THE OHIO STATE UNIVERSITY

OFFICIAL PROCEEDINGS OF THE

ELEVENTH MEETING OF THE

WEXNER MEDICAL CENTER BOARD

Columbus, Ohio, April 8, 2015

The Wexner Medical Center Board met on Wednesday, April 8 at the Richard M. Ross Heart Hospital, Columbus, Ohio, pursuant to adjournment.

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Minutes of the last meeting were approved.

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Ms. Link called the meeting of the Wexner Medical Center Board to order on Wednesday, April 8, 2015 at 10:05am.

Present: Leslie A. Wexner, Chairman, Janet B. Reid, William G. Jurgensen, Cheryl L. Krueger, Abigail S. Wexner, Corbett A. Price, David B. Fischer, Stephen D. Steinour, John F. Wolfe, Jeffrey Wadsworth, Michael V. Drake, Sheldon M. Retchin, Geoffrey S. Chatas, E. Christopher Ellison, and Michael A. Caligiuri.

Ms. Link:

Good morning, we are going to convene the meeting of the Wexner Medical Center Board. A quorum is present.

The minutes of the January meeting were distributed to all members of the board and if there are no additions or corrections, the minutes are approved as distributed.

First, we're going to hear from Dr. Sheldon Retchin for the CEO update and the Medical Center Initiatives Scorecard.

Dr. Retchin:

Good morning. If you'll turn behind the tab labeled "CEO Update" in your board books, I'll walk through the scorecard, in terms of year to date actuals and against targets.

You'll see a lot of green and some red.

The first row is inpatient mortality. This is an adjusted figure, I'm sure as most of you know, observed over expected. The methodology on the expected takes into account, as it should, the severity of illness and comes up with an expected figure. You want an index less than one, that is, that the observed mortality is less than the expected. In fact, The Ohio State University Wexner Medical Center is in the top three in the University Health System Consortium, which is a consortium of about 125 academic health centers in the country. This is a point of great pride and I think reflects the outstanding care delivered at the medical center.

The second piece of the scorecard is inpatient satisfaction, more broadly would be labeled patient experience. As you can see, there is some red there. We have set some very ambitious targets, as you'd expect that we would. In the first row is the inpatient HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) which is the consumer assessment hospital performance survey that has been in place for about the last 15 to 20 years. I was actually on the original technical advisory panel that came up with HCAHPS.

You can see that our goal is to be in the top decile and we have fallen short of that. That is the bad news. The good news is that over the last couple of months, we have achieved higher than that. We are in the top decile in terms of performance. Seventy-nine percent of those surveyed, who have had an inpatient experience, would have scored us nine or 10 on a 10-point scale. This is a very ambitious target and the good news is that we are now in the top decile over the last two months. Remember, we look back on a rolling average of 12 months. If you were to do that and then extend it back over the last three years, the trajectory has been inexorably going up, which is good news. I am pretty confident, in talking to my colleagues that we are on the right track there.

The second one is the outpatient, physician office, patient experience, and satisfaction survey. There we have an even more ambitious target. Here, I think, reflects a lot of variation. We are not there in terms of where we need to be, which is in terms of satisfaction with the experience in the outpatient setting. There is a lot of effort on that. I think that we call these coffee meetings?

Dr. Thomas:

Coffee conversations.

Dr. Retchin:

Coffee conversations. I knew it was something that had a dialogue to it.

There is a great effort here to follow up on those, such as following up on test results after seeing a doctor. I am pleased with the results but the target remains. We are not changing the target which is to be a high performer.

On the *U.S. News and World Reports* Best Hospitals in terms of specialties ranked and the number of specialties in the top 20, you can see where our targets are, and where we've been in terms of FY14. I believe these reports come out in July. The data is pending in terms of where we will be, but you can see our targets are also ambitious to be ranked in 11 specialties and have six in the top 20. That is a very ambitious target.

Going down to financial viability. We will go into this in a little more detail in Mr. Geier's report but you can see our balance sheet is moving in the right direction, better than target, with about 81 days in cash and the physicians group with 56 days in cash. Both beating target and approaching the target for FY19.

Revenue enhancement and scale; in terms of where we are at, looking at both revenues and expenses, as well as development. First on revenue, you can see that we are beating the target for per adjusted admission or discharge. Our target was $20,484. We are at $21,415. This is a very healthy performance. We will go into that later.

We are not meeting target with the development dollars but we have a lot of opportunity out there. There are a number of gifts in the pipeline at the modest and higher levels; about $250,000 and $1,000,000 respectively. We are cautiously optimistic. Patty Hill-Callahan is here to answer any questions if the Board has any.

Mrs. Wexner:

Sheldon, can I go back to the days cash on hand? Is FY15's target of 72 days below where we were this last year?

Dr. Retchin:

That is a good question. If you look back, we were at 69 days at the end of FY14 and the target was to go up three days. I think that's been a target for the last several years. Geoff or Pete.

Mr. Geier:

Yes, that is right. The 72 would be the budget essentially for FY15, the current year we are in, three days growth over last year, and we are at 80 days; close to 81 days actually.

Mrs. Wexner:

Against our target of 72?

Mr. Geier:

Against the target of budget for 72, right.

Mr. Wexner:

And a day is how much?

Mr. Geier:

About $4 to $5 million. It's growing because the depreciation and interest is now hitting the income statement. It is about $5 million.

Mr. Price:

Yes, but that is very anemic. I don't think we should fool ourselves.

President Drake:

It is anemic but it is rising rapidly.

Mr. Geier:

And as a point, it is now at 82 days as of the end of March.

Mrs. Wexner:

Are we readjusting the FY19 target then?

Mr. Geier:

Yes. We are going to have to readjust the budget and the target for five years out. This will all be part of the budget discussion. We have to reset that simply because, as you see, we've beat it and by a big margin.

Mrs. Wexner:

Ballpark, what would you guess that target would go up to?

Mr. Geier:

In 2015?

Mrs. Wexner:

In your FY19 target.

Mr. Geier:

Five years out.

President Drake:

Let me make a statement before Pete answers. It is a complicated question. One would be what trajectory we might hit if we are trying to budget and what we could do if we were maximizing days of cash. The other would be to decide what number of days of cash was healthy and how we should modify that.

Forgive me for interrupting, Pete.

Mr. Jurgensen:

No one has ever made an argument that this is the right number. No one has ever made an argument that we want it this low. We've consistently and all agreed that it needs to be significantly higher. We need to be realistic about the four or five things that keep us getting there faster rather than slower.

Mr. Chatas:

I will add that we need to look holistically at the College of Medicine and the physician practices. This is just one piece of the puzzle that we all talk about. To talk about days cash on hand when you're having an issue somewhere else needs to be analyzed.

Mr. Geier:

I think that is a good point. We will need to get in there with the finance committee and on the budget with this whole discussion of cash because it is not just what do we want the target to be. The cash we are spending on routine annual capital, which we talked about before, is probably not where is should be in terms of the depreciation numbers. This has to be gutted out. What is the right number or where do we want it to go?

Mr. Jurgensen:

Where directionally, we all agree, needs to be higher and we know why it would be better if it were.

Dr. Retchin:

Are any questions on the development? Thank you for that question.

Patty, do you have any comments?

Ms. Hill-Callahan:

There are $22 million of verbal commitments that are in the pipeline and are not documented. The scorecard next month and for the next two months will look really different.

The activity is up, but it's not reflected due to the timing of documentation.

Dr. Retchin:

The next row on the scorecard is expense and cost management. In terms of expenditures, this is on an adjusted admission basis. This takes into account both inpatient and outpatient costs in a consolidated way and then adjusted over, I think, about 105,000 of adjusted admissions.

If you look at that, we are ahead of the target of $18,792 per adjusted admission; now resting around $18,600. That really doesn't tell the entire story because there is a wide variation, but on a consolidated basis with 105,000, we are beating target.

Mr. Wexner:

I wanted to change some things and probably look to Geoff. On the cash of the whole medical center, Abigail was asking the right question. Knowing what has happened is not unimportant, but if we're projecting cash at the end of this fiscal year and next fiscal year, what would it be; looking at the current trajectory in days and dollars?

I am talking about in terms of reporting. The university should want to know, not where we are, but where we are estimating out 12 months. If we're in decline, that would be good to know in the here and now, but

how deep is it going to look a year from now? I think if we're on the acceleration, what does it look like, close enough for government purpose? It would seem to me on this acceleration, if I only look at this number, I would guess that it is not impossible that about 12 to 18 months from now, the cash would be about 100 days or about $500 million.

Mr. Chatas:

It could be if you take the trajectory of the same.

Mr. Wexner:

Well we could argue why we wouldn't keep the same trajectory.

Mr. Chatas:

This is why I would encourage you to think about that grid with the College of Medicine and the health systems. You have these questions on how much depreciation you would spend, how much you want to invest?

Mr. Wexner:

I understand accounting and I understand the cash. Cash is real money and depreciation isn't, and why you have those things. I think it would be useful for the board to start thinking about not what has happened, because we've been following the elephant, I want to get ahead. When we're looking at days of cash, if it were down, we would raise all kinds of questions.

If we are on the ascendency, I'd like a look forward because that informs our thinking. The next 12 months will happen very rapidly. I think the board should be sensitive to all the things that contribute but I want to get into more of the, this is what was, this is, and this is where we are going towards.

Dr. Retchin:

Just a comment, Les on that, and maybe Geoff, Pete, you guys chime in. You can get to a cash balance that could be 100 days or it could be 60 days. At the end of the day, looking at the net change in your assets really depends on where we go with competing needs. Medical center investments and then CAPEX (capital expenditure). Depreciation is depreciation.

Mr. Chatas:

I meant CAPEX as a proxy for how much are you going to reinvest back into your plant.

Dr. Retchin:

That's it. You can always freeze capital and you can improve.

Mr. Wexner:

I'm agreeing with that. I want to get into a discussion later with some other things in capital expenditures and things we have looked at in facilities. I am expanding the time span of our look. We know our current. What does the future look like? You want to roll all of this stuff up; you've got to look at CAPEX and you have to look at expenses. If I don't know what the CAPEX is, then I can't get to a future projection. If everything is falling rapidly, then I care much less about the future and more about the past.

If we are going to move forward we have to be more aligned in understanding what was, what is, and what's going to happen, let's say, in an 18 month cycle, and really know what is going to happen in an 18 month cycle. I have been reflecting on some of our meetings. We are approving things that essentially

are already approved. We're approving something, an agreement was made for a facility in Arlington that wasn't in the plan, at least at a Board level, and we are discussing it in real time, not looking out. I could believe a five year projection but if I've got $100 million or $200 million of CAPEX that kind of wanders onto the table for immediate approval but was never in the CAPEX plan, I don't believe anything.

Mr. Chatas:

You may remember, Abigail, you pointed this out at one of the first meetings. When we looked at a five year plan and said we're going to hold the medical center investment flat, you asked how can that be?

There are all these variables and levers that have to be.

Mr. Wexner:

We can make tradeoffs between expenses and depreciation. I'm just pushing harder to get into a more thoughtful future state because us knowing what happened to the elephants doesn't help us much. We don't, as a board, add much value.

Dr. Retchin:

I think that is a very rich discussion and I certainly agree with all of the remarks. Are there any other questions on the expense or the expense management? It's been a successful year and I congratulate those who have spent a lot of time, by the way, trying to trim back expenses. I will talk a little bit more about that later.

On extramural funding, you can see that the arrow is red. I can talk a little bit more about that. The target is $97 million, which is actually below last year. The target was set at that because of the federal spending levels being contracted both with sequestration and other efforts at the federal level. You can see that today, through the end of January actually, we are about $48 million.

Investigating that, there are a variety of drivers. There are some successes with different agencies. The sort of target date, year to date, can often lag. A lot of awards are given in the last part of a fiscal year. I am cautiously optimistic that we will still get to target but today we are behind target.

Dr. Wadsworth:

Sheldon, could I ask a question about the NIH? Does that really mean all research funding? Are there other places?

Dr. Retchin:

No, that's "bell weather" but it is a good point Jeff. No, it does not include, for example, industry. It only includes the NIH, it doesn't include NSF, DOD, or any of the other sources. Many academic health centers, appropriately so, have been looking at other sources. The cancer center has been getting awards. In fact, I saw one this morning for radiation biology from the DOD that would not have counted towards this.

Dr. Wadsworth:

It might be interesting to know what the total is.

Ms. Marsh:

If you add all external funding sources, it is $124 million.

Dr. Wadsworth:

Ok, thank you.

Dr. Retchin:

Congratulations by the way. That was great news on the radiation biology award, and those are not frequent. It's an area of research that often is not rewarded.

You can see that the *U.S. News and World Report* on the medical school list, that ranking is actually on research, and we are at 31; target was 33. I want to actually congratulate my predecessor. I'd love to take credit for great news. You know what, I will take credit. Thanks for being here Steve.

On talent management, you can see, the data on the engagement surveys are still to be reported.

That is my report Mr. Chairman.

Mr. Wexner:

Thank you. Any questions or comments? Pete.

Mr. Geier:

This is the financial report through February, some of which we have covered. I will go into a little bit more detail.

This is for the consolidated hospital system through February. We have not completely closed March; however, from what I have seen so far, March will be another good month. I think these trends will continue and given the earlier discussion, we are going to be redoing even our forecast for the rest of this year. We are early into the budgeting process but March will be, I think, another solid month.

Admission volume, you can see we are on target, above budget: James Cancer Hospital and University Hospital East Hospitals are having a very strong year; University Hospital (UH) and Ross are basically on budget; Harding is a little small, about 200 admissions under budget. I think we have talked about this issue before in terms of what we are seeing at Harding with the Medicaid expansion. You will see much more acute patients who can now get psychiatric care. Previously they couldn't. The length of stay had been up about a day in Harding, although they are working to get it down, but beds are full so admissions are down.

Surgical volume, we're up. Inpatient is basically flat; that is about 10,000 surgeries. Our outpatient is about 16,000 and that is continuing in double digit growth which we expect to continue for the rest of the year and into next year. Outpatient visits are really strong across the board at University Hospitals; about 9.5% over budget, the James 6.5%. That trend is continuing with all of our sites.

The ED (emergency department) is off a little bit. To give you some context to size, the emergency department visits of about 80,000 about 45,000 are at this hospital and about 35,000 are at University Hospital East. They're actually over budget. With the opening of the full ED opening last night, we've raised this issue of diverts before, I think we are hopeful, and Andy maybe you want to comment on this, I think we have been doing a better job of getting people in. Now we have opened the full ED. We did renovations on the old one. The full 100 bays, as of 4:00 am, are all open. We expect to see that improve and will be watching that one closely.

Dr. Retchin talked a lot about the ratios on operating revenue per adjusted admission.

Mr. Wexner:

On the ED, there is probably a professional term, but do we look at what I'd call the back-up? If you've got 100 bays in emergency room, I can fill them all and not be able to clear them because I don't have hospital beds.

Mr. Geier:

Yes, that is monitored every morning, every day, and there are a lot of metrics we track in the ED: time to bed placement, which is when the time you are in there; left without being seen, that is another ratio we watch quite closely.

Andy, you manage this whole process for us.

Dr. Thomas:

Yes, thank you Pete. If you were to look, Mr. Wexner, back in October or November, we were averaging on weekdays between 12 and 14 patients a night that spent the night in the emergency department waiting for a bed in either UH or the James. At the end of March it was 3. By the expansion that we did in August and the other expansion upstairs in December with the opening of the new hospital, we have already brought that number down. The next step of the opening will be the 20 plus additional bays in the ED today, which will be the next step in making sure that we are not backing up in the waiting room.

Dr. Retchin:

Will TeleTracking influence that and do you want to?

Dr. Thomas:

TeleTracking should influence that. TeleTracking is a system that we purchased and will make live in October. It is essentially an add-on to our electronic medical record which makes the bed placement process more efficient. It allows us to have a better real time view of what beds are open and what beds are going to come open later in the day.

It will add to the efficiency part of the time it takes to place a patient. But, if there are no beds open, there are no beds open. In UH this morning, we had zero step down beds, zero surgical beds, and one medical bed open for the entire hospital. We are adding beds.

President Drake:

Critical beds versus med/surg (medical surgical) beds; when we have the backup, which is the cause?

Dr. Thomas:

At this point, it is not typically critical care beds because we've added new beds with the tower expansion. For example in the medical ICU (intensive care unit), we had 35 total medical ICU beds before the opening of the expansion and now we are up to 46. Typically it is step down right now and have with nursing, recruited some additional beds to be open over the next six to eight weeks. We have already opened 16 new medical, med/surg beds, the lowest level of acute care, in January.

Dr. Retchin:

The only other thing I will add is, in essence from a business standpoint, there is always tension trying to balance your inventory or supply with demand. You don't want to over supply because then you have staffed up for patients that never come. On the other hand you don't want to leave people in the emergency room without a bed.

Dr. Thomas:

Yes. We budget to be 85% off, it's the average throughout the week. Our goal is closer to 90%, it is just a little bit above that.

To your point, Dr. Retchin, it is hard when you have semi-private rooms to manage gender and also with patients who need isolation for infection. Sometimes that will close a bed. By this time next year we will be moving to all private rooms with brain and spine opening in the University Hospital and that will help that issue as well.

Mr. Wexner:

We don't have to discuss it now but I am curious to understand that flow. It is a simple model. If we had all the emergency room beds filled, for whatever reason, then probably emergency patients would be diverted to other hospitals.

Dr. Thomas:

Correct.

Mr. Wexner:

Ok, how are we doing with 100 beds and clearing them? What I think I am hearing you say is you'd like to have about 10 slots always open. You can't predict with great accuracy, or maybe you can. You want to have the capacity, let's say within reason, to always have space for emergency patients. That would be a good thing because that would just be a good thing.

Dr. Thomas:

Yes. There are actually intraday peaks as well. From about 11:00 am until about 11:00 pm, is a much different number than from 11:00 pm to 11:00 am. We built the new ED with enough treatment bays based on our projected need from five years ago. We think we have about the right number now open today.

Mr. Wexner:

You know what I am looking for is for us to watch that, you to watch it. In terms of the ED, we estimated it five years ago and it looks like it works, let's say today.

Three months from now, what would we then think because this is the feeder for the whole hospital? We might have it exactly right or be short 10 beds.

Dr. Thomas:

We will know much more, I would say, in the next six to eight weeks.

Mr. Wexner:

That is what I am getting at. Exactly.

Dr. Retchin:

Andy there is one other element of that, receivables. You have beds that you know are going to open but they don't open soon enough in the day or they go over to another day only because we couldn't discharge them before 9:00 am. That is another effort, a big variable. I don't know what percent of orders are written before 9:00 am for discharge.

Dr. Thomas:

It is a little bit like a hotel problem; getting your people out early in the morning to get the next admission in. We've had a targeted early discharge project focused mainly on the Department of Internal Medicine and with the Department of Internal Medicine leadership.

Dr. Moffitt-Bruce:

The last metric showed that we are at 39% with orders being put in before 10:00 am and we know that it takes them two hours to depart. The majority of our patients are leaving later in the afternoon which means we are then bedding them later.

That is up from 10% and we are continuing to work on that.

Dr. Retchin:

The lower length of stay will enable us to take care of some of this?

Dr. Moffitt-Bruce:

Right. Measuring that is making sure that the length of stay and admission rate isn't affected by targeted discharge process as well.

President Drake:

I want to say a word for those who don't practice medicine in the room and don't live in this world.

The concept is that the backup tends to be in the hospital where there is not a place to put people who come into the emergency room. It's not that the emergency room is overflowing and can't do things. Once a patient is there you can't get the patient to a bed in the hospital. Those are in two categories, either critical care beds or regular stepdown and med/surg beds in the hospital.

When the ED closes often times you go to divert. Not because there's not room in the emergency room, because there's not room in the hospital in case you happen to get a critical care patient into the hospital. Managing the flow through the emergency department depends on having space in the hospital to take care of patients when they come in. Whatever their condition happens to be is one thing. What we're speaking of now is when we know that a patient is going home tomorrow. Tomorrow is either 10:00 am in the morning tomorrow or 5:00 pm in the afternoon. That makes a big difference because if it is 5:00 pm in the afternoon and you're going home, that bed is still not available.

One of the levers that we have to pull is how accurately we anticipate a discharge and to make that bed available so that the flow through the emergency room happens in a way that keeps that fluid. The good news is that this is manageable and is something that we can address. If it is critical beds for instance, that's a big expenditure because you have to build those or you can't do anything much with them and that's very expensive. If it is things like we're speaking of now, getting the discharge orders written sooner or getting the patients who we know are going home today out of the hospital an hour earlier, that then opens your capacity and allows things to flow through much better.

Dr. Thomas:

You are exactly right Dr. Drake. The key thing is the messaging to assure residents and faculty that the goal is not to get 100 patients out by noon, because then that patient can get a test back at 3:00 pm that says the patient can go home and the last thing you want someone to do is to incentivize them to keep them overnight because that is a real problem. You want people to get out once you have the information that says they are able to be discharged safely. That is why we set reasonable goals that aren't 100% but they are not 10% either.

Dr. Moffitt-Bruce:

The whole value stream has to be looked at because we're dependent on the facilities taking in patients on a timely fashion which depends on getting the insurance approved, as you know, and having the tests back before 10:00 am. We are working on all different kinds of different issues.

Ms. Marsh:

I don't want to drag this out but I will add one more dimension. We have over 20 outlying hospitals across Ohio sending us patients every day and they are vying for the same beds that our patients coming through the emergency department are vying for.

Dr. Thomas:

We track that as well, in terms of patients that are pending admission from another hospital.

Mr. Wexner:

Great example of teaming. The three of you can finish each other's sentences.

Dr. Thomas:

We spend a lot of time in the same room.

Mr. Wexner:

That's great.

Dr. Caligiuri:

I would like to add that we completed the opening of the James Cancer Hospital beds. We have 306 beds all open now as of last week. We have a little more capacity.

Mr. Wexner:

How does your backup look?

Dr. Caligiuri:

Same system. The ED that was opened at 4:00 am this morning is the cancer ED, which is part of the bigger ED and works in the same system. When we are full, they will go to UH hospital who have beds there.

Mr. Wexner:

The pressure is off; you have capacity?

Dr. Caligiuri:

We have just opened all 306 beds so there is a little pressure off, but the point of length of stay should be reemphasized; efficiency is key.

Mr. Steinour:

Mike, does that imply the top floors?

Dr. Caligiuri:

We still have a floor and a half to build out to 72 beds. That is still there but we're now fully staffed at all 306 beds.

Mr. Steinour:

Thank you.

Mr. Wexner:

We are going to talk about that later.

Mr. Geier:

Just wrapping up the financial report. The operating revenue and rates, you can see, were up over last year.

We're under budget; $10 million on expenses and about $26 million of that is in salary and benefits. Supplies are about $5 million. That's $31 million under budget but we're over in drug costs. This is an issue that we will talk about in the budget. We are actually over on depreciation and interest. That was the timing of bringing the building on. Expenses are under budget by $10 million.

The year over year increase of $48 million is, basically salaries, benefits, and supplies being all flat, drug costs are up $23 million, depreciation is up $12 million and interest is up $8 million. That is the bulk of the growth and the expenses. We will get into some of these discussions when we start talking about some of the budget issues for next year.

Dropping down to the margins. You see the operating EBIDA and days cash; we've talked about that. At the end of March they will close the cash books. That'll be 82 days and I am actually relooking to forecast for the end of this fiscal year at June 30th where we think we will end up. I originally thought it would be 80, as I reported, but we're above that now. I will have a report on that at the next board meeting. You can see debt service coverage is well within our tolerances. So far, good year. March looks like it is going to continue with pretty much the same trend.

Mr. Wexner:

What do you think it will be at year end?

Mr. Geier:

I think it will probably be closer to 85 if the trend continues that we are seeing for the remainder of the year.

We typically have some big cash transfers at the end of the fiscal year, some for departmental transfers and medical center investments. I think we will be close to that if we are at 82 now.

Ms. Krueger:

Pete, I have a question. Where it says excess revenue over expenses and looking at the gain from operations, why, if compared to budget, is there a big delta there? What is driving that?

Mr. Geier:

Are you looking at the gain over the budget?

Ms. Krueger:

Yes. Budget was our best thinking at the time but I am curious as to where the consistency is?

Mr. Geier:

If we go back to the discussions we had a year ago looking at the budget, I think we were all concerned and worried. I think at the time I said it was the budget I had the least confidence in putting together for two big reasons. One was the opening of the new hospital. It was a huge unknown, we were very cautious. I think we had a lot of discussions with this board about the volumes.

We were conservative. We weren't sure what the volumes would hold and how fast the backfill would go. We have exceeded that. At that time we had some new surgeons coming on. There is always hesitancy when the recruits of new surgeons come on and how fast they will ramp up. I think many of them have exceeded our expectations so that all has translated into greater volume than we had in the budget.

Second. We were into a lot of the OEE (operational efficiency and effectiveness) work on cost and cost control; particularly around the supply chain and staffing. Again, we were early with that and we didn't lay a lot of that into the budget and count on the cost savings and we've realized that. I think that has created the delta from our thinking of a year ago. The gain of our operations and all the hospitals are doing well.

Dr. Drake:

I have a really good news story of several things working better, but also many people working very hard.

A year ago would have been the first meeting that I was aware of, on the phone, I was nearby. Pete, you and several others began to work earnestly on cost controls at that time, looking at what might be possible. That, with a better onboarding of James Cancer Hospital than we would have necessarily predicted, and people working really hard made the top line better and the expenses go down at a faster rate than might have been predicted. I think that is really reflective of a lot of hard work by a lot of people. Congratulations on that.

Ms. Krueger:

Yes, I am not being critical, I was just curious as to what strung it.

Mr. Wexner:

I bet you, or Geoff, or Tim, somebody would remember. Let's say about two years ago, which was about the time the Wexner Medical Center Board was created, from memory, the cash would have been about 60 days at about $4 million a day. It would have been about $250 million and now we're looking at $425 million.

Mr. Geier:

Roughly, yes, that's about right.

Mr. Wexner:

About 18 months. I don't think that the non-professional members of this board can take credit for that except it did happen on our watch. If it had gone otherwise, I would have taken the blame.

Mr. Jurgensen:

The balance sheet two years ago versus today's balance sheets are a little different too. What we need from a liquidity point of view, which to me is the most important part of this whole dialogue, around cash on hand.

It's not some number that has some magic to it. It's a liquidity issue. Our assets are up a bunch, our debt is up a bunch, the volumes are up a bunch, and all that's going to cause, what this needs to be over time, to move and move up.

Mr. Wexner:

I won't debate that versus equity. Jerry ran an insurance company and I sell underpants so we have very different viewpoints about debt and equity. I count cash. Cash is king. I think people that loan people money for 100 years are stupid. If anybody would like to loan the medical center money for 100 years, I'd take a billion or two. God bless them.

The point is we have a responsibility for watching liquidity. It wasn't that long ago that the board of the university was concerned because we didn't think we had any days of cash. In fact, I think we had no days of cash. We have come a long way.

I am being celebrative of these important milestones. We have some liquidity, we also have some income, and this year we have record income, by a whole lot.

Mr. Geier:

To put another point on that, if you look at the prior year, we were sitting here at this time at 64 days and we will likely end this fiscal year at least 20 days higher than that in a year.

Mr. Chatas:

Just to complicate things, the health system is owned by the university. As an example, we work with Moody's every quarter to monitor liquidity in whole for the university and the health system. As long as they are combined, the trajectory across both over that same 18 months, has been quite strong in terms of overall metrics.

Yes, we are borrowing more but our financial health in total is stronger. We have, I think, about a $1.8 – $2 billion of liquidity at the university which includes this cash as part of that bigger amount. We can certainly get into that but it's part of a broader narrative that we all need to discuss.

Mr. Geier:

That completes my report.

Mr. Wexner:

Questions, comments?

Let's talk about real medicine, Dr. Kaeding. Chris and I just met so I am a fan.

Dr. Kaeding:

For better or worse…

Mr. Jurgensen:

It's probably for the best you haven't met him before because when you do meet him it means something isn't working right.

Dr. Kaeding:

I say for better or worse, I have met quite a few people in this room. Hopefully now, for the better.

Thank you for the opportunity to talk to you about sports medicine, a topic near and dear to my heart. It is what I am passionate about and gets me out of bed every morning.

I want to introduce a couple of people who work closely with me in building the sports medicine program, Garth Dahdah, Tom Caldwell, and Dan Like. I want to thank them for all of their efforts and the success we've had the last several years.

What is sports medicine? The traditional definition is taking care of athletes. Here at Ohio State, we've expanded that definition and this is reflected by our mission statement. Our mission is to improve people's lives by enhancing physical activity across the lifespan. If you think about that statement, whether you're a junior high or high school athlete who is trying to avoid an injury, we want to be leaders and help that happen. If you've been unfortunate and had an injury, we want you to recover from that injury and we want you to recover to as high a level as quickly as possible.

If you're a team that wants to deal with certain issues about anything from drug testing, et cetera, we have the expertise to help you with this. If you're an aging athlete, you're someone who has always enjoyed being active, you're getting older and now you're starting to have aches and pains of age, we are there to help you. In fact, that is our largest demographic. At the OSU Sports Medicine Center, the biggest population we see are baby boomers who, many are in this room, want to stay active. They are having some of these issues and we are here to help them stay active.

OSU Sports Medicine is not just about that elite athlete. In fact, these baby boomers, you could argue, are the first generation that a large percentage of them refuses to just settle down and sit in a rocking chair as they age.

It used to be 100 years ago, when you turned 60, you can't walk and would sit in your rocking chair on the porch. The baby boomers want to stay active and we want to help them stay active for lots of different reasons: helps them enjoy life and they stay healthier, and it's good for their general health. We like to say, whatever the problem, whatever your age, we want to help keep you active. This is what OSU Sports Medicine is about.

What is our model? If that's our mission, how are we going to achieve that model? How do we make that happen? If there's one thing Ohio State is, it's large. A benefit of being large is the breadth of expertise. Ohio State has an expert in essentially everything. We may not have the expert but we have an expert in just about anything and everything.

In a field that is as broadly defined as we do for sports medicine, why don't we take advantage of the breadth of expertise of Ohio State and bring all these different disciplines together under one umbrella of OSU Sports Medicine? That is what we've done. I like to use the term, we are an integrated, multi-disciplinary, multi-mission program.

Multi-disciplinary, that's all these different disciplines you can see listed here in the slide. Multi-mission meaning clinical care, research, education, performance, and service to the community. We are bringing all those together in an integrated fashion.

Now, we've taken that concept even lower. We don't want these different disciplines to function in many silos within this comprehensive center. We have developed these multi-disciplinary teams, I'll call them

specialty programs. For example, in our performing arts program; we work with BalletMet and we work with the School of Dance here at Ohio State. We have athletic trainers, physical therapists, and physicians who all work together to work with our dancers. We are starting to work with the musicians.

Our endurance medicine team, his is cyclers, swimmers, runners, and again, athletic trainers, physical therapists, surgeons, non-operative physicians, bio mechanists, all working together to become experts in that area to maximize our care of the athlete. It also lends itself to prospective data collection and allows us to do research and helps us also couple with industry. When a running company, wants to talk to someone about looking at a product, they can come to Ohio State and talk to our endurance medicine team. We have everyone from surgeons to non-surgeons to biomed and PhDs who understand swimmers, bikers, and runners.

Within that, you can have a bike fitting, a bike analysis, you can have a gait running analysis. In the new building we hope to be able to do swim stroke analysis. Again, this multi-disciplinary specialty team is at OSU Sports Medicine.

This has led to us to develop these collaborations within the university.

The College of the Arts. I've talked about the School of Dance we work with, the School of Dance and BalletMet overlap quite a bit. We are starting to work with the School of Music. You may ask what music has to do with sports medicine. To perform in today's society, takes a lot of repetition, and with repetition, you get overuse injuries. Musicians have the same thing. They put their body in a certain position and they do the same movements over and over again and they get the tendinitis and overuse injuries that we also get with the other athletes. They have reached out to us and we have physical therapists going to the Schools of Dance and Music, interacting with them.

The College of Education and Human Ecology: We are expanding our interaction with the exercise and then sports and nutrition.

Student life. We have been meeting with student life recently and expanding our interactions with the intermural program. We have upwards of 10,000 intermural club athletes at Ohio State. A lot of them participate in high risk sports for concussion: flag football, ice hockey, lacrosse, and rugby. I think the university recognizes there is some potential liability exposure with the fact that we have these students participating in these activities. They have approached us about how do we do some base line neurocognitive testing to provide care to make sure we are doing the right thing for these student-athletes, again, expanding into the student life arena.

These are some of our external partnerships. You can see in the top row, these are all entities that we interact with on the research side.

On the athletic side: We provide an athletic trainer to the USA rugby team. Rugby will be an Olympic sport in 2016. When you watch the USA Eagles, the USA rugby team, and the Olympics next year, the athletic trainer working with them is an OSU employee. We just came from their annual Rugby Sports Medicine conference, the only rugby conference in the country, and OSU is a major medical partner in that entity.

We are the medical providers to the Columbus Clippers, the AAA team for the Indians, the Ohio Machine, the professional lacrosse team in town, Capital University's athletics, Columbus State, the Columbus East Side Running Club, the Upper Arlington School District, Columbus City School's 17 high schools, several YMCAs that we have actually provided physical therapy at the YMCA; we do programmatic work with the Ys. We have quite a footprint, I think, in the Columbus Area.

Research collaborations: These are the two large programs that I, as an orthopedic surgeon, am involved in: the MOON (Multicenter Orthopaedic Outcomes Network) and MARS (Multicenter ACL Revision Study) cohorts. One is for primary ACL (Anterior Cruciate Ligament) reconstruction and one is for revision. They are the largest cohorts in the world that have 80% follow-up and they are the strongest outcomes

consortiums for looking at ligament reconstruction. My point is, Ohio State, was the leading clinical contributor to both of these.

If you look at MOON there are seven founding sites, under MARS there are 63. If you list the sites and who contributed patients to that consortium, Ohio State is number one in both of those. We are making an impression nationally.

Speaking of making an impression nationally, since 2011, these are significant awards OSU Sports Medicine has won, 15 national research awards. I would challenge any of the other peer groups across the country, I don't think Mayo Clinic, Pittsburgh, has won this number of awards in the last four years. We are making a splash nationally. People come up to me and say, Chris, what are you guys doing at Ohio State, it's unbelievable, you've got all this activity and growth. I am very proud of that.

Education: You can see our formal curricular program. We touch on many different disciplines at different levels.

Continuing education program: Again, we are active in the community. We work closely with the Ohio High School Athletic Association. Coaches have to have sports medicine training, we provide numerous, at many of these coaches conferences. We have four sports medicines grand rounds a year where we bring in a named, visiting professor nationally, to Ohio State. I don't know if any other Sports Medicine program in the country that does that many visiting grand rounds presentations every year.

We have five symposia every year. The Concussion Symposium was just last Friday. Last Friday was an interesting day for me. We had our Concussion Symposium, which was sold out, the Fire Department wouldn't let us put any more people in the room without violating fire code. We had a national visiting professor.

We were hosting the European travelling fellows. US does it, Europe does it, Pan-Asia does it, and South America; they have societies where they identify young, promising, sports medicine specialists and we have exchange programs. This year, Ohio State was selected as one of the five or six sites for both the South American and European traveling fellows. We were selected by our national society to be a showcase for what American sports medicine is all about. On Friday, we're hosting the European fellows, I was doing some overflow VIP type surgeries that had to get done and then we were hosting this concussion program, all on Friday and I thought, look how the program is growing, we have all these things going on simultaneously, I can't even be at all these different programs.

Patient care by the numbers: You can see just last year, we were just short of 90,000 physical therapy visits, just over 40,000 outpatient visits. Those 130,000 ambulatory visits and the surgeries were provided by and supported by just over 200 staff. When I assumed my current position about nine or 10 years ago, we had 13 employees of OSU Sports Medicine. Now we are up to 207.

I know Sheldon will ask, well are you making any money, but with that has come appropriate growth.

Mr. Wexner:

I will ask that question.

Dr. Retchin:

I am not a mercenary. I was following you all along Chris, until we got to that.

Dr. Kaeding:

Here are the numbers on research and education, you can see our research grant. We have just over $12 million in federal NIH type funding and just under $4 million in industry funding. Our fellowships in sports medicine continue to grow and we can touch on that in the next session.

We've done a nice job of being leaders in innovation and our marketing people have done a nice job. You can see, Tim Miller here at the bottom, had a nice exposure, national press, we had a lot of contacts and interviews with him. He devised a new technique for Achilles tendon repairs.

Dr. Flanagan, number two on that bullet point, my partner, has become a leader in ortho-biologics, cartilage restoration, how do we grow new cartilage people's knees.

Increasingly we have local and national press contact us, whatever the hot issue of the day is. In fact, we track those metrics. We track how many times we have media exposures and that's going up every year. Whatever the topic is, sometimes it is sickle cell, a concussion, heat exhaustion, hamstring injuries, and they need to interview an expert by the five o'clock news. We want them calling us and they are doing more of that. We have it set up that when they call, we find one of our experts to make sure we respond to them in a timely fashion.

Google Glass: We were fortunate enough, we were the very first people in the world to do a surgery using this Google Glass technology; that was about, 18 months ago. We had a huge media explosion on that. It went viral around the world; using this head mounted, hands free networking with the internet where you can send and receive audio and video back and forth, while you're doing surgery.

More recently, we were the first ones in the country to implant this plastic meniscus. In fact, we just had this media release, and this release, as of 5 o'clock yesterday, generated 1,529 emails.

(Video)

Mr. Wexner:

Chris, did you guys invent this thing? Do we have a patent?

Dr. Kaeding:

We did not invent it, which is obviously where we want to be. We were approached because we have a reputation for doing clinical trials. I will speak to that in the next session about our strategy moving forward.

They approached us, and I think Duke, and about four or five sites in the country to look into how effective the implant is. We were the first one to get someone enrolled in it and as a consequence we got a lot of media exposure on this. I just asked one of our clinical research associates yesterday, and he said as of five o'clock yesterday, we had received 1,529 emails from people around the country saying they saw the press release and want to come here; they have a knee that wants to be in this.

We had 239, I think, phone calls and we had over 100 new patients come in to be evaluated for this. Now unfortunately, this particular trial is so narrow, we actually only enrolled four more people, but four, for this particular trial, because the FDA defined it so narrowly, is actually a fairly big number. But my point is, it's very impressive how much exposure we got nationally and locally by being the clinical trial lead for this particular product.

Mr. Wexner:

In numbers, I'm just curious, the clinical trial is four, when would you anticipate the FDA would expand it?

Dr. Kaeding:

We just met last week at the orthopedic academy with the principle investigators in this and it does not look like they are going to expand indications for who we can put it in now for this particular trial. I am hoping this trail will be done, three to four years where the FDA will approve it for more common use. At that point, if this thing works as well as I think, it will really expand the population of who we can put it in.

Mr. Wexner:

So it's three years?

Dr. Kaeding:

Correct.

Dr. Wadsworth:

That was very interesting. I want to ask you about the strategic partnering with suppliers of new materials. It is a very competitive field developing new material for medical products and as you pointed out, the number of users is burgeoning. It is a very dynamic market of selling stints or knee joints. Is there a way to get a strategic partnership with a leading group to try and become the innovator as well as the first user?

Dr. Kaeding:

That is a very timely question, in fact, I was going to address that in our next session. That is part of our strategic planning.

We are excited about opening up the Jameson Crane Sports Medicine Institute next year. This will obviously be our hub for the collaboration between the clinicians, researchers, educators, and will help us leverage resources across the university and outside the university. We are very excited about the opening of the new building.

Dr. Retchin:

Chris, to build on what Jeff and Les said, do you know, in a new device like this, is there an opportunity to get some sort of an exclusive contract for a region over a series of years? I say that because as a beta test site, we did that with the artificial heart. We were going to introduce it but in exchange, contractually, we would want some sort of exclusivity. Do you know?

Dr. Kaeding:

Again, I think this goes to our strategic planning. I think partnering with industry is going to be key for us moving forward on a lot of different fronts and that is one of the ways we can partner and I think that is a possibility in question.

That is it for my public session presentation.

Mr. Wexner:

That's great, thank you Chris.

Ms. Link:

The board will now recess into executive session to consider business sensitive trade secret matters required to be kept confidential by Federal and State statutes and to discuss the purchase and sale of real property.

May I have a motion?

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

Attest:

Leslie H. Wexner	Heather Link
Chairman	Associate Secretary