medical Center Board, which is required by both the University Hospitals as well as University Hospital East. Andy, do you want to tell us a little bit more about this as well?

Dr. Thomas:

Yes, thank you, Ms. Krueger. Every three years, the American College of Surgeons Committee on Trauma does a site visit for every designated trauma center around the country. This is one of many re-designated programs for us. The burn program goes through a similar review. One of the requirements in that accreditation process is that the governing body of the organization provide an endorsement of that application.

One new item this year, you'll notice in the resolution it mentions a Level 3 trauma program at University Hospital East. That is a new change for us to have a trauma program there. You could imagine there are a number of patients who may have a trauma in the vicinity of East Hospital and currently those folks are being taken to Grant Hospital or to another facility because, by state law, if there is a trauma involved EMS has to take the patient to an actual trauma center. Or, if a patient were to walk in and have a trauma, they have to be transferred to another hospital. Just to give you a sense of the scale of our current trauma program, this is before even the addition of the Level 3 program at East, in calendar year 2017, we had 2,738 total trauma patients. Just under 1,000 of those actually came from the scene of the trauma; 1,250 of those came as a referral from another hospital. We get patients from all over the state that are sent here either by air or by ground ambulance. We obviously get local patients that are brought to us by ground ambulance, but the opening of a Level 3 trauma center at East will substantially change the nature of that hospital, because EMS drives by it for certain things. We've already seen the change with the opening of a program for heart attacks and a stroke program there. EMS is finding we have more and more resources there that will help the hospital over time in a great way.

Mary Howard and Elizabeth Seely, in her time prior at East, have been really wonderful to work with. The medical staff has really been engaged in this as well as our trauma

program leadership. I think it will be a terrific project to change the trajectory of East Hospital over time.

UNIVERSITY HOSPITALS TRAUMA CERTIFICATION

Resolution No. 2018-82

Synopsis: Applications for a Level 1 trauma verification for University Hospitals and a Level 3 trauma verification for University Hospitals East by the American College of Surgeons-Committee on Trauma, are proposed.

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

WHEREAS the Wexner Medical Center is committed to maintaining the high standards required to provide optimal care for all trauma patients at University Hospitals emergency departments; and

WHEREAS the Wexner Medical Center is cognizant of the resources needed to support a Level 1 Trauma Program at University Hospitals and a Level 3 Trauma Program at University Hospitals East, and the contributions of these programs to its tripartite mission; and

WHEREAS on February 12, 2018, the University Hospitals Medical Staff Administrative Committee approved the proposed applications for a Level 1 trauma verification for University Hospitals and a Level 3 trauma verification for University Hospitals East by the American College of Surgeons-Committee on Trauma; and

WHEREAS on March 27, 2018, the Quality and Professional Affairs Committee of the Wexner Medical Center Board approved the proposed applications for a Level 1 trauma verification for University Hospitals and a Level 3 trauma verification for University Hospitals East by the American College of Surgeons-Committee on Trauma:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the applications for a Level 1 trauma verification for University Hospitals and a Level 3 trauma verification for University Hospitals East by the American College of Surgeons-Committee on Trauma.

Mr. Wexner:

Thank you.

Dr. Thompson:

Comments? I'll entertain a motion to approve the resolution. This requires a roll call vote because the approval resides with the Wexner Medical Center Board.

Upon the motion of Dr. Drake, seconded by Ms. Krueger, the Wexner Medical Center Board members adopted the foregoing motion by unanimous roll call vote, cast by board members Dr. McPheron, Mr. Papadakis, Dr. Drake, Mr. Schottenstein, Mr. Steinour, Mrs. Wexner, Ms. Krueger, Mr. Jurgensen, Dr. Reid, Mr. Shumate and Mr. Wexner.

Dr. Thompson:

The motion carries.

Mr. Wexner:

Before we adjourn, let's take a couple of minutes. Our second son was a high school varsity rower, and he is now in his junior year at college and he strokes an eight-person boat. I don't know how many of you know about rowing, but that's about what I know. What he tells me is when the boat is in harmony, there's all kind of great vibrations and it just feels better and they happen to go faster, too. There's a great book called "The Boys in the Boat," which talks about that experience. It's focused on the experiences of all the boys in the boat, the coach, the stroke and what they did and what they

accomplished. In the spirit of getting all the boys and girls in the boat rowing together, I think that's what we're seeing today. First of all, it took us a while to get through an agenda on time, and we've been practicing this for multiple years, but we actually had an agenda end on time, which is one measure of growing together.

Also, when you look at the performance, whether it's improvement in reputation, NIH grants, clearly the financial performance, it means a lot of people are in the boat and rowing together. You saw with Dr. Farrar and Dr. Pollock that they are stroking their boat and not only how they report, but just the fact that they really know each other, shook hands afterwards. I thought you and Raph were going to kiss each other, but there's actually real human relations and real tangible proof of working together.

When you look at the financial support, and I thought the gift that was announced today, all these gifts are significant and many people that make large gifts would prefer to make them anonymously and if not anonymously, do it very quietly. We implored our donors to be present, because if gifts are made and no one knows, then there's no standard. It's the tree that falls in the forest and no one hears. So I appreciate not only the gift, but the fact that they gave it publicly. In that same spirit of their $18 million gift, we had broad support in the community for the medical center, by individual gifts of time and money, the support for Pelotonia, the success of the cancer cruise. So, in terms of the community supporting us and individuals supporting us, there's strong evidence in the broad community that the work of the medical center and the university is really appreciated. Not only are boys and girls in the boat stroking, but there is an audience that is visible and appreciates the work that we're doing.

Another example is that a lot of time and effort went into the strategic plan, and when people reference the strategic plan as this is guiding our work, this is what we said we would do, these are the deliverables, and then you know the strategic plan is alive and well and is a functioning part of the university. It is particularly in the medical center.

We've all experienced strategic plans that were made, shelved and then things just went back to normal, and the work that went into the strategic plan had nothing to do with the tactics and strategy on a day-to-day basis. The board has been supportive, put an enormous amount of time into it; the staff and administration of the medical center and the university have worked towards this. There's real evidence of the leadership and the followership, whether it's the med students, the doctors or the community being supportive. We're beginning to feel, at least I'd ask you to think about it, if it doesn't feel more like we're in rhythm and the boat is going faster. I think we're just at the beginning of the beginning and that's a remarkable accomplishment.

I want to shift to the support. The role of the medical center board, and I think all public boards, we have a fiduciary responsibility and we also have a responsibility not to park our brains when we come into these meetings. We actually can think things through, understand things, challenge things, be a supportive force.

I was talking to David and I was thinking back not that many years ago, when the medical center board took a pretty courageous step in supporting the development of the neighborhood facility in Kingsdale. How big should it be? Should we do it? Is it too close to the campus? Is it a good idea or bad idea? It turned out to be a spectacular idea. If that decision wasn't supported by the board, that 100,000-square-foot facility wouldn't have proved the ability of the medical center to operate these neighborhood facilities, which provide great services to the community, but also provide a theater here at the physical center of the medical center. That leads to the work that collectively we've done to build, to begin to plan, these many community hospitals or facilities around the city, which will probably be between 150,000 to 200,000 feet. Those buildings will change the trajectory of our support in the community and our support for the community. And so, by understanding and taking the time to understand, we've been a supportive force, and we've been a supportive force for other easy decisions and some of the tough ones.

When the medical center board was formed, both Janet [Reid] and Jerry [Jurgensen] were there at the first meetings and have had damn near perfect attendance and 100 percent participation. I worked with Jerry when I was on the board of The Ohio State University, and him being on the board of the medical center has been vital. Jerry and I don't always agree, which is a good thing. I respect his opinion and his judgement and certainly the dedication that he has had to The Ohio State University. It is not his alma mater. Likewise, Janet, when recruited to the board of The Ohio State University and then asked to serve on the medical center board, she's commuting up regularly from

Cincinnati and has been tremendously influential to the university board, as has Jerry, but her experience at Mercy, her experience with HR, has been a major contributor to what we've done. On a personal basis, having been on the board of the university and known a number of its trustees, in the life of a trustee — which is nine years — the time put in is at a minimum 3,200 hours. If you want to divide 3,200 hours or 4,000 hours, it's in that range by nine years, by eight hour days and it's a couple or 2.5 days a month between phone calls and committee meetings and board meetings. You're talking about at least a year of one's life in working days. I appreciate those contributions and I particularly appreciate Jerry's and Janet's because it was more than perfect attendance, it was damn near perfect work. I know you're about to retire from the university board and from this board, and for all of us, we appreciate your contribution and personally, I appreciate it very much and I want to thank you.

Neither of you are generally at a loss for words.

Dr. Reid:

First of all, thank you for the kind words. Health care has been something that I have been involved with for many, many, many years, and being on this board in particular was a great joy to see it start from the beginning and then to shape it into what it is now. To produce a meeting like what we had today, and to see the harmony and the boat rowing, and you know all of that from where it started is just, I mean what a great time to step away because it's in a great place. I want to thank all of you. You know, we've gone through a lot together and we're in an excellent place.

Mr. Jurgensen:

Just to echo everything Janet said, actually, the medical center board was about the first thing that I got an opportunity to do when I got to Columbus in 2000. I was recruited by Hagop Mekhjian to this board and it was very interesting for me. I grew up in a medical family. My father was a physician and my brother is an OBGYN. I wasn't smart enough to get into medical school; otherwise, there would have been three Dr. Jurgensens. But, it has been great and we've seen a lot. When I first joined the university board with Les, that was a billion dollars and a new tower was just happening and it has been terrific. As you all know, and Andy [Thomas] maybe a little more than anybody else, I had the opportunity to experience what we do firsthand with what Patty [Jurgensen] went through, and I just couldn't be more thankful for how everyone treated her and the quality of care that she got here. I'll never forget that, so it's been great.

Dr. Drake:

That brings us to the close of the public session, and I wanted to echo a couple of things. First, thank you very much, Mr. Wexner, for your thoughtful comments, which really did reflect the things I'm going to echo. One is the very hard work of the people sitting to my left over this past year. There were real, actual decisions made. There were real, actual administrative changes made. There was a real, actual different direction plotted. It took hundreds of hours of work. I'm thinking of Bruce [McPheron] and the hundreds of hours of work that the provost put into this, which wouldn't have been the case normally. And the hundreds of hours of work as we go down the line and look at Craig [Kent] and David [McQuaid] and Mark [Larmore] in particular during this last year. It's important to focus on how well it's going now, and how much better this is than it was before. And that's with all of this work going on over just the past year. I want to make a real acknowledgement of the teamwork of the entire group. It has been amazing. And then the work of the board to be supportive, ask the right questions and elevate this discussion is something that brings us to this great place. And then the wonderful work of our retiring members as great exemplars of the best that we can be.

We would be exactly on time with our agenda, had we not had prolonged applause, so I'm going to count that as bonus time and say it has been great and we will call to an end this part of the meeting, thank you.

Dr. Thompson:

At this time I will entertain a motion to recess into executive session to consider business-sensitive trade secrets required to be kept confidential by federal and state statutes, to discuss quality matters required to be kept confidential under Ohio law, to

consult legal counsel regarding pending or imminent litigation, to discuss the purchase of real property and personnel matters of public officials. May I have that motion?

Upon the motion of Mrs. Wexner, seconded by Mr. Steinour, the Wexner Medical Center Board members adopted the foregoing motion by unanimous roll call vote, cast by board members Dr. McPheron, Mr. Papadakis, Dr. Drake, Mr. Schottenstein, Mr. Steinour, Mrs. Wexner, Ms. Krueger, Mr. Jurgensen, Dr. Reid, Mr. Shumate and Mr. Wexner.

Dr. Thompson:

Motion carries. You are in executive session.

Attest:

Leslie H. Wexner
Chairman

Blake Thompson
Secretary


Every Transplant
Saves a Life
THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Solid Organ Transplantation

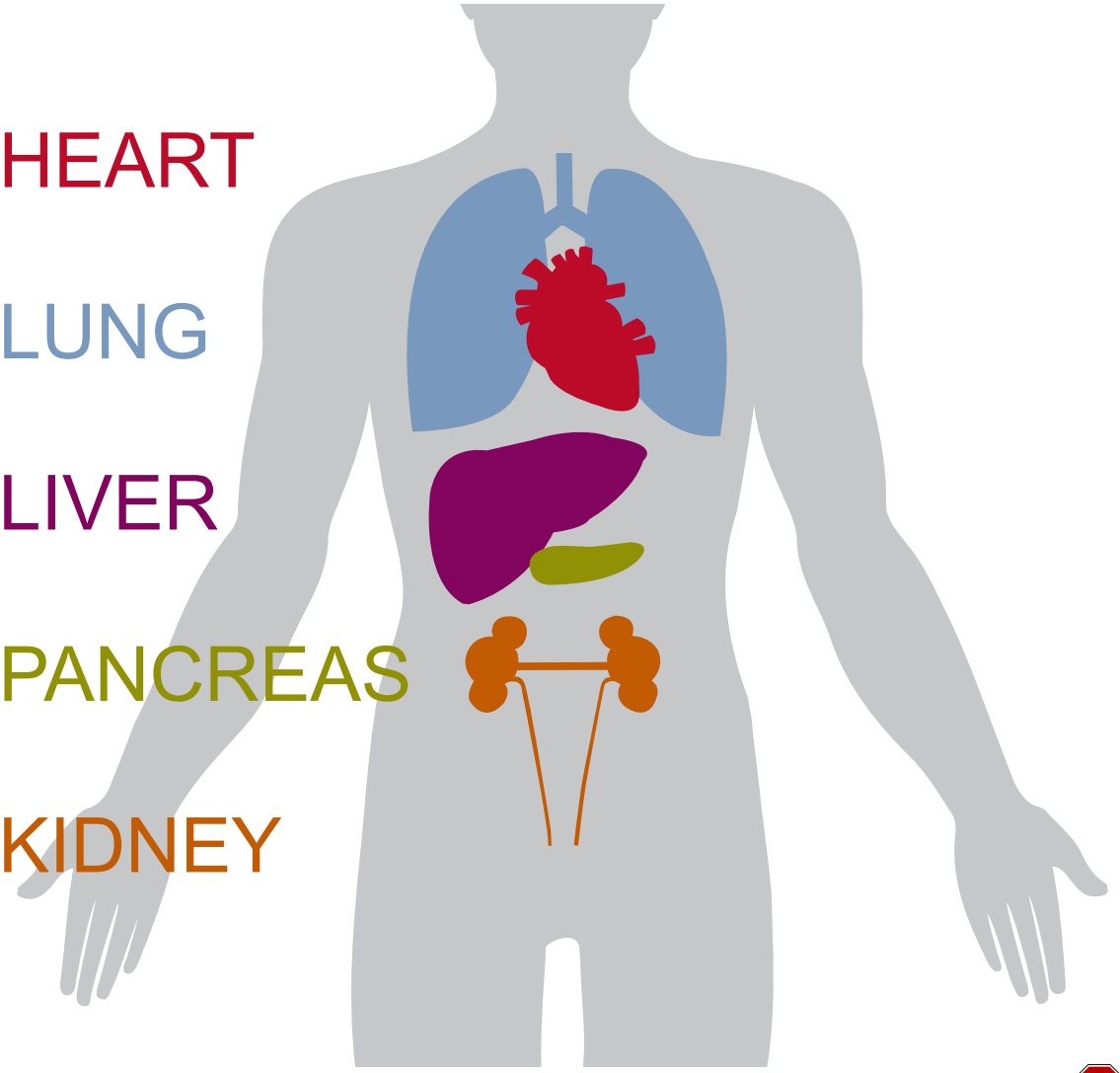
HEART

LUNG

LIVER

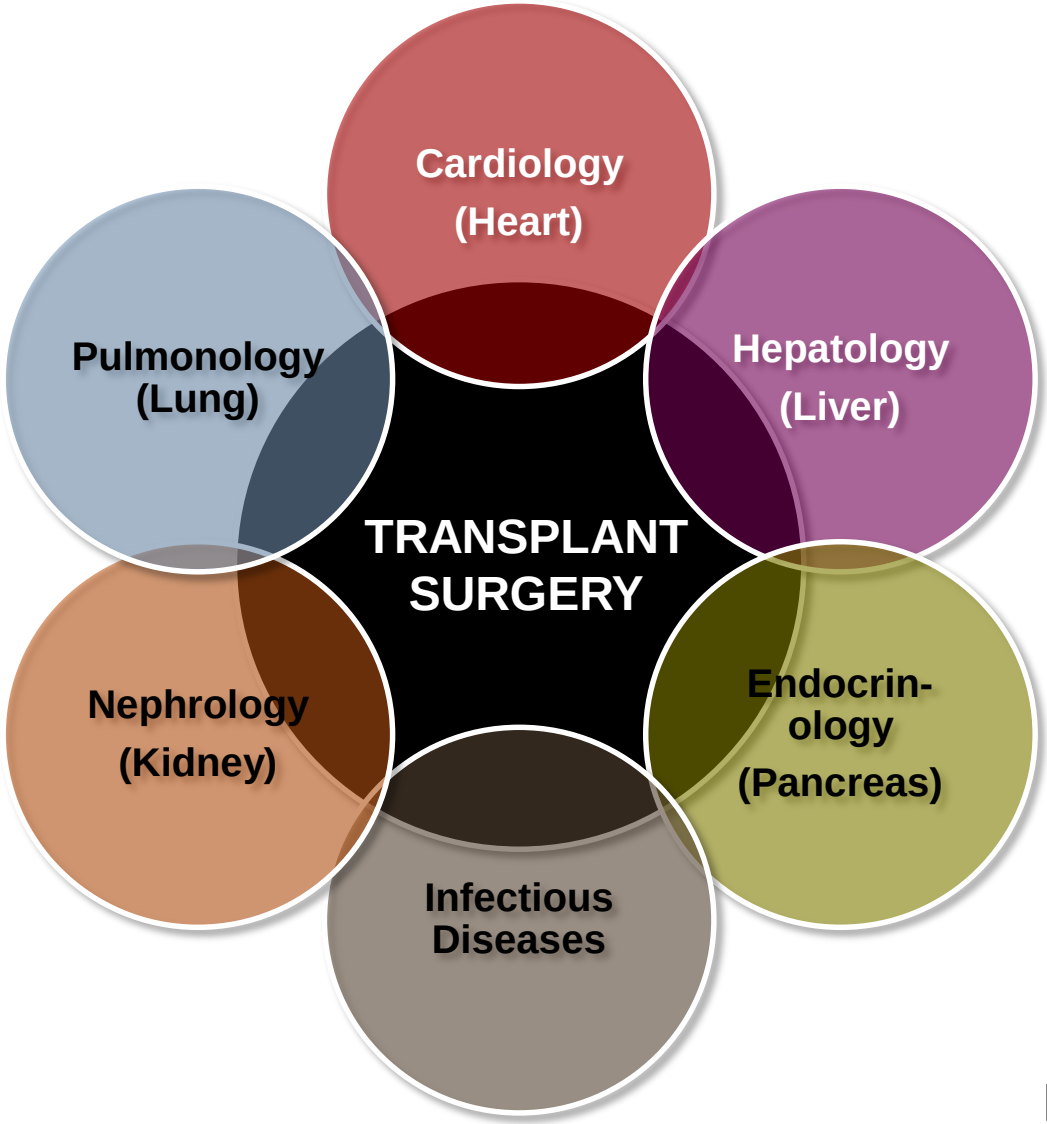
PANCREAS

KIDNEY

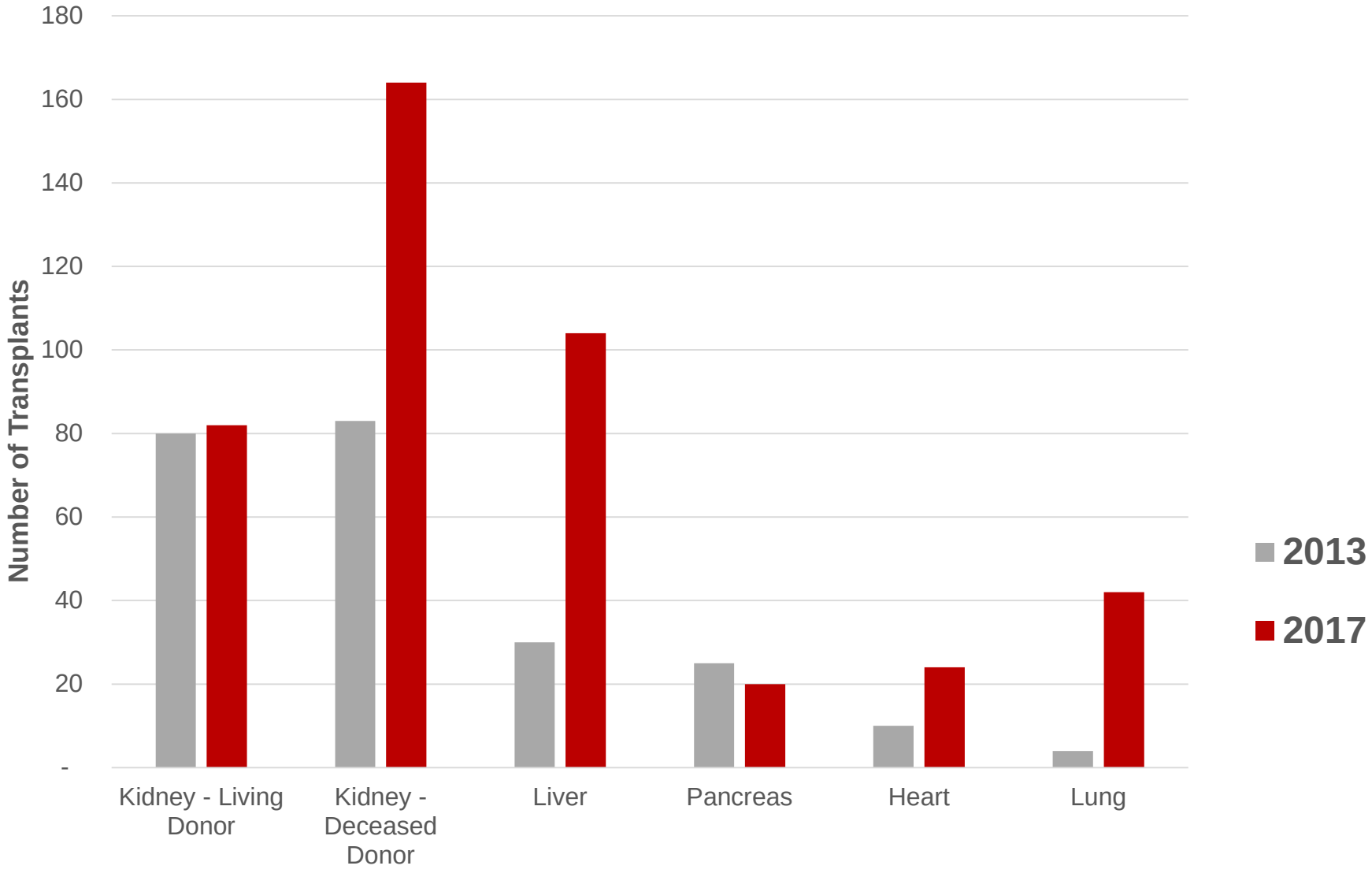


Multidisciplinary Team

*Comprehensive Transplant Center = **100+ faculty and staff***

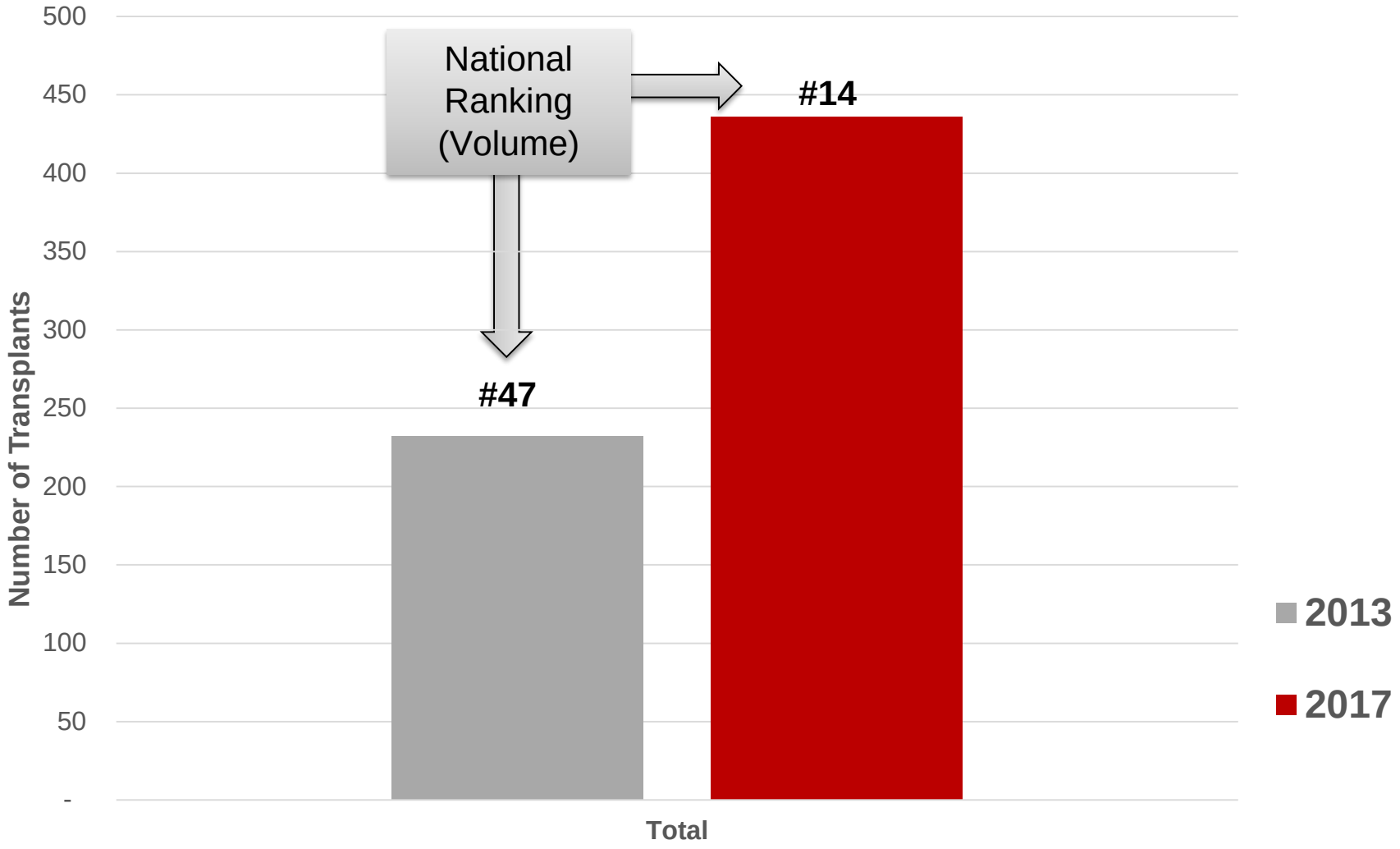


5 Year Trended Growth in Organ Transplants at OSUWMC



Source: OPTN

5 Year Trended Growth in Total Organ Transplants at OSUWMC



Source: OPTN

- *Celebrating 50 years of comprehensive transplant care*
- *Performed more than 9,250 solid organ transplants*

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

OHIO STATE COMPREHENSIVE TRANSPLANT CENTER

1-YEAR PATIENT SURVIVAL

(Patients Transplanted: 7/1/2014 – 12/31/2016)

		OBSERVED	NATIONAL
BEST IN OHIO	HEART	93.14%	91.35%
	LUNG	89.41%	88.58%
BEST IN OHIO	LIVER	92.41%	92.29%
	KIDNEY	97.71%	97.36%
	KIDNEY/ PANCREAS	100%	97.72%

Source: Scientific Registry of Transplant Recipients, ***www.srtr.org***

Ex-Vivo Lung Perfusion (EVLP)

- Only 2,000 lung transplants are performed in the U.S. each year
- Each year many deaths from lung failure
- There is a need for more organs
- EVLP can increase the number of available organs
- First in Ohio, among only 20 centers nationwide

Wexner Medical Center Board
Public Session
Health System Financial Summary

June 6, 2018

The Ohio State University Health System

Financial Highlights
For the YTD ended: April 30, 2018

Admissions	
Budget	0.4%
Prior Yr	4.5%
Actual	53,503
Budget	53,275
Prior Yr	51,176

Surgeries	
Budget	0.4%
Prior Yr	2.5%
Actual	37,177
Budget	37,025
Prior Yr	36,258

O/P Visits	
Budget	-0.3%
Prior Yr	3.1%
Actual	1,501,453
Budget	1,506,069
Prior Yr	1,456,331

Worked Hrs / Adjusted Admit	
Budget	0.4%
Prior Yr	-0.6%
Actual	201
Budget	202
Prior Yr	200

The Ohio State University Health System

Financial Highlights
For the YTD ended: April 30, 2018

Operating Revenue	
Budget	2.8%
Prior Yr	9.3%
Actual	$2,481,714
Budget	$2,413,706
Prior Yr	$2,270,371

Controllable Costs	
Budget	-2.6%
Prior Yr	-8.1%
Actual	$1,906,742
Budget	$1,857,745
Prior Yr	$1,763,138

Excess Revenue over Expense	
Budget	12.3%
Prior Yr	31.9%
Actual	$213,345
Budget	$190,010
Prior Yr	$161,728

Days Cash on Hand		
Jun FY17	14.5%	
PY MTD	23.9%	
Actual	146.2	$1.0B
Jun FY17	127.6	$826M
PY MTD	118.0	$755M

The Ohio State University Health System

Consolidated Statement of Operations
For the YTD ended: April 30, 2018
(in thousands)

OSUHS	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	$ 2,481,714	$ 2,413,706	$ 68,008	2.8%	$ 2,270,371	9.3%
Operating Expenses						
Salaries and Benefits	1,077,946	1,058,017	(19,929)	-1.9%	1,004,504	-7.3%
Resident/Purchased Physician Services	90,378	90,574	196	0.2%	86,789	-4.1%
Supplies	266,083	257,287	(8,796)	-3.4%	251,975	-5.6%
Drugs and Pharmaceuticals	259,009	237,155	(21,854)	-9.2%	223,072	-16.1%
Services	254,016	255,134	1,118	0.4%	236,005	-7.6%
Depreciation	128,197	132,797	4,600	3.5%	118,363	-8.3%
Interest	31,781	31,989	208	0.7%	33,279	4.5%
Shared/University Overhead	44,533	44,533	-	0.0%	40,846	-9.0%
Total Expense	2,151,943	2,107,486	(44,457)	-2.1%	1,994,833	-7.9%
Gain (Loss) from Operations (pre MCI)	329,769	306,220	23,549	7.7%	275,536	19.7%
Medical Center Investments	(125,625)	(124,942)	(683)	-0.5%	(123,441)	-1.8%
Income from Investments	9,090	8,732	358	4.1%	9,746	-6.7%
Other Gains (Losses)	110	-	110	---	(113)	---
Excess of Revenue over Expense	$ 213,345	$ 190,010	$ 23,335	12.3%	$ 161,728	31.9%

The Ohio State University Health System

Consolidated Activity Summary
For the YTD ended: April 30, 2018

OSUHS	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
CONSOLIDATED ACTIVITY SUMMARY						
Activity						
Admissions	53,503	53,275	228	0.4%	51,176	4.5%
Surgeries	37,177	37,025	152	0.4%	36,258	2.5%
Outpatient Visits	1,501,453	1,506,069	(4,616)	-0.3%	1,456,331	3.1%
Average Length of Stay	6.37	6.22	(0.15)	-2.4%	6.29	-1.3%
Case Mix Index (CMI)	1.85	1.85	0.00	0.2%	1.79	3.5%
Adjusted Admissions	101,233	99,669	1,563	1.6%	96,628	4.8%
Operating Revenue per AA	$ 24,515	$ 24,217	298	1.2%	$ 23,496	4.3%
Operating Expense per AA	$ 21,257	$ 21,145	(112)	-0.5%	$ 20,645	-3.0%

OSU Wexner Medical Center

Combined Statement of Operations
For the YTD ended: April 30, 2018
(in thousands)

	ACTUAL	BUDGET	ACT-BUD VARIANCE	BUDGET % VAR	PRIOR YEAR	PY % Var
Health System						
Revenues	$ 2,481,714	$ 2,413,706	$ 68,008	2.8%	$ 2,270,371	9.3%
Expenses	2,268,368	2,223,696	(44,672)	-2.0%	2,108,641	-7.6%
Net	213,345	190,010	23,335	12.3%	161,728	31.9%
OSUP						
Revenues	$ 359,003	$ 359,971	$ (968)	-0.3%	$ 351,102	2.3%
Expenses	346,800	358,478	11,678	3.3%	317,666	-9.2%
Net	12,204	1,493	10,711	717.4%	33,436	-63.5%
COM/OHS						
Revenues	$ 193,600	$ 195,235	$ (1,635)	-0.8%	$ 182,319	6.2%
Expenses	175,848	181,276	5,428	3.0%	160,012	-9.9%
Net	17,754	13,959	3,795	27.2%	22,307	-20.4%
Total Medical Center						
Revenues	$ 3,034,317	$ 2,968,912	$ 65,405	2.2%	$ 2,803,792	8.2%
Expenses	2,791,016	2,763,450	(27,566)	-1.0%	2,586,319	-7.9%
Net	243,303	205,462	37,841	18.4%	217,471	11.9%

This statement does not conform to Generally Accepted Accounting Principles. Different accounting methods are used in each of these entities and no eliminating entries are included.

OSU Wexner Medical Center

Combined Balance Sheet
As of: April 30, 2018
(in thousands)

	April 2018	June 2017	Change
Cash	$ 943,259	$ 734,302	$ 208,957
Net Patient Receivables	438,898	410,404	28,494
Other Current Assets	407,093	395,833	11,260
Assets Limited as to Use	403,245	403,052	193
Property, Plant & Equipment - Net	1,490,650	1,503,002	(12,352)
Other Assets	453,163	428,241	24,922
Total Assets	$ 4,136,308	$ 3,874,834	$ 261,474
Current Liabilities	$ 355,176	$ 323,892	$ 31,284
Other Liabilities	125,470	93,741	31,729
Long-Term Debt	803,432	852,129	(48,697)
Net Assets - Unrestricted	2,257,836	2,026,145	231,691
Net Assets - Restricted	594,393	578,927	15,466
Liabilities and Net Assets	$ 4,136,308	$ 3,874,834	$ 261,474

This Balance sheet is not intended to conform to Generally Accepted Accounting Principles. Different accounting methods are used in each of these entities and no eliminating entries are included.

The Ohio State University
Wexner Medical Center
FY2019 Budget

DRAFT

Draft

OSUWMC Combined Income Statement

For the years ended June 30

	Forecast 2018	Budget 2019	% Change
OPERATING STATEMENT (in thousands)			
Total Operating Revenue	$3,649,289	$3,867,878	6.0%
Operating Expenses			
Salaries and Benefits	1,944,000	2,058,909	5.9%
Supplies and Pharmaceuticals	653,114	742,708	13.7%
Services	374,315	401,634	7.3%
Depreciation	175,005	186,153	6.4%
Interest/Debt	49,460	47,330	-4.3%
Other Operating Expense	136,611	147,834	8.2%
Medical Center Investments	9,794	4,629	-52.7%
Total Expense	3,342,299	3,589,197	7.4%
Excess of Revenue over Expense	$ 306,990	$ 278,682	-9.2%
Financial Metrics			
Adjusted Admissions	121,340	125,516	3.4%
Total Revenue per AA	$ 24,516	$ 24,669	0.6%
Total Expense per AA	$ 21,211	$ 21,600	1.8%

Draft

OSUWMC Combined Income Statement

For the years ended June 30

(in thousands)	Forecast 2018	Budget 2019	% Change
Health System			
Revenues	$ 2,974,756	$ 3,173,085	6.7%
Expenses	2,710,103	2,916,936	7.6%
Net	264,653	256,150	-3.2%
OSUP			
Revenues	$ 431,942	$ 443,066	2.6%
Expenses	423,364	437,268	3.3%
Net	8,578	5,798	-32.4%
COM/OHS			
Revenues	$ 242,591	$ 251,727	3.8%
Expenses	208,831	234,993	12.5%
Net	33,760	16,734	-50.4%
Total Medical Center			
Revenues	$ 3,649,289	$ 3,867,878	6.0%
Expenses	3,342,299	3,589,197	7.4%
Net	306,990	278,682	-9.2%

Thank You

Wexnermedical.osu.edu

STANDARD CARE ARRANGEMENT

FOR THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Synopsis: The Ohio State University Wexner Medical Center commits to maintain high standards needed to provide optimal care of all patients and recommends the following standard care arrangement for approval.

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

WHEREAS The Ohio State University Wexner Medical Center will use the standard care arrangement for collaborative practice between its employed physicians and Advanced Practice Registered Nurses (APRNs) prior to engaging in clinical practice; and

WHEREAS this standard care arrangement shall be governed by and construed in accordance with the laws of the state of Ohio, which requires review and approval in accordance with the bylaws of the medical staffs and by The Ohio State University Wexner Medical Center's governing body; and

WHEREAS the commitment to maintain the high standards needed to provide optimal care of all patients, with the medical staffs' support of the collaborative practice of The Ohio State University Wexner Medical Center's employed physicians and APRNs to enter into this standard care arrangement prior to engaging in practice, was approved by The Ohio State University Wexner Medical Center's Credentialing Committee on May 7, 2018; the University Hospitals Medical Staff Administrative Committee on May 9, 2018; the James Cancer Hospital Medical Staff Administrative Committee on May 11, 2018; and the Quality and Professional Affairs Committee on May 29, 2018:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the use of this standard care arrangement to maintain the high standards needed to provide optimal care of all patients and to support the collaborative practice of the Wexner Medical Center's employed physicians and APRNs.

The Ohio State University Hospitals

James Cancer Hospital and Solove Research Institute

OSUP Physicians, Inc. (OSUP)

Standard Care Arrangement for the Advanced Practice Registered Nurse

The following Standard Care Arrangement (SCA) is written to provide guidelines for the collaborative practice between an Advanced Practice Registered Nurse (APRN) and physician(s) (references to "physician" include collaborating podiatrists) prior to engaging in practice.

All APRNs must also be appropriately credentialed according to OSUWMC policies and procedures prior to engaging in practice.

Contact Information
Name:
Specialty:
Business Address:
City, State:
Zip:
Business phone:
OAC 4723-8-04(C)(4)

Services Offered by the APRN
Services offered may include, but are not limited to: ▪ Obtain history and physical exam ▪ Provide care and determine eligibility for treatment protocols as appropriate ▪ Prescribe medications appropriate for treatment in accordance with APRN education, training and specialty area of practice (in accordance with Prescriptive Authority herein below) ▪ Manage the prescribed treatment ▪ Obtain and order diagnostic tests/laboratory studies as appropriate ▪ Management of disease and/or treatment related health problems/effects ▪ Monitor health status in an ongoing basis ▪ Initiate referrals to other health care professionals as appropriate
Additional services offered: ▪ _____ ▪ _____ ▪ _____
OAC 4723-8-04(C)(5) APRN approved clinical privileges

Criteria for Consult with and Referrals to Collaborating Physician(s)
I will consult with and/or refer to my collaborating physician(s) regarding patient management in the following circumstances: ▪ In the event that my patient becomes medically unstable

- In the event that my patient's condition warrants direct care by the collaborating physician
- In the event that my patient may need to be taken into surgery
- In the event that my patient may need to be admitted/discharged into the hospital
- For nurse midwives, in the event of a breech or face presentation or any other abnormal obstetrical condition

OAC 4723-8-04(C)(7)(b) and (c)

Plan for Coverage in Case of Emergency or Planned Absences of the APRN or Collaborating Physicians(s)

At all times, there will be a physician responsible for the patient's care. The collaborating physicians(s) and I will determine the appropriate protocols to follow during the absence of either party.

- The collaborating physicians(s) or I will notify each other of all emergency or planned absences
- A physician will be designated as having overall responsibility for patient care during absences of the collaborating physician
- I will inform the collaborating physicians(s) of personnel wo will cover my responsibilities during my absence

OAC 4723-8-04(C)(8)

Arrangement Regarding Reimbursement

Depending on my direct employer, I will be reimbursed in accordance with the OSU Wexner Medical Center or OSUP employment guidelines.

OAC 4723-8-04(C)(10)

Process for Resolution of Disagreements Regarding Matters of Patient Management

Should a disagreement arise between the collaborating physician(s) and me regarding the patient's plan of care, I will communicate with the physician(s) and attempt to reach consensus.
The collaborating physicians(s) will be available for consultation with me at all times. In the event that the collaborating physicians(s) is/are unavailable or further consultation is necessary, I will follow the chain of command for communication outlined in the nursing standards of practice and policies for each hospital or clinic site.

In addition, any of the following options may be used to resolve the conflict:

- Consult with physicians, APRN colleagues or other disciplines or medical services with knowledge and expertise related to the specialty area
- Refer to current professional literature appropriate to the area in question

In the event that an agreement cannot be reached between the collaborating physician(s) and me, the ultimate decision regarding patient care rests with the collaborating physicians(s). In the event this situation occurs, the physician assumes care of the patient and the APRN may be recused of care. The physician shall present the care options to the patient and obtain the proper consent.

OAC 4723-8-04(C)(9)

The Ohio State University Hospitals

James Cancer Hospital and Solove Research Institute

OSUP Physicians, Inc. (OSUP)

Plan for Incorporating New Technology or Procedures

- Share and discuss knowledge and skills related to new technology and procedures and integrate them into practice protocols as appropriate
- Identify new core competencies as indicated to facilitate patient management
- Prior to performing specialized skills, demonstrate and document competency in accordance with corporate credentials protocol for obtaining additional privileges

OAC 4723-8-04(C)(6)

Quality Management and Service Review Process

The quality management and service review process shall be conducted in accordance with The Ohio State University Wexner Medical Center's (OSUWMC) Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) policies for all credentialed health care providers in order to maintain or improve care delivery.

The quality review will at a minimum include:

- A periodic review of representative samples of prescriptions written by the APRN
- A periodic review of representative samples of schedule II prescriptions written by the APRN
- Provisions to ensure that the nurse is meeting all the requirements of rule 4723-9-12 of the Administrative Code related to review of a patient's OARRS report, consultation with the collaborating physician prior to prescribing based on the OARRS report and signs of drug abuse or diversion as set forth in rule 4723-9-12 of the Administrative Code, and documentation of receipt and assessment of OARRS report information in the patient's record.
- Quality assurance standards consistent with rules 4723-8-04 and 4723-8-05 of the Administrative Code.

OAC 4723-8-04(C)(7)(a)
OAC 4723-8-04(C)(7)(d)
OAC 4723-8-04(C)(11)(c)
OAC 4723-8-05(E)
OAC 4723-8-05(F)

☐ I will **not** be prescribing as a part of my job at OSUWMC (by checking this box you are indicating the next box does not apply to your practice).

Prescriptive Authority

The APRN with prescriptive authority shall not exceed the prescriptive authority of the collaborating physician or podiatrist, including the collaborating physician's authority to treat chronic pain with controlled substances and products containing tramadol as described in ORC 4731.052.

The APRN may prescribe in accordance with ORC 4723.48, the rules of the Ohio Board of Nursing, and with the formulary as established by the committee on prescriptive governance and adopted by the Ohio Board of Nursing (ORC 4723.492).

1. The APRN may prescribe drugs newly approved or approved for a new indication by the FDA & reviewed by committee on prescriptive governance subsequent to the date of biennial review of the SCA.

2. **Off-Label Use**
   The APRN may prescribe medications for off-label use if the following criteria are meet:
   - The off-label indication(s) must be consistent with the APRNs' Scope of Practice and that of the clinical specialty or subspecialty.
   - Standard clinical practice and literature support with greater or equal to level 3 evidence.

3. **OAARS Reporting**
   The APRN will comply with all requirements of OAC 4723-9-12, standards and procedures for review of OARRS (Ohio Automated Rx Review System).

4. **Prescribing parameters for Schedule II controlled substances** The APRN may prescribe schedule II controlled substances as indicated for patients in accordance with Section 4723.481, ORC; Chapters 4723-8, 4723-9 and 4731-11, OAC; the Formulary published by the Ohio Board of Nursing; and the scope of prescribing practices established in this SCA.

☐ I will be prescribing to minors as a part of my employment at OSUWMC and I will comply with all requirements in accordance with ORC Section 3719.061 when prescribing opioids to minors (by checking this box you are indicating the **does** apply to your practice).

OAC 4723-8-04(C)(11)
OAC 4723-8-04(C)(11)(v)
APRN approved clinical privileges

The collaborating physician(s) and I have mutual responsibility for abiding with the guidelines of this agreement. Involved parties may request in writing, to revise or rescind this agreement at any time and must be agreed to by the undersigned, in writing, and incorporated as part of the SCA. This includes notification by either party that patient care will no longer be provided by any individual signing below at any OSUWMC location and/or they will no longer be part of OSUP. Any final actions taken against licensure and/or clinical privileges must be disclosed immediately to all parties signing this SCA.

By entering in this SCA, I hereby acknowledge that I have a copy of the Ohio Law Regulating the Practice of Advanced Practice Nursing and Rules promulgated from therein and have read the same and am familiar with their content. I also acknowledge that I am familiar with the content of the Policies and Procedures of The Ohio State University Wexner Medical Center, which includes OSUP.

I consent to the inspection of all records and documents that may be material to an evaluation of such qualifications and my competence to carry out the clinical privileges I request, as well as my moral, ethical and personal qualifications and agree to execute whatever releases necessary to exonerate and release individuals and all parties from liability arising out of acts performed in good faith and without malice in connection with the evaluation of me and my credentials, and I do, by making application, release from liability all individuals and organizations who provide information to the hospital in good faith, and without malice concerning my competence, morals, ethics, character, and other qualifications for employment or staff appointments and clinical privileges.

The Ohio State University Hospitals

James Cancer Hospital and Solove Research Institute

OSUP Physicians, Inc. (OSUP)

I agree to report to the collaborating physician(s) and the Director of Advanced Practice Providers or OSUP's Compliance Department, any suspensions, revocations or limitations of any professional license I may possess and/or refusal to register or reinstate for professional licensure.

I agree I will notify the Ohio Board of Nursing of an addition or deletion of a Collaborating Physician no later than thirty (30) days after such change takes effects.

OSUWMC, or OSUP, as my employer will maintain the most current copy of this SCA on file. Upon request of the Ohio Board of Nursing, OSU, OSUP or I shall immediately provide a copy of this SCA upon such request.

Initial date of execution:_____ Signature of APRN:_____

Initial date of execution:_____ Primary Collaborating Physician:_____

OAC 4723-8-04(C)(1) and (2)
OAC 4723-8-04(D) and (E)

Each biannual review must be signed and dated by both the APRN and the Primary Collaborating Physician

Date of 1st biennial review:_____ Signature of APRN:_____

Date of 1st biennial review:_____ Primary Collaborating Physician:_____

Date of 2nd biennial review:_____ Signature of APRN:_____

Date of 2nd biennial review:_____ Primary Collaborating Physician:_____

Date of 3rd biennial review:_____ Signature of APRN:_____

Date of 3rd biennial review:_____ Primary Collaborating Physician:_____

Date of 4th biennial review:_____ Signature of APRN:_____

Date of 4th biennial review:_____ Primary Collaborating Physician:_____

Date of 5th biennial review:_____ Signature of APRN_____

Date of 5th biennial review:_____ Primary Collaborating Physician:_____

OAC 4723-8-04(C)(3)
OAC 4723-8-04(C)(7)(a)

The Ohio State University Hospitals

James Cancer Hospital and Solove Research Institute

OSUP Physicians, Inc. (OSUP)

Collaborating Physician(s)			
Date executed/ reviewed	**Physician name and signature** ***(please print)***	**Physician specialty practice and area**	**Physician address and phone number**

OAC 4723-8-04(C)(1)

The Ohio State University Hospitals

James Cancer Hospital and Solove Research Institute

OSUP Physicians, Inc. (OSUP)

Addendum #1

Exceeding the thirty (30) MED average for treatment of acute pain

As the collaborating physician, the APRN(s) and I have discussed circumstances as to when the APRN(s) may exceed the thirty (30) MED averages in treating acute pain. The following conditions are acceptable and may be appropriate for the APRN(s) to exceed the thirty (30) MED averages.

(a) Traumatic crushing of tissue;

(b) Amputation;

(c) Major orthopedic surgery;

(d) Severe burns

The APRN(s) and I have reviewed and are familiar with OAC 4731-11-13.

Initial date of execution:_____ Collaborating Physician:_____

Initial date of execution:_____ Signature of APRN:_____

RATIFICATION OF COMMITTEE APPOINTMENTS 2018-19

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves that the ratification of appointments to the Quality and Professional Affairs Committee for 2018-19 are as follows:

Quality and Professional Affairs Committee
CHERYL L. KRUEGER, Chair
JANET PORTER
Bruce A. McPheron
Michael A. Papadakis
David P. McQuaid
Andrew M. Thomas
David Cohn
Jon P. Walker
John C. Grecula
Scott A. Holiday
Iahn Gonsenhauser
Mary G. Nash
Kristopher M. Kipp
ABIGAIL S. WEXNER (ex officio)

APPROVAL TO ENTER INTO PROFESSIONAL SERVICES AND CONSTRUCTION CONTRACTS

APPROVAL TO ENTER INTO PROFESSIONAL SERVICES AND CONSTRUCTION CONTRACTS

Doan – 6th and 7th Floor NICU

APPROVAL TO ENTER INTO CONSTRUCTION CONTRACTS

OSU East – West Wing Expansion/Renovation

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

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

	Prof. Serv. Approval Requested	Construction Approval Requested	Total Project Cost	
Doan – 6th and 7th Floor NICU	$0.7M	$6.8M	$7.5M	Auxiliary Funds

WHEREAS in accordance with the attached materials, the university desires to enter into construction contracts for the following projects:

	Construction Approval Requested	Total Project Cost	
OSU East – West Wing Expansion/Renovation	$23.9M	$26.0M	Auxiliary Funds

NOW THEREFORE

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

BE IT FURTHER RESOLVED, That the president and/or senior vice president for Business and Finance be authorized to enter into professional services and construction contracts for the projects listed above in accordance with established university and state of Ohio procedures, with all actions to be reported to the board at the appropriate time.

Project Data Sheet for Board of Trustees Approval

Doan – 6th and 7th Floor NICU

OSU-180809 (CNI#15000068, 18000154)

Project Location: Doan Hall

- **approval requested and amount**

professional services/construction	$7.5M

- **project budget**

professional services	$0.7M
construction w/cont	$6.8M
total project budget	$7.5M

- **project funding**
  - ☐ university debt
  - ☐ development funds
  - ☐ university funds
  - ☒ auxiliary funds
  - ☐ state funds

- **project schedule**

BoT approval	06/18
design/bidding	06/18 – 07/19
construction	08/19 – 02/20

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

- **planning framework**
  - this project is included in the FY2018 Capital Investment Plan
  - this project is in cooperation with Nationwide Children's Hospital

- **project scope**
  - this project will renovate the NICU areas on the sixth and seventh floors of Doan
  - improvements to address standard of care requirements include increasing the patient, staff and parent areas, unifying the NICU, improving collaborative work zones, and providing a central entrance for parents, care givers and families
  - project costs will be shared evenly with Nationwide Children's Hospital

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

- **project team**

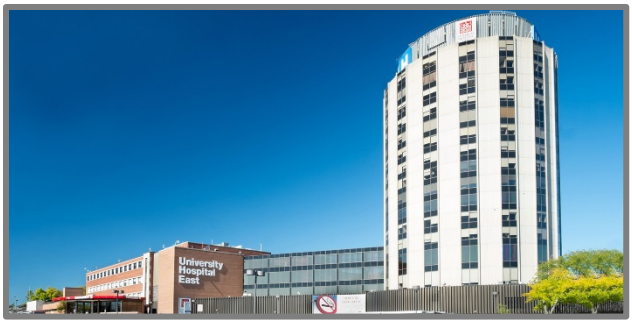
University project manager:	Brendan Flaherty
AE/design architect:	TBD

Project Data Sheet for Board of Trustees Approval

OSU East – West Wing Expansion/Renovation

OSU-170319 (CNI#16000036)

Project Location: University Hospital East



- **approval requested and amount**

construction	$23.9M

- **project budget**

professional services	$2.1M
construction w/contingency	$23.9M
total project budget	$26.0M

- **project funding**
  - ☐ university debt
  - ☐ development funds
  - ☐ university funds
  - ☒ auxiliary funds
  - ☐ state funds

- **project schedule**

BoT prof services approval	06/17
design	07/17-08/18
BoT construction approval	06/18
construction	09/18-01/20

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

- **planning framework**
  - o this project is included in the FY 2017 Capital Improvement Plan

- **project scope**
  - o renovation of 11,800 GSF and expansion of 23,200 GSF on the first floor of the west wing of the hospital tower
  - o expansion and redesign of the operating rooms and pre-operative/PACU space and respiratory suite; consolidates imaging areas; improvements to patient arrival experience and entrance aesthetics

- **approval requested**
  - o approval is requested to enter into construction contracts

- **project team**

University project manager:	Nikolina Sevis
A/E:	Moody Nolan
CM at Risk:	Elford

The Ohio State University
Wexner Medical Center Board

June 6, 2018

APPROVAL FOR ACQUISITION OF UNIMPROVED REAL PROPERTY

LOCATED AT SAWMILL PARKWAY AND HOME ROAD
IN DELAWARE COUNTY, OHIO

Synopsis: The of purchase approximately 29.56 acres of unimproved real property located at the northeast corner of Sawmill Parkway and Home Road in Delaware County, Ohio, is proposed.

WHEREAS the property is located at the northeast corner of Sawmill Parkway and Home Road in Delaware County, Ohio; and

WHEREAS the property will be utilized for the construction of an ambulatory care facility, which is a key component of the Wexner Medical Center's strategic plan; and

WHEREAS the acquisition will be contingent upon zoning changes that will allow construction of a medical facility; and

WHEREAS it has been recommended by the Office of Planning and Real Estate, in coordination with the Wexner Medical Center, that the university purchase the land; and

WHEREAS funds for the acquisition will be provided by the Wexner Medical Center:

NOW THEREFORE

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

BE IT FURTHER RESOLVED, That the president and/or senior vice president for Business and Finance be authorized to take any action required to effect the sale of the property and to negotiate a purchase contract containing terms and conditions deemed to be in the best interest of the university.

APPROVAL FOR PURCHASE OF UNIMPROVED REAL PROPERTY
SAWMILL PARKWAY AND HOME ROAD
LIBERTY TOWNSHIP, DELAWARE COUNTY, OHIO

Background

The Ohio State University's Wexner Medical Center (WMC) seeks to acquire vacant land for the development of additional ambulatory care facilities in Delaware County, Ohio. Acquisition of this land is important in meeting the objectives of WMC's ambulatory care strategy, which is in turn a key component of the WMC Strategic Plan and its mission to improve health in Ohio and across the world through innovation in research, education and patient care.

Location and Description

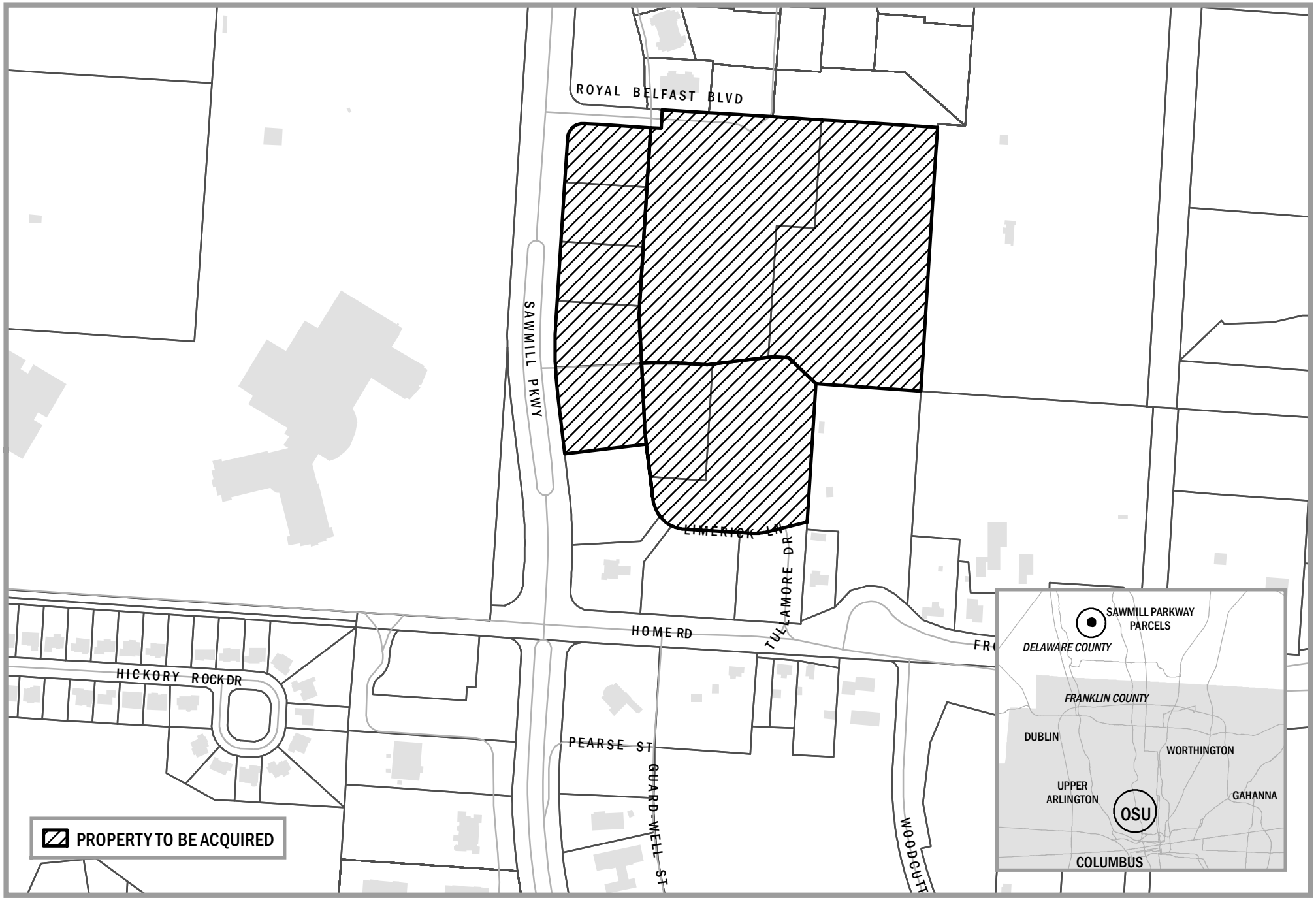
The subject property is located in Liberty Township, Ohio, and is part of the Golf Village North development. It is well located at the northeast corner of the intersection of Sawmill Parkway and Home Road, across from Olentangy Liberty High School, and is surrounded by additional school improvements, a few retail structures and residential subdivisions. The subject includes seven parcels totaling approximately 29.56 developable acres. The site is zoned PC (Planned Commercial District). Because zoning changes may be required in order to allow the planned use, the seller has agreed that the purchase contract will be contingent upon obtaining the necessary entitlements to allow medical facilities.

Property History

The property is currently owned by Golf Village North LLC, and will be acquired in the name of the state of Ohio for the benefit of The Ohio State University.

Purchase of Property

WMC recommends that the +/- 29.56 acres of unimproved real property described above be acquired on terms and conditions that are in the best interest of the university. The source of funding for the acquisition and subsequent development of the property will be the Wexner Medical Center. The acquisition price is $8,000,000, subject to appropriate adjustments and prorations at closing.



THE OHIO STATE UNIVERSITY

SAWMILL PARKWAY ACQUISITION SITE
SAWMILL PKWY & HOME RD
DELAWARE COUNTY, OHIO

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